PUBLIC MEETING

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

Thursday, September 26, 2019
9:30 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
CHARLES MILLIGAN, JD, MPH, Vice Chair
TRICIA BROOKS, MBA
MARTHA CARTER, DHSc, MBA, APRN, CNM
FREDERICK CERISE, MD, MPH
KISHA DAVIS, MD, MPH
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WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

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P R O C E E D I N G S

[9:30 a.m.]

CHAIR BELLA: Okay. If everyone could take their seats, we are going to get started, please.

Good morning. Welcome, everyone, to our September meeting. We are going to get started with a draft report on the oversight of IMDs, and Erin is going to kick us off. Thank you.

IMD ADDITIONAL INFO ACT: REVIEW OF DRAFT REPORT ON STATE OVERSIGHT OF INSTITUTIONS FOR MENTAL DISEASE (IMDs)

* MS. McMULLEN: Good morning. As Melanie said, today I'm going to present MACPAC's draft report on oversight of institutions for mental diseases, or IMDs.

Before I present the findings from our draft report, I'm just going to briefly discuss the details of our congressional mandate to conduct this study and how we've structured this report to be responsive to Congress' request.

So as a reminder, this is being done outside of our usual reporting cycle with our report to Congress due on January 1st. Per the SUPPORT Act, our report must address

the different items that are listed on this slide. I'm not going to go over these in detail now, but as I walk through the findings for the draft chapters you'll hear me kind of frequently mention, you know, this is a SUPPORT Act mandate, this is how we went about addressing it.

In carrying out this study, Congress also directed us to seek input from stakeholders. If determined appropriate by the Commission, the report may also include recommendations.

So in order to satisfy SUPPORT Act requirements, we conducted this study with three different components, which were presented to you at our April Commission meeting. In May of this year, we issued a request for public comment, inviting any interested stakeholder to submit comments to MACPAC on the relevant topics that were included in this study.

We sent the request for public comment out through our listserv and posted it on our website. We wound up getting responses from about 20 different individuals and organizations. That included managed care entities, state Medicaid agencies, beneficiary advocates, and provider associations. So the relevant feedback that we received

through that public comment period has been incorporated throughout the draft report.

The report has been divided up into five different chapters, and in conducting our study, Congress directed us to look at a selected group of states that represented a mix of managed care and fee-for-service. Throughout each chapter, we summarized findings from the same seven states. That's California, Colorado, Florida, Massachusetts, New Jersey, Ohio, and Texas. And the facility standards that we looked at in the various chapters include those related to both inpatient and residential mental health and substance use treatment facilities. We also looked at standards that apply to select outpatient behavioral health providers. We did that for a few reasons. Primarily, the Commission has expressed interest in looking at the whole continuum of care, not just IMD levels of care for behavioral health treatment.

Throughout the chapters, we also differentiate standards between those being applied to substance use treatment facilities and mental health treatment facilities. Where applicable, we also try to further differentiate between inpatient, residential, and

outpatient care.

Now I'm going to walk through the five chapters and some of our key findings.

The first chapter is really meant just to provide some context and history of the IMD exclusion and de-institutionalization, as well as the establishment of Medicaid. The chapter also summarizes the different payment mechanisms that can be used through the Medicaid program to make payments to IMDs.

The IMD exclusion has been in place since the inception of the Medicaid program, and it was established to assure that states, rather than the federal government, were responsible for funding inpatient psychiatric services. The prohibition was also established, due to changes in policy, clinical practice, and then public opinion around the institutionalization of people with mental health issues.

Despite the perception that the IMD exclusion precludes all Medicaid payment to these facilities, there are, in fact, multiple different ways that states can make payment to IMDs that are listed in the bottom half of this slide. If you look at these different authorities, across

all states, you can see that states are pretty much all using at least one authority to make payment to IMDs. Some states are even using up to three different authorities.

Moving on to Chapter 2, the SUPPORT Act required MACPAC to describe IMDs receiving Medicaid payment in selected states. That included identifying how many IMDs there were in each state and what sort of services they provide. For the purposes of doing that, we have separated the chapter into a section on substance use facilities and then mental health treatment facilities.

Overall, we found it challenging to come up with a complete census of IMDs in all seven states that were included in our study. In part, this stems from the fact that an IMD isn't one type of facilities. Rather, it could be an inpatient or residential facility that provides mental health or substance use treatment or, in some cases, both.

This particularly holds true for nursing facilities, where their designation as an IMD could change based on their patient mix and the number of patients there that need mental health services.

We wound up using two SAMHSA-administered surveys,

that I discussed in April, to identify the number of IMDs in each state, and the next few slides show some of the findings from the work we were able to do, using SAMHSA's data.

This graph here represents residential and inpatient substance use treatment facilities, and we looked at whether or not these facilities are providing medication-assisted treatment, or MAT. Generally, we found most IMDs that we identified through our study offer some form of MAT. In all seven states, we generally found that facilities were more likely to provide buprenorphine or naltrexone than methadone for the treatment of opioid use disorder.

The SUPPORT Act also charged us with identifying whether IMDs offered any sort of outpatient treatment, that is, if they have that continuum of care available onsite. This chart here, again, represents residential and inpatient substance use treatment facilities. For substance use treatment facilities, we found the majority of IMDs in California, Colorado, Massachusetts, and New Jersey did not offer any form of outpatient treatment.

And on the mental health side, we found some similar

variation in the offering of outpatient mental health services in inpatient psychiatric facilities and residential mental health facilities.

Over 40 percent of the facilities in Ohio, New Jersey, Florida, and Colorado offered no outpatient mental health care.

Moving on to Chapter 3, this is where the bulk of the report findings are. The SUPPORT Act required us to summarize state licensure requirements for institutions for mental diseases, and our key findings are captured on the next three slides.

I just want to remind you that in this chapter, throughout it, we talk about several different types of licensure categories -- inpatient, residential, and outpatient -- and we differentiate between mental health and substance use throughout.

As discussed at our April meeting, the federal oversight that applies to the majority of the nation's health care system through Medicare certification doesn't apply to many different types of facilities that are IMDs, including residential substance use treatment facilities and adult health residential facilities. As such, states

are the primary regulator for many types of facilities that may be considered IMDs.

We found that mental health and substance use treatment facilities were often regulated by multiple state agencies. Often the single-state substance use authority or mental health authority was involved in the regulation of these facilities.

We also found that states do not have licensure criteria specific to IMDs. Rather, states have separate licensure processes for facilities that offer residential substance use treatment or residential mental health care.

We also found that licensure standards for these facilities that may be considered IMDs, very considerably, both within and across states, and whether the facility provides mental health or substance use care. This variation extended to what sort of standards states adopted, but it also extended to the licensure process itself.

We did find a few commonalities across the different licensure categories that we looked at both within and across states. Generally, facilities have to conduct patient assessments and provide individualized treatment

planning as a condition of licensure. Usually state regulation also requires these facilities to provide certain types of services, like maybe individual or group counseling, but again, that varied by state.

The greatest variation we saw was standards related to staffing. This extended to whether facilities are required to meet certain staffing ratios or hire certain types of clinical professionals.

The SUPPORT Act also charged us with identifying how states determine licensure standards have been met. We found that outside of the initial and renewal licensure process, enforcement of state licensure standards is largely complaint based. Licensure standards, however, could be enforced through other mechanisms, depending on state law and regulation.

We did find that some states have the ability to assess penalties to providers who failed to meet licensure standards. Generally, most states require residential and inpatient providers to report certain incidents, such as a communicable disease outbreak or a patient death or injury, to the state. We also found that some state licensure agencies have the ability to waive certain licensure

requirements for facilities upon facility request.

Moving on to Chapter 4, the SUPPORT Act also asked us to summarize standards that IMDs must meet in order to receive Medicaid payment, and how states determine if those standards have been met. Throughout this chapter, we looked at standards that were established through Medicaid fee-for-service but also managed care.

The key findings of this chapter are on the next three slides. Generally, we found that the Medicaid provider enrollment process was the main mechanism through which states ensure providers meet Medicaid standards. This complements the licensure and accreditation process that are discussed earlier in the report. Typically, states outlined enforcement mechanisms and their provider agreements detail what would happen if a facility failed to meet Medicaid standards. And then if providers fail to enroll, they are not able to bill for Medicaid services.

We also found that some states applied different standards to providers that may be considered IMDs. This was either done by the state Medicaid agency, a managed care entity, or, in some instances, both. We found a number of instances where state Medicaid agencies applied

additional personnel requirements, maybe requiring additional staff at IMD facilities. We also found that all of the states we reviewed applied treatment planning requirements to one of the behavioral health facilities that we looked at through this study. We also found that managed care entities in all seven states, as well as the state on fee-for-service side, adopted discharge planning requirements, treatment planning, that sort of thing.

We also found that services that are delivered in these facilities have to be medically necessary, but how states and how their managed care entities define medical necessity varied somewhat.

Additional findings from this chapter are listed on this slide. I'm not going to go through all of them. I will just draw your attention to the first one. We spent a lot of time talking about Section 1115 demonstrations for substance use disorder. There were three states that we looked at through this study that had approved Section 1115 waivers, while we were conducting our analysis, and interviewees in all of those states noted that the standards that they were required to meet and that providers were required to meet as part of this waiver

really improved the quality of care within their treatment system. Some states also reported improved access to care.

And then Chapter 5 is the final chapter of our report. It summarizes protections for individuals with mental health and substance use disorders under the ADA. It also discusses the Mental Health Parity and Addiction Equity Act and summarizes additional state protections that are afforded to people with mental health and substance use disorders.

This chapter wasn't specifically required under the SUPPORT Act, but we felt like our analysis would not be completed, based on your feedback, if we didn't discuss patient protections for these facilities.

For the most part, patient rights are articulated in other federal statutes and state law. Federal and state patient protections for individuals with behavioral health conditions typically apply to all individuals, not just those enrolled in the Medicaid program. The ADA does prohibit discrimination against individuals with disabilities, including those with a mental health condition. However, it does offer more limited protections to individuals with a substance use disorder.

In addition, federal protection and advocacy systems that help ensure the ADA is enforced only apply to individuals with significant psychiatric disabilities.

And finally, the Mental Health Parity and Addiction Equity Act -- this isn't something we've really talked a lot about here, but it came up a great deal when we were interviewing state-level interviewees. Parity requires Medicaid managed care entities and state Medicaid programs to treat services for behavioral health conditions equitably when compared to medical and surgical benefits.

One of the themes that we heard through our public comment period, as well as through interviewing stakeholders, was that limitations under the managed care rule, which allows managed care entities to pay for 15-day stays in IMDs, as well as stay limits on average length of stay in IMD facilities, under Section 1115 demonstrations, were at odds with parity.

So that summarizes all five of the chapters. I look forward to your discussion on this. It would be really helpful to hear if you feel like we're highlighting the right things and the overall tone of the report.

Thank you.

CHAIR BELLA: Thank you, Erin. Just to remind the Commission and those in attendance, this report is due January 1st. We will have the report externally reviewed. So in order to meet all those timelines, this is the last meeting that we will be publicly discussing this report.

So Martha, then Peter.

COMMISSIONER CARTER: Erin, thank you. I think this report answers our charge from Congress.

One of your endnotes -- I was wondering if maybe the endnote in the end of Chapter 1, which I missed originally, discusses how the IMD exclusion was really initially applied only to psychiatric services, because in the 1960s, we treated mental health -- I mean, substance use disorder in a completely different way than we do now.

And so I think it's important to perhaps maybe move some of that to the main text, or consider doing that. It may be more than you wanted to take on. But I think that we just need to highlight that there are really two separate sets of services that are covered by the IMD exclusion. And I think you did a pretty good job throughout the paper, but I think those first two endnotes at the end of Chapter 1 help explain it a little bit more.

I know that the Commission maybe doesn't want to go into this at this point, but I'd like to put a pin in that, and say maybe we should go back to this. I think there are ways that the states are able to pay for medically necessary services for people with substance use disorder, but they have to jump through a lot of hoops, and there are four different mechanisms to get paid.

And so as states struggle with the opioid epidemic, and, you know, realizing that some people with a substance use disorder need hospitalization, that we shouldn't put up barriers to access. So I'd like to look at that, maybe separately, at another time, and just highlight that there are different types of services that are covered by the IMD exclusion.

CHAIR BELLA: Peter.

COMMISSIONER SZILAGYI: Really great job, Erin.

I just had a question about the medication-assisted treatment, the MAT, and the tremendous variability across these states in the percentage of IMDs that offer MAT. I know our job wasn't to get under the hood about, you know, the quality of the care. But do you have a sense for why the variability? Are they contracting out? Or what is

going on? Because that might raise some questions as people read this descriptive chapter.

MS. McMULLEN: Yeah, so I feel like there's probably multiple different reasons why some of the facilities have variation in their offering around medication-assisted treatment.

First, I think the way states structure their licensure requirements for these facilities I think also varies greatly. Some facilities are required to have an MD or NP or a prescriber on-site, you know, maybe certain hours a week or maybe they're required to have a medical director. In other states, maybe those same requirements aren't there, or maybe they're allowed to contract out certain services. So I think that's one piece.

Another piece is I do think there are some differences between states that have Section 1115 demonstrations and those that don't. Under the demonstrations, states are required work with residential providers to gradually make sure that MAT is being offered. So the data in our report is a couple years old, but I would -- in states that have an approved waiver, I would expect them to see increases in MAT, and some of the early evaluations that we've talked

about here out of Virginia have seen that increase in MAT. So I think that's one other maybe reason why there's some variability in MAT offerings.

And then I think the final thing, you know, different states have different issues. In some states, opioid use disorder isn't kind of the leading cause of overdose deaths in their states. Some states are seeing increases in methamphetamines and deaths from other types of drugs for which there is no medication-assisted treatment, so I think that's kind of one more piece in this puzzle that's probably not reflected in our graphs.

CHAIR BELLA: Kathy.

COMMISSIONER WENO: In Chapter 2, you mentioned about SUD facilities that screen for mental health, and I was wondering about the reverse. Do SUD facilities screen for mental health disorders? And if they do, then what's the follow-up?

MS. McMULLEN: Yeah, so the different types of services that we outlined in Chapter 2, we were limited to how the questions are posed in the SAMHSA survey. So, unfortunately, I don't have information on whether -- like what the follow-up looks like. What I can say is when we

looked at the licensure requirements in these different states, most of them, if not all of them, required some sort of screening when someone was admitted to the program or prior to admission. And in several instances, that could have included a full mental health evaluation and referral out for services if they found anything. Other states were less prescriptive in their screening requirements, so I think it really depends on the state.

We did hear from one of the states in our study that they were really working to improve the number of facilities they had that could treat people with co-occurring conditions and not have to refer them out to specialty mental health providers.

CHAIR BELLA: Okay. I have a couple questions or comments. First, thank you for all this work. Actually, it will be a big relief when you hit "Send" on the report.

I appreciate the addition of Chapter 5 when we're looking at rights and protections, and although outside of the scope, it triggered for me thinking about at some point does the Commission want to look at parity, particularly around individuals with substance use disorders, not as part of this, but it seems that that's something that is

worth looking at, or at least understanding if there are gaps, particularly as we see this increasingly prevalent. And I won't pretend to be an expert in what those gaps might be, but I saw enough in this chapter to think that it might be something that we might want to think about in another context.

I don't know if you have anything to comment on that. Again, it's not germane to this report per se. It's broader.

MS. McMULLEN: Yeah. I would just say I agree based on the limited amount of information we looked at, just for the seven states around their parity analysis and the work that they've done. I think it's an area that we could probably dig into more and perhaps maybe shed some light on how states are going about complying with parity.

CHAIR BELLA: Okay. And then my other comment is also a little bit broader, but it relates, Peter, to what you said. We talked in the past about understanding how states are providing a continuum of coverage services around SUD and inpatient and outpatient partial programs, all those things. As we think about -- this is only coverage in this setting or what we think to be this setting, but it does

sort of remind me that periodically we might want to think about how we're understanding and how states are providing a continuum, and if the evidence base continues to develop in ways that it might be helpful to make sure that states are kind of tracking with that.

Again, it's a broader comment than for this report, but this triggers kind of looking at that variability and trying to understand why and what we might do to make sure that where there is a basis for coverage, that we are trying to get that word out.

Fred.

COMMISSIONER CERISE: I was struck also on the continuum of care issues and in the 1115 waiver the expectations there, which I thought were, you know -- first off, it's a great report. It's incredibly informative on this confusing issue. But I was struck that there were very good and strong expectations around continuum of care, more so than this area, almost to a different standard than you see in other parts of the waiver program where, you know, you do a lot of support for other providers for physical health in the waiver program without nearly the same level of expectations around the continuum of care

issues. And so, you know, I thought maybe there are some lessons to learn on the physical health side in terms of building in the protections and conditions. If you're going to participate and if you're going to do this, you know, here's what we'd like to see, not just payment for this episode of care.

CHAIR BELLA: Why don't we go ahead and ask for any comments from the public? Would anyone like to make any comments on the record? Good morning. You can just use the microphone right there.

PUBLIC COMMENT

* MS. MATHIS: Hi. Thanks. Jennifer Mathis from the Bazelon Center for Mental Health Law. I just wanted to make a very brief comment. Thank you very much for that analysis. It's extremely helpful information, just in terms of Chapter 5 and the legal requirements, protections for people with disabilities. I would just add if you're going to mention the ADA, the Americans with Disabilities Act, protections and also parity in terms of kind of protections that apply to sort of the whole system to states' coverage, then I think it's also important to mention the ADA's integration mandate, which also is

relevant here, obviously, the Olmstead decision and the requirement that states administer services to people with disabilities in the most integrated setting appropriate, which also is obviously relevant.

The other thing is I think with respect to the parity issue, to the extent that there's a discussion of a 15-day limit being inconsistent with parity law, I think it's also important to just include in that discussion that, of course, the context for this is the Medicaid statute actually barring federal participation in these facilities. And so the 15-day limit was, I think, in recognition of the fact that you had that statutory limit in the first place.

Thank you.

CHAIR BELLA: Thank you. And you will see in the report we do get into those areas, but that's a helpful reminder. Thank you.

MR. KESSLER: Good morning, Andrew Kessler on behalf of Faces and Voices of Recovery. I have a question. I was curious if the report would be looking into the impact of states that underwent Medicaid expansion versus those that did not and the impact of expansion on IMD enrollment or IMD participation in Medicaid plans.

EXECUTIVE DIRECTOR SCHWARTZ: No, the report doesn't look at any measures around use of services by different populations. It strictly looks at standards, as we were asked to do in this report.

MR. KESSLER: Thank you.

CHAIR BELLA: Any other comments from the public?

[No response.]

CHAIR BELLA: Commissioners?

[No response.]

CHAIR BELLA: Erin, do you have what you need from this group?

MS. McMULLEN: Yeah.

CHAIR BELLA: Okay.

MS. McMULLEN: This was helpful. Thank you.

CHAIR BELLA: Thank you very much. See, it wasn't so painful. That went quicker than you thought.

[Laughter.]

CHAIR BELLA: All right. We are now going to turn to use and oversight of directed payments, and Moira and Rob are going to get us started.

USER AND OVERSIGHT OF DIRECTED PAYMENTS IN MEDICAID MANAGED CARE

* MS. FORBES: Good morning. So before Rob starts on directed payments, I just wanted to bring back the discussion on managed care a little more broadly. The last time the Commission talked about managed care was last December. We presented findings from some work we did on network adequacy and talked about the Administration's proposed amendments to the managed care rule. And we're still waiting for publication of that final rule, but in the meantime, there's a number of other activities that we're working on.

So I'll start off this session by recapping just some of our prior work just to sort of level-set and then talk about some of the things that we're working on before handing it over to Rob, who will present findings from the first piece of that that we've got for you this report cycle.

So a lot of the Commission's work on managed care focuses on really the shift from responsibility and accountability from states to managed care organizations and on the oversight of Medicaid spending, the bulk of money that's now flowing through managed care plans. Specifically, we've looked at the adequacy of managed care

oversight, whether the current requirement structures and processes for oversight are sufficient, and whether the current regulatory framework leads to the right outcomes.

States and managed care plans are still implementing the changes to the 2016 rules, and CMS is continuing to make changes to that rule. So the first overarching policy question that we look at for a lot of our work is: What are the effects of recent changes to federal managed care payment and network adequacy standards?

Second, because there have been a lot of significant changes to what's required in managed care rate-setting processes and what's allowed and because rate-setting standards are really the primary mechanism for defining value in managed care, we framed the second policy question as: Are processes for federal oversight of rate-setting methodologies sufficient to ensure that rates are sufficient and consistent with statutory goals, that there's appropriate use of taxpayer funds?

So just to backtrack a little, CMS finalized the comprehensive update of the managed care regulation in June 2016, although some provisions weren't implemented until 2017 or later. On November 14th last year, CMS published a

Notice of Proposed Rulemaking to amend that rule. And then in the spring, OMB published what's called its "unified regulatory agenda" that said that in October, next month, they expect to publish the final rule. We have heard that it's moving through the process. We don't know if it will actually come out in October, but we're monitoring the Federal Register to see if it'll come out.

So we've discussed the federal rules for managed care oversight several times in several different ways at these meetings. I'm just going to recap the provisions that affect the work that we have underway this report cycle.

The effective date of the rule was July 5, 2016. Most state managed care contracts follow the state fiscal year, which usually starts on July 1. But because the rule went into effect on June 5th, states couldn't change their contracts and their rate-setting in three weeks, so a lot of the provisions didn't take effect until a full year later, or July 1, 2017. And then some have been phased in over even a longer time frame. So we've put the effective dates here.

The rule included more detailed actuarial soundness requirements and additional standards for documenting and

developing capitation rates. It created an explicit approach within the actuarial soundness rules, which previously had required capitation payments and still do require capitation payments to cover all costs for the enrolled population.

This new additional provision allows states to direct payments to providers as part of delivery system and provider payment initiatives, and Rob's going to talk more about that in a few minutes.

The rule also clarified that while supplemental payments are permissible in fee-for-service, pass-through payments that aren't connected to services or delivery reforms aren't consistent with standards for actuarial soundness, and it provided a schedule for phasing out these payments in states that were already making them.

To align Medicaid a little closer to the requirements for the individual and Medicare Advantage markets, the rule created minimum loss ratio requirements. It only required that MCOs report information by 2018 and that states factor MLR information into the capitation rates by the 2019 contract year. The 2016 rule also created a more uniform national approach for network adequacy, requiring states to

develop time and distance standards by the 2018 contract year.

The rule also required states to develop more comprehensive quality strategies, increase reporting and transparency, and increase involvement of stakeholders. There's an intention to develop a more formal quality rating system for Medicaid managed care plans similar to that used for exchange plans and for Medicare Advantage. That requires some separate federal action before states have to implement it, and that action hasn't happened yet.

Finally, the rules gives states explicit permission to the use the in lieu of provision within the rate-setting guidance to allow plans to cover services provided in IMDs, as Erin just talked about in her session.

So on November 14, 2018, CMS published a Notice of Proposed Rulemaking to amend the 2016 rule. It affected many parts of the rule, including a lot of the payment provisions. CMS at the time said that its proposed amendment to the rate-setting rules were intended to strike a balance between state flexibility and CMS' responsibility to ensure that capitation rates were actually sound. They're also just reacting to a couple years of experience

of working with states and implementing the 2016 rate-setting provisions. They reversed a provision in the earlier rule and, again decided to allow states to use a rate range instead of a specific capitation rate for each rate cell. They prohibited states from retroactively adding or modifying risk-sharing mechanisms to contracts late in the year. They provided additional guidance that states should follow when developing rates across different populations that receive different federal match.

They did make some significant changes to the directed payments provision that they had just introduced in 2016. In 2016, they said that states had to get CMS approval. It was a new provision. They said you have to get approval for all directed payment policies. CMS was only giving approval for one year at a time.

What they proposed last year is that if a state is proposing a directed payment that they require a fee schedule that's based on the state plan rate -- and, of course, the state plan rates are approved as part of fee-for-service -- then CMS doesn't need to reapprove that. They will also consider multiyear directed payments.

The proposed rule also removes the current requirement

that states can't direct the amount or frequency of expenditures made by the MCOs. They will allow states to have that kind of directed payment if it's part of a value-based purchasing program.

They also proposed significant changes to pass-through payments. In 2016, they were going to require states to gradually phase them out over ten years or to convert them into directed payments. What they proposed last year was to allow additional states to introduce pass-through payments as long as they meet certain limits and are for a certain defined amount of time.

CMS also proposed some changes to network adequacy standards. The revised rule will eliminate the 2016 requirement for a time and distance standard. It would allow states to just meet any quantitative standard chosen by the state and allow states to define specialist types. They also proposed some changes to quality ratings. They would allow states -- I'm sorry. They would require states to use the core set of measures but remove CMS preapproval for state-specific quality rating systems because states would all be using the core set of measures.

So before that proposed rule had come out, at the

beginning of last year, actually starting late in 2017, the Commission had been looking at 1915(b) managed care waivers. At the beginning of last year, the Commission made three recommendations about streamlining the process to obtain the authority to enroll beneficiaries in managed care. And part of the rationale for those recommendations was that the federal rules for managed care now provided much more uniform standards and oversight requirements for all managed care programs, regardless of the authority.

But when making those recommendations, the Commission had noted that the requirements and standards alone aren't sufficient and that the process and resources for oversight also need to be in place at the state and federal levels.

Then when the Commission reviewed the process for managed care network standard oversight and reviewed the proposed changes to the 2016 rule, the Commission submitted comments in January on the proposed rule and made a few comments, including asking for transparency and provider-level data, stressing the importance of public engagement when changing network adequacy standards, and commenting on IMD data.

One thing I want to mention, although not sort of

directly related to managed care but related to this overall portfolio of work, the directed payment and pass-through payment provisions that were introduced in the 2016 rule and then the changes that CMS proposed last year addressed the fact that many states that used managed care to implement payment and delivery system reforms have also sought to preserve hospital supplemental payments while complying with actuarial soundness rules, and we've done a lot of work in both these areas. We've looked at a lot of delivery system reforms. We've looked a lot at supplemental payments. And you can see there's a lot of projects we've done here since 2014 looking at value-based payment models, looking at DSRIP, going back and looking at supplemental payments, including the recommendations you made just last spring on UPL supplemental payments.

So our work looking at the effects of changes to managed care rate-setting and payment rules touches on how managed care intersects with both delivery system reform and supplemental payments. So that leads a lot into our areas of focus for this report cycle.

Going back to those two overarching policy questions, these are the five areas of policy that we're trying to

investigate more this year and some of the specific research projects that we have underneath them.

First, we're looking at how states are using the pass-through and directed payment options. We've catalogued a lot of the currently approved -- I don't know. Is it dozens? Hundreds? There's a lot of state requests for pass-through and directed payment options. We've looked at the types of payments, the funding sources, the associated quality goals. We'll present findings on that today.

We've looked at how state efforts to implement -- we're looking at how state efforts to implement value-based payments under managed care contracts work and what are the outcomes. We're doing an environmental scan of states. We're planning to do an in-depth review of a subset of states. We'll be getting a report on that in a few months and expect to make a staff presentation in early 2020.

Third, how does telehealth factor into how MCOs determine network adequacy? We plan to review state network adequacy standards and the extent to which they include telehealth. We're planning to interview states and health plans. We expect to bring findings from this work back next spring.

Fourth, what are the mechanisms for monitoring oversight and accountability of dental services provided to children? How does this really work in practice, the oversight? We're working with a contractor to review documents and conduct interviews with state officials and managed care contractors. We expect to finish that work this winter and have a staff presentation at a future Commission meeting.

And, last, why do states choose not to exercise their option to recoup money under a minimum medical loss ratio requirement? We're going to review actuarial analysis reports that others have done on Medicaid medical loss ratios, survey current state policies. We may interview states, and we'll bring findings from that work back in the spring.

So this morning we'll have a staff presentation on findings from the review of approved directed payment plans and state quality strategies that we did over the summer. At subsequent meetings, we'll present the findings from the work on pediatric dental oversight, value-based payments, telehealth, and MLR recoupments.

We plan to bring you information. Our goal is to

support a discussion of policy questions and policy options. We can't say yet whether any of this will lead to recommendations. We don't know whether or in what form anything will be published. That, of course, depends on what you think, what you ask -- you know, what further research you might ask us to do and what follow-up. So, you know, we certainly look forward to what you think of the work, but we wanted to give you a heads up of what to expect and let you know that what we're doing this morning is the first step in a somewhat cohesive body of work related to managed care. And, of course, we're waiting for that Federal Register notice of the final rule, and we'll see how that affects, you know, any of the work we have planned or anything that you would like us to do in the future.

And I can turn it over to Rob or answer any questions at this point.

CHAIR BELLA: Does anybody have any questions for Moira? Any clarifications? Comments? If not, we'll --

Chuck?

VICE CHAIR MILLIGAN: Moira, just for consideration about access and some of this, one of the other items that

seems to be in a lot of discussions around access is the relationship to non-emergency medical transportation, because if you don't have providers where you live, one form of getting access to those providers is the transportation benefit, and so the interrelationship between some of the changes and the transportation benefit and how that may or may not affect access to care, I think is also worth keeping an eye on.

CHAIR BELLA: Sheldon ?

COMMISSIONER RETCHIN: Moira, you reported on the network adequacy in December, and I think that's an area -- I think this is really important, and I'd like to see us do more.

So I'd like to see us follow up on the network adequacy and the rule changes that are being proposed, but in particular, I don't know that we've actually drilled down enough in the relationship to work for supply and the variations among the states.

So, for example, Mississippi, the number of primary care physicians per 100,000 population is actually 58 percent of the national average. So there are tremendous state variations, and I'm not saying that I know how or why

the policies should be changed away from or giving more flexibility around time and distance, but at a minimum, I'd like to see us explore that more in terms of network adequacy and particularly -- and we just talked about this -- in behavioral conditions, but specifically as well in primary care.

CHAIR BELLA: Anything else before we turn it to Rob?

[No response.]

CHAIR BELLA: Thank you, Moira.

* MR. NELB: Thanks so much.

So, with that overview, I will now do a deep dive, taking a closer look at the use and oversight of directed payments and managed care.

I'll begin with a brief background about the directed payment option, building off from what Moira talked about, about the relationship between directed payments and supplemental payments and fee-for-service, and then I'll walk through our findings from a review of currently approved directed payment options, focusing on the two broad categories of directed payments that CMS authorizes: directed fee schedules which specify a particular amount that managed care plans must pay providers, and value-based

purchasing arrangements, which tie payments to particular quality goals.

Finally, I'll conclude by raising some policy questions and talking about potential next steps for the commission's work on this issue.

So, first, a little more background about supplemental payments in managed care. Prior to the 2016 managed care rules, states were not allowed to make supplemental payments for services provided in managed care, and the rationale for this was the principle of actuarial soundness. If managed care rates were sufficient to cover reasonable costs to the services provided under the contract, the thought was that providers wouldn't need additional payments for those services.

Despite this policy, several states required MCOs to make additional payments to providers known as a "pass-through payment." In general, under these arrangements, a state would increase the capitation rate to plans and then require MCOs to direct the additional funding to particular providers.

These payments are often made in a lump sum and were not tied to the amount of services provided.

The 2016 managed care rule, as Moira mentioned, the rule phases out the use of pass-through payments but creates a new option for directed payments that meet specified criteria.

Unlike pass-through payments, directed payments must be tied to the services provided under the managed care contract. In addition, directed payments cannot be contingent on agreements to provide intergovernmental transfer funding, or IGTs, to finance the non-federal share of the payment.

Lastly, directed payments must advance at least one of the goals for the state's managed care quality strategy.

These arrangements are approved by CMS as part of its review of managed care contracts, and they're not reviewed automatically.

This table compares some of the requirements for directed payments to two other types of supplemental payments that the commission has previously reviewed -- UPL payments, which help offset low base rates in fee-for-service; and Section 1115 supplemental payments, such as DSRIP.

First, in terms of the upper limit on the payment

amount, directed payments are really just limited by the amount that CMS approves in its review of the directed payments, and they are not subject to the UPL like in fee-for-service. So, as a result, directed payments could potentially be higher than what Medicare would have paid, as long as CMS approves it.

Second, in terms of the duration of approval, directed payments are currently only approved for a year at a time, which is shorter than other types of supplemental payments, although CMS is proposing a multiyear approval for some types of value-based arrangements.

Lastly, in terms of monitoring and evaluation, the requirements for directed payments are a little bit stronger than what they are for UPL but not quite as extensive as the evaluation requirements for Section 1115 waivers.

In general, states are expected to assess the extent to which direct payments advance at least one of the goals of the state's quality strategy, but there's not really much guidance about what that means.

So to better understand the use of directed payments, we review directed payment arrangements that have been

approved as of June of this year. Overall, there were 121 unique directed payment arrangements that had been approved in 34 states.

CMS was able to provide us the approval documents for these arrangements; however, it is worth noting that they are not currently publicly available or posted on CMS's website.

To better understand how directed payments relate to state managed care quality strategies, we also reviewed the most recent version of quality strategies that CMS provided. These quality strategies are not formally approved by CMS, but they are required to be posted on states' websites. CMS helped provide us the links to the most recent version of these quality strategies.

This figure shows the distribution of directed payment arrangements that we looked at. Of the 121 arrangements, about three-quarters were directed fee schedules, which require the plans to pay specified amounts. Most of these were minimum fee schedules, typically requiring plans to pay the Medicaid or Medicare rate at a minimum. However, about one-third provided a uniform dollar or percentage increase to providers that was based on some other state-

defined amount.

About one-quarter of directed payment arrangements are for value-based purchasing. Most of these are sort of pay-for-performance arrangements that provide incentives for meeting particular goals; however, some states are using directed payments to implement population-based approaches, such as ACOs, or bundled payments, such as episodes.

Taking a closer look at directed fee schedules, as I mentioned, the minimum fee schedules are often based on Medicare or Medicaid rates, but it's this other piece, the uniform dollar or percentage increase that's state-defined and was a bit hard in our review to see kind of how these payment amounts were determined.

As I mentioned before, directed payments are not subject to UPL rules. So it's possible for some of these increases to result in payments that are larger than what Medicare would have paid.

Many of the arrangements we looked at were directed towards hospitals and financed by them, either through a provider tax or intergovernmental transfer arrangement, and the amount of funding under these arrangements varies widely. We thought it was worth noting that in some

states, the total amount in these directed increases was actually larger than DSH or non-DSH supplemental payments to hospitals.

In terms of tying to quality goals, the stated intent of most state-directed fee schedules was to improve access, but in our review approval documents measures of access weren't really described. And so it wasn't clear how states were going to actually assess whether the fee schedule was achieving its goal.

Next, looking closer at the value-based purchasing arrangements, here we find that they advance a wider range of quality goals. Access is a key part, but also some arrangements are trying to reduce the cost of care or just improve quality for particular areas.

About half of these arrangements were targeted towards hospitals, but about half were targeted to other provider types, such as physicians or behavioral health providers.

In terms of assessing the effectiveness of these, because most of these are pay-for-performance arrangements that tied payment to particular measures, the states typically plan to just track performance based on how providers performed on those different measures.

In our review, we did notice that two states -- California and Massachusetts -- currently operate directed payment, value-based payment arrangements, alongside of their DSRIP programs. We thought this was notable since in recent DSRIP approvals, CMS has indicated its intent to phase out DSRIP funding and has encouraged states to consider ways to support DSRIP objectives through managed care instead.

So, in both California and Massachusetts, many of the same providers that receive DSRIP funding can also receive the directed payment funds, but they have to meet slightly different quality goals. As I mentioned earlier, the evaluation requirements for directed payments aren't quite as extensive as what these states have to do to evaluate their DSRIP programs.

To help facilitate your conversation today about potential next steps for work, we've outlined a couple potential policy questions for you to consider. First, similar to some of the types of questions that we've asked in our prior work on supplemental payments, we kind of have this threshold question here about "To what extent are directed payments and fee-for-service supplement payments

interchangeable?" Also, the question of whether the processes for overseeing these different types of payments should be different.

Some other questions to consider include "What are the implications of directed payments on actuarial soundness requirements?" and lastly, "How do directed payments relate to other approaches to promote the use of value-based payment in managed care?"

So, as Moira mentioned, we already have a few projects under way that might help inform some of these questions. This fall, we are planning to interview states and MCOs about their approaches to promote the use of value-based payment in managed care, and as part of that project, we plan to include a couple states that are currently using the directed payment option to advance those goals.

This fall, as Moira mentioned, CMS may finalize proposed revisions to the 2016 managed care rule, which would provide an opportunity to take a closer look to see whether the commission's prior concerns about directed payments have been addressed and sort of understand the lay of the land going forward.

Lastly, this fall, I also wanted to note that there

may be a potential proposed rule on fee-for-service supplemental payments, and if you're interested, this could potentially provide an opportunity to comment about whether some of the oversight processes in place for directed payments should apply on the fee-for-service side.

So that concludes our presentation for today. I really look forward to your feedback and thoughts as we continue this work.

CHAIR BELLA: Thank you, Rob.

Darin, then Martha.

COMMISSIONER GORDON: Thank you for this. Always helpful.

I really do like the direction of helping us keep in mind how this compares to what's being expected on the fee-for-service side. I think having different standards in one versus the other could create different barriers maybe for states that may be considering moving to managed care and just understanding the differences that would help to understand if there is that dynamic that's playing out.

I do think the transition of the change that was to the rule that was dealing with the transition period, giving it three years, I think that was kind of getting at

that point, that some states that might be considering going to managed care wouldn't otherwise, because that is a tough sell to the industry to say, "We're going to do this, but we're going to stop all these payments because we can't do them." So I think just keeping that in mind, I like your direction there.

I think when you look at directed payments -- and we talked about it from a payment perspective purely and VBP, to some degree, which would include quality as well -- I do know that there's some payments that it doesn't fit in that bucket, but similar to all your work on hospitals, it may be in order to get this payment, though, you have to participate in the program, getting to access, that there's stipulations behind those types of things that I do think serve a broader purpose than just you're pushing out a payment and actually is an incentive to participate in the program broadly.

So to the extent we see there's other things, maybe it is VBP broadly or other expectations for those directed payments, I think understanding what some of those expectations are just gives us a sense really what are they driving at with these payments.

You also talked about directed increases. I would assume there's also directed decreases as well, depending on if there's budgetary actions that are taking place.

I do think when you talked about that there doesn't always seem like there's a rhyme or reason, some of that is, I would suspect, driven by legislative action in a particular state, that there may be particular policy objectives the legislature is trying to address. I know that has happened time and time. I've seen that, but I've also, again, not just going up, seen it going down, and that, in some cases, could be the motivation.

You did talk about that there's not a UPL measurement for some of the directed payments. You can never get away from hospital payments. But isn't there a requirement, though, that it can't exceed uncompensated care?

MR. NELB: There's not currently any particular limit there.

As part of CMS's review, they often will ask states for information about how the total payment will compare to hospital costs or compare to other payers or compensated care, but there's no sort of formal guidance or rules in place now.

COMMISSIONER GORDON: Yeah. I think that's maybe a good place, after seeing the broad analysis, that we may want to spend a little bit more time on.

Then, lastly, thank you for the recognition. I remember with the Managed Care Act first came out, I was sharing with CMS that not only were we directing payment -- or directing how plans pay for value-based purchasing initiative as we were moving away from fee-for-service and said we're going to pay retrospective episodes, but also they were unaware that -- they were talking about maximum payment levels that you would dictate. You seem to have picked up on the to her realities that we actually put corridors, say you can pay hospitals more than X, but you can't pay less than Y. We didn't have a fee schedule, but it was to be able to make sure that there was a sensible rate range that was being done and that providers weren't being taken advantage at a level that we didn't think could maintain access and function. So I appreciate you picking that up as well.

CHAIR BELLA: Martha, then Stacey.

COMMISSIONER CARTER: I was interested in the section on value-based payments and Medicaid managed care and your

plan to interview states about how they're implementing that.

I think this could be a place that the commission could demonstrate our concern regarding maternal morbidity and mortality in this country. I'm curious how many state Medicaid programs require the MCOs that they contract with to report on maternal mortality and morbidity.

We call out dental care, and we call out telehealth. So even I was thinking that the commission might want to put together sort of a hot list of topics that we think -- that may be overstepping, but things that we want to really pay attention to, and I think we need to be paying attention to maternal health.

CHAIR BELLA: Stacey?

COMMISSIONER LAMPKIN: Thanks. I'd actually like to go two different places -- one, just a little bit of a process in relationship to actuarial soundness commentary; and then potential areas to go deeper in, if that's okay.

So directed payments, a lot of interesting stuff going on in this area for sure, and just in terms of how the process works and the actuary's involvement and how it gets into capitation rates, I just want to take a minute or two

there.

For some of our clients, we do help with the preprint process, and for other clients, we're not as involved in the preprint process, just depending on what the client needs. But what we get at the end of the day is a CMS-approved preprint for a directed payment contract language that requires the MCO to make this payment, and what we are developing is a capitation rate that reflects the reasonable and attainable cost of the contract -- services, administrative costs, any specific surround provider payment. All that gets considered and baked into the capitation rate. So that's how the process flows through today.

Sometimes we are involved in helping our clients respond to questions about directed payments or show what the directed -- what the fee schedule may look like relative to some other benchmark. We can get involved in that sort of thing, if asked. So maybe that was helpful, just for somebody to walk through.

In terms of where this goes next, though, for me -- and I think it's really useful to think about VBP-oriented directed payments separately from fee schedule-oriented

directed payments or access-oriented directed payments.

Actually, starting with the access ones first, the thing that is interesting to me in the rule around access-related directed payments is the potential for two completely different ways to try to get at the same thing in the capitation rate, and here's what I mean. The new rule also included language that actuaries needed to consider network adequacy requirements in the capitation rates as well.

So when I said that the capitation has to include all the costs of delivering on the contract, if there are network adequacy standards in the contract, then what the MCO has to pay providers to meet those network adequacy standards is a legitimate question for the capitation rate. And the new rule acknowledges this by saying, "Actuary, make sure you're looking at this," right?

So then a directed payment from the state saying, "We think we have an access problem, and we want to require our MCOs to pay something specific to address the access problem," is in a way a completely different way of going about that animal than the network adequacy requirement in the capitation rate. Does that make sense?

So my question is this, and yet I understand how it can come about, right? We have a personal care assistant, an access challenge we think we need to raise. Our fee-for-service fee schedule by $2 per hour, and we want the MCOs to pay our fee schedule. It makes sense, right? But shouldn't the MCO already have to do that to meet the network adequacy standard if that's really what the benchmark is?

So my question is this about the access piece of it. Are the states really having meaningful measures of access improvement and access challenge that leads them down this path of the directed payment? Do they demonstrate an access problem, put the directed payment in place, and then measure an improvement against that, or if they're not, why aren't they? Or do we need to worry about any of the directed payments that maybe produce a higher payment for a service to a set of providers or subset of providers where that set of providers or subset of providers is not the most cost-effective way to deliver that service? So the access could exist somewhere else in a more cost-effective way.

I don't know exactly how you get to that, but I do

think that there are pieces of directed payments where that's a relevant question.

MR. NELB: I'll just say in our review, as I mentioned, there were really no clear measures of access, and a lot of these are focused on hospitals. Most of the hospitals do participate. So it wasn't clear exactly where the access piece was. But, obviously if the -- yeah.

COMMISSIONER LAMPKIN: So my question is, if there's a network adequacy standard in the MCO contract, the MCO is meeting that, and then the state comes along with a directed payment to address an access problem. I don't understand that.

CHAIR BELLA: Can I clarify something now based on that? The requirement that it has to tie the person to quality strategy applies to whether it's a fee schedule or a value-based payment, correct? But it would seem that we would have a better look at seeing a relationship there on a value-based payment side than we're going to on a fee schedule side, yet the majority are fee schedule-based payments. Am I thinking about that right?

MR. NELB: Yes.

CHAIR BELLA: Okay. But none of that is public or

transparent.

MR. NELB: Right.

CHAIR BELLA: Again, the preprint, they say tie over to which part of your quality strategy, because that hasn't -- none of that is in the -- is required yet. MR. NELB: Yeah. The quality strategies are supposed to be public, and as part of the quality strategy it is supposed to actually talk about network standards. So there could be some overlap. But the --

MS. FORBES: Where did you find that?

MR. NELB: Oh, well, the quality strategies we found were pretty vague about what these goals are, and then in terms of how they're being monitored and different things. So there's a lot to -- even though those are becoming more public, there is still work to be done on sort of improving the quality strategy piece, and sort of what that actual link is and how it's being evaluated.

CHAIR BELLA: All right. Darin, did you have a specific comment on that? Then we have about eight people in line, starting with Peter.

COMMISSIONER GORDON: Just following up, because I think it is hard to get to where you're trying to go,

because in some cases those arrangements have been in place for a while, and it's what the effect of pulling them out of the system. And some of it is anecdotal, because, I mean, we had the situation where hospital systems were in negotiation with plans, and basically said they wanted us to remove the requirement to access the substantial directed supplemental payments that they have to be in the network, because they didn't want to lose access to that. And we said we're not going to do that, which then kept them at the table.

So, to your point, it's hard to get to. It's complicated. I mean, I think your points are all valid. I do think it's very complicated to be able to understand the connection and the effectiveness of that connection.

CHAIR BELLA: Peter, then Sheldon, then Chuck.

COMMISSIONER SZILAGYI: Yeah. I had exactly the same point as Stacey. I would love to just -- it seems to me that some of the products that we do in which we do a deep dive with certain states or certain programs that other states or other programs can learn from. And to the extent that we could do a deep dive where states are really linking access measures to the directed payments, or the

value-based payments, at least to the extent are they focusing on certain populations? Is there any better evidence for children, for example, or complex care? Is there better evidence for prevention versus, you know, sort of other dimensions, and to what extent can some of these additional payments be tied to really improved access. Even if this is qualitative, I think this would be a really helpful addition to our repertoire.

CHAIR BELLA: Sheldon.

COMMISSIONER RETCHIN: Yeah. I just -- I'm going to get a little squeamish on this, but I just wonder if you have either run across or plan to ask about the special circumstance of provider-sponsored MCOs and directed payments to the sponsor?

MR. NELB: As part of that interviews project we are going to include hopefully some provider-sponsored MCOs, as well as, you know, national and regional plans. These directed payment arrangements, they apply to all MCOs in the state, so you can't have one that's specific to just one plan. It has to be kind of for all plans in the state.

CHAIR BELLA: Chuck, then Toby, then Tricia. Sheldon, is that -- we can come back to you. Think about it. We'll

come back. We understand where you're going. You decide if you want to go any further while we go to Chuck.

COMMISSIONER MILLIGAN: Yeah, I can --

COMMISSIONER RETCHIN: I don't want to go any further.

[Laughter.]

COMMISSIONER MILLIGAN: -- I can see the thought bubble from here.

I think it's really good work to do something that's foundational and that is kind of descriptive, and start working on this, and I think driving the transparency piece is going to be a good thing.

When I hear this, and I hear the access comments, and VBP piece of this, where my hypothesis goes is that it's really addressing the overall reduction in hospital utilization overall, and a lot of the overall reduction in hospital utilization is because of, in fact, a lot of redirecting service and value-based contracting toward preventive services, outpatient services, et cetera.

And so I tend to think that a lot of what is motivating these activities -- and I think this should be part of how we kind of try to get at the analytic framework for this -- is this addressing the fact that in some

hospitals they are seeing lower census, lower bed days, because of just what's happening in terms of the redirection of care to outpatient and preventive services, and yet states and hospitals, hospital associations, don't want to see those hospitals close or become unable to sustain themselves because they're running at 50 percent capacity.

And so part of it, to me, is there is an all-payer dimension to this story, where Medicaid might be -- if, to the extent Medicaid is paying above Medicare, if, to the extent Medicaid is not linked to UPL requirements, and to the extent that DSH cuts are kind of always kind of hanging out there, depending on how Congress chooses to address that, that it is a form of work-around to get revenue into hospitals that otherwise might be at risk of becoming unable to continue operating because other payers, as well as Medicaid, are looking at driving utilization out.

And so I do think there is an important component to not just look inside of the Medicaid frame but to the implication of utilization. And, to me, the access threat is rural hospitals, teaching hospitals, others where a lot of payers are moving volume out, and what is the risk to

access if Medicaid doesn't step with some of these directed payments? Which is not to say that, you know, as further scrutiny develops we are not going to have concerns, but I think great work -- please look at utilization as a potential driver, and VBP driving lower utilization deliberately, in certain ways, and outside of just the Medicaid utilization impacts of those trends but the all-payer utilization dynamics of those trends that Medicaid is trying to address.

CHAIR BELLA: Toby, then Tricia.

COMMISSIONER DOUGLAS: Yeah. Building up on what Stacey was saying, one area I just want to make sure that we're not connecting everything back to fee-for-service, given this is really around actuarial soundness, and there are so many other dimensions besides fee-for-service and adequacy.

And so if we are considering looking at linking it to upper limits of fee-for-service, we really need to think through how that impacts actuarial soundness. And as you do your follow-up in talking to states, I think another area, it would be good to talk to consulting actuaries that work with the plans and get their perspective on all the

different dimensions that they take into account unreasonableness that go beyond Medicare as the upper payment limit.

COMMISSIONER BROOKS: So thanks for all of this. I know when you get into the managed care world, and particularly the rules, it is very complex and broad.

I appreciate the work that's going on around children's dental services. We finally, somewhere along the way, discovered that the mouth is connected to the body and has impact on health.

But I think there is equally a large gap area around children's access to behavioral and emotional health services, and recognition of the importance of dyadic treatment. CMS has now opined on dyadic treatment as being appropriate under EPSDT, which would be really important in states that haven't expanded Medicaid. But I would hope that -- I know that we have a very dense agenda for the next year -- that we keep that out there on the list to do similar work, as we are doing on the dental side.

CHAIR BELLA: Kit, then Fred.

COMMISSIONER GORTON: So in terms of the access piece, I think we need to be challenging ourselves and everybody

else to look at, you know, access to what? The fact that a hospital participates in Medicaid doesn't necessarily mean that it provides a full array of services that somebody might turn to a hospital, right? They may have had to close their ER. They may be shutting down their maternal stuff. They may not -- in my world they may not be able to provide meaningful pediatric inpatient care.

And so there is this element of -- and the other piece I want to say before I jump to my "and so," is we tend to think about the provider community as siloed. There is so much less siloed anymore. So who are the major employers of practitioners? It's the health systems, right? So not only do they have provider-sponsored plans, they own the practitioner base as well.

And I know I've heard comments of, well, yeah, we'd like to have another pediatric orthopedic person in our community, but we can't afford to pay them. If we can figure out -- right, because the aspirations of the practitioners, in terms of their income levels. As we have moved more and more to an employed practitioner base, then it falls on the institutions, whether they are federally qualified health centers or whether they are health systems

or other large organizations, it falls on them to be able to attract the practitioners to be able to further the care. And they have got to compete.

In Massachusetts, if you're trying to hire a pediatric cardiologist to work in Worcester, which is only 40 minutes from the medical capital of the universe, then you have to compete with what Mass General is paying, with what the Children's Hospital is paying, right? And not only do they have the prestige of working at the center of the universe but they are also being paid better, because those institutions use every lever that they can find to optimize their revenue.

And so I just think that as we look at it, we need to think about -- we need to be asking the question, why do they need the money? And it may not be that they need the money to keep 50 med surg beds open in X county of Y state. It may be that in order to attract a pediatric psychiatrist on an itinerate basis to wander through twice a month, that they have got to come up with a funding source for that, and the episode of care-based revenue is not sufficient to support access to that very critical service.

So I think we need to ask about that, and that may

take us down the path, the deep and murky path, of looking at health system margins, and where the money is going.

And so, again, I'm not sure I want to go a whole lot farther than that, but it's something that the actuaries talk about, at least when the door is closed. And so we sort of need to think about that. I mean, the Washington Post yesterday was talking about the UVA Health System CEO's salary, and asking the question, when is a not-for-profit entity really a not-for-profit entity, particularly when they are causing bankruptcies left and right.

So, anyway, a lot of interesting questions. Some of this may be very legitimate behavior, in order to meet very legitimate needs, and we need to make sure that that doesn't get wrapped up together in empire building and that sort of thing.

CHAIR BELLA: Fred, and the I'm going to ask if there's any folks in the audience that would like to comment, and then I have a couple of comments to wrap up.

COMMISSIONER CERISE: So, first, I think the policy questions you raise are the right questions. Those are dead on. You know, I do think that a number of -- as Chuck said, these are used as work-around, places trying to

preserve various funding streams. There is the group that you talked about, maybe struggling hospitals, rural hospitals, and others. But there are also other hospitals that are doing quite well, that, you know, want to look and expect a payment to make up every piece of a Medicaid shortfall, and that shortfall is often built on higher costs, and so there will be a shortfall there.

So the access issue has a couple of components it to it then. So you may have the rural hospital that's got access challenges, and so that's an access standard that is pretty clear to see. But other systems that have ability to provide services, I think you could develop some real access metrics around that, like the Medicaid specialty service that's difficult to get at.

I mean, you could put access expectations in there that you not only react on the ED side and the inpatient side and acquire these costs passively, but you can demonstrate that are supporting access outside the hospital, and you can look at metrics on, you know, well, are you doing the same amount of elective stuff in Medicaid, are your affiliated provider groups really participating in Medicaid at the same level that you would

expect from payers proportionally, and that sort of thing? So I think we can do work and get at that.

And then the other one, I just wanted to reinforce what you have spoken about, and that is more provider-specific data and trying to look at, you know, instead of numbers in the aggregate, how are these numbers actually playing out at more of a provider level.

CHAIR BELLA: Thank you. Any of the members of the audience, would you like to comment?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. Well, let me wrap this up. I think you've heard, kind of clearly, the intent of the Commission on looking at access and kind of thinking about access.

Just two more pieces, just to make sure that what I'm hearing is pretty concrete. One is there is an interest from the Commission in the notion of a limit, and trying to kind of think about what that limit might be and what that might look like and what the relationship would be. And then related is just the notion of transparency. It's very consistent with this body's work to say, let's understand

what payments are being made to which providers, and let's also be able to look at if there's a DSH payment and a UPL payment, and now a directed payment, what, in aggregate, what is the payment amount that a particular provider is having?

And so that, to me, is just an ongoing theme that comes up, and it's coming up today, and so I think that's something that we should definitely keep in mind, particularly as we see what appears to be more interest in moving to directed payments, getting out of DSRIP, and all those sorts of things. The 121 approved directed payments could be, you know, very quickly, it sounds like, kind of blossom.

So I think that those three things, in particular, would be really helpful as you continue to work on this, and we want to see what the Administration comes out with, with the rule.

Any final comments? Anything else that you guys need from us?

[No response.]

CHAIR BELLA: No? Okay. Thank you very much.

We are now going to take a short break. I would ask

folks, we will restart at 11:15, talking about the home and community-based settings rule. Thank you.

* [Recess.]

CHAIR BELLA: Okay. We're about ready to get started if everyone can make their way back to their seats, please.

All right. Thank you, everyone. Kristal is going to talk to us about the status of implementation for the home and community-based services settings rule. Thank you.

HOME AND COMMUNITY-BASED SETTINGS RULE: STATUS OF IMPLEMENTATION

* DR. VARDAMAN: Thanks. Good morning, Commissioners. Today I'm bringing to you an update on the implementation status of the HCBS settings rule. This is an area of significant state activity in the LTSS arena, so we just wanted to give you a status update. In your meeting materials, you'll find a draft issue brief which we plan to publish after receiving your feedback at the meeting today.

I'll start with a bit of background on HCBS and then provide an overview of the rule and the implementation process, including some status updates. Next I'll move on to discuss the results of 15 stakeholder interviews we conducted with federal and state officials, state

associations, and representatives from beneficiary and provider groups. I'll end with some next steps for your discussion.

As you all know, Medicaid covers a wide range of HCBS which helps individuals with disabilities live in the community. All states cover some HCBS even though it's an optional benefit. Over the years, the federal government and states have been working to rebalance long-term services and supports, or LTSS, shifting spending towards HCBS and away from institutions; and since 2013, Medicaid has spent more on HCBS than institutions at the national level.

The HCBS settings rule was published in April 2014. The current compliance deadline is March 17, 2022. This reflects a three-year extension that was granted by CMS in 2017. Prior to the rule, HCBS settings had relatively few specific federal requirements. The intent of the rule is to ensure that HCBS settings are different from institutions, and, furthermore, the rule focuses on individuals' experiences such as their opportunities for employment and community integration in determining whether a setting is eligible for Medicaid HCBS payment rather than

the type or physical location of the setting.

The rule applies to Section 1915(c) waivers and Sections 1915(i) and 1915(k) state plan options, and CMS is also applying it to the terms and conditions of Section 1115 demonstration waivers as there are a few states that deliver HCBS solely through those waivers.

This list of requirements gives you an idea of the principles of compliance which settings must operationalize. So, for example, settings should allow individuals to seek competitive employment rather than employment in a setting like a shelter workshop for people with disabilities; in residential settings, like a group home or assisted living, ensuring privacy looks like having locks on rooms or units, with access provided only to authorized staff that needs it. Optimizing autonomy and life choices includes things like having meals and snacks available to individuals when they want to eat rather than only having food available during restricted meal times. It also includes practices like giving individuals choice of roommates and having open hours for visitation. Under the rule, provider-controlled settings are required to provide residents with leases or resident agreements.

I also wanted to note that institutions such as nursing facilities are explicitly excluded from payment for HCBS under the rule, as are other settings with isolating qualities that cannot be overcome, which I'll return to later.

Now we'll move on to discussing how states are implementing the rule. Each state has submitted a statewide transition plan which describes how they will assess providers and bring them into compliance. States must also evaluate their own regulations and processes and bring them in line with the rule.

For example, Tennessee amended its Department of Health rules that had limited the hours that adult care home residents could receive visitors or access common areas.

As of an update CMS gave us last week, 17 states have received final approval for their statewide transition plans. CMS has been providing states that have not received final approval with feedback. For example, they may have told a state that before they can receive final approval, they need more information on how they will ensure providers' continued compliance. So the state will

then go back and address those issues before resubmitting the plan to CMS for its reconsideration.

States can use different methods to assess compliance such as provider self-assessments, which can be supplemented with site visits by state staff in order to observe settings in action. States can also survey or interview beneficiaries to understand their experiences in the setting.

So a few minutes go, I mentioned that institutions like nursing facilities are explicitly excluded from HCBS payment under the rule. There are other settings that are in a more gray area. The rule excludes settings that have certain institutional qualities that isolate beneficiaries from the broader community. These settings could include those located in a public or private institutional building and a building adjacent to or on the grounds of a public institution or those with other characteristics that have the effect of isolating individuals who use HCBS from the broader community.

In March of this year, CMS released guidance on factors that they consider isolating and described the heightened scrutiny process by which states have an

opportunity to justify why certain settings should remain eligible for participation in Medicaid HCBS despite what might be considered isolating characteristics. So in order to pass heightened scrutiny, these settings need to have mitigating factors that exhibit those principles we went over earlier despite characteristics that might initially seem like red flags.

If a state determines that settings do have enough mitigating factor by July 1, 2020, they do not have to submit what's called an evidence package, which I'll describe a little later, to CMS. They do still have to identify which settings they determine met those standards so that the public has an opportunity to say if they disagree.

If a setting is not compliant by July 1, 2020, but can comply, states have to develop what's called an evidence package for CMS' review. States are to include information to illustrate the qualities of the setting, how to integrate it in the broader community, how policies and procedures support access of individuals to the community, and how the setting supports individuals' person-centered service plans.

CMS will review a random sample and agree or disagree, and CMS says it expects states to apply feedback given regarding the random sample across the settings that they did not review.

Providers who do not comply with the rule by March 17, 2020, will be ineligible for Medicaid HCBS payments. It's unclear at this point the extent to which providers may choose not to comply. With know that some HCBS providers, such as some assisted living facilities, may serve few Medicaid beneficiaries, and so they might not wish to invest in the necessary changes for a small proportion of the individuals they serve. However, given that the compliance deadline is still over two years away, we can't say at this point the extent to which this will be an issue, although we did hear a few anecdotes in our interviews, which I'll talk about in a minute.

The statewide transition plans discuss how states will manage transitions to other providers if beneficiaries can no longer receive services from a setting that chooses not to be in compliance after the compliance deadline. So, for example, the District of Columbia statewide transition plan describes using a person-centered process to facilitate

transitions.

Now I'll move on to discuss the results of the stakeholder interviews that we conducted. We conducted 15 interviews with federal and state officials, state associations, and provider and beneficiary groups. The next few slides will describe the key themes we heard.

Our discussions with CMS and the Administration for Community Living centered around their implementation activities, which includes technical assistance to states and providers, which is ongoing. For example, there are several provider-specific webinars that are planned for this fall.

Officials emphasized the rule's potential to make HCBS delivery more person-centered and to help beneficiaries become more integrated into the community.

States that we spoke with were largely supportive of the rule's goals. In fact, several told us that the rule's changes reflected a direction that they were already going in in terms of facilitating community integration and making HCBS more person-centered.

A challenge that we heard was regarding the slow rollout of CMS guidance, particularly the heightened

scrutiny guidance, which had been in clearance for quite a while. So, for example, by the time the heightened scrutiny guidance came out, one state had finished reviewing providers and had already submitted a package to CMS. Then the guidance said that it did not have to submit an evidence package for certain settings, so some of that work was no longer relevant.

We heard a lot from states about the outreach that they are providing to providers, beneficiaries, and families to help providers to come into compliance and educate beneficiaries and their families about any changes.

We also heard from states that some HCBS providers were initially reluctant to the changes that are required by the rule, which was often due to the cost of implementing them. However, generally states seemed optimistic that most of their providers could comply.

There are a few anecdotes we heard about settings that do not have enough Medicaid beneficiaries to justify investing in remediation, but as I noted earlier, it's not possible to determine how widespread this issue may be across states.

We heard some concerns from stakeholders about

applying the rule across different populations that use LTSS. So some felt that the rule had been intended to focus on eliminating segregated settings for people with intellectual or developmental disabilities, or IDD, but that some of its requirements weren't as appropriate for older adults. So example we heard from providers, adult day providers, that some of these providers work on a medical model where beneficiaries are there during the day to receive a number of medical services, and that some of those community activities might take away from the time they had to receive those services that they were authorized to receive adult day care for.

We heard mixed opinions on CMS's communication with stakeholders. Some found the agency responsive, and others were more critical. Beneficiary advocates were concerned about states' transparency, particularly given that the March heightened scrutiny guidance gave states more flexibility with states not having to submit evidence packages for those settings that were deemed compliant by July 1, 2020. They emphasized to us that the material states are releasing is not always easy to find on state websites and it's very technical, so it can be difficult to

find, interpret, and provide meaningful comments in a short time frame.

Furthermore, with the release of the heightened scrutiny guidance came some concern about some HIPAA requirements and whether states would even be able to specifically identify certain settings in a way that allows for meaningful public comment.

We also heard quite a bit about adult day centers' ability to comply given that some may be on the grounds of nursing facilities. CMS emphasized to us that each setting is going to be assessed individually and that the focus is on the setting's practices rather than their location.

Providers also brought up that there are costs to comply with the rule, with transportation to community activities being of greatest concern, along with additional staff that might be needed to support those community activities. And they were concerned specifically that the rates have not been updated to reflect those new costs.

In terms of next steps, we'll continue to monitor implementation. If the Commission's interested, we can return next year after some of those heightened scrutiny deadlines have passed and there is new information to share

on that process and whether any effects of access are becoming more apparent. The Commission could also hear from stakeholders in a panel or communicate directly with CMS.

If you have any additional feedback on other information that would be useful, please let me know, and I can follow up on that with you. And, finally, as I mentioned earlier, we'll be publishing the issue brief soon.

And so, with that, I'll turn it back to the Chair, and I'm happy to answer any questions.

CHAIR BELLA: Thank you. I'll start with a question. So 2022 seems far away. It's not that far away. There's a lot of work to get in compliance with these things. How do we feel like -- do people understand what has to be done, like the provider community? I assume some states have been more successful than others in trying to explain this. But how would we gauge whether people even understand this work that needs to be going on right now, and then that might inform how we might best involve ourselves or not in sort of trying to make sure that in 2022 indeed things are ready to go like they're supposed to be?

DR. VARDAMAN: Sure. So I'd say we heard primarily from what are called intentional communities and also adult day services about, you know, some uncertainty about what it will take to comply. There's been a lot of talk about community integration and activities that have to take place. But a lot of the feedback we heard with that, it's uncertain what the bar is, like to say that they have to be engaging beneficiaries in the community, well, how often? What about, you know, for example, an adult day where people aren't there always each day of the week, they're having services on certain days and other people aren't there? How are settings supposed to manage some of those issues?

So we did hear quite a bit of uncertainty from those groups. I think what we heard from CMS and ACO was about their recognition that there needs to be some more outreach to providers.

We did hear from some states about activities they are doing in terms of technical assistance. In the issue brief, there's a description of Minnesota's Guide for Providers which gives some examples of things that they can do. But there's definitely, I think -- what we heard from

certain provider associations where multiple providers from different states were represented was that there was a feeling that it was uneven across states, that some were giving providers quite a bit of technical assistance that they were finding useful, in others they hadn't heard as much from. That may also be partially due to the fact that those states aren't as far along in the CMS approval process with their transition plan. So that's what we heard.

CHAIR BELLA: Kit and then Bill.

COMMISSIONER GORTON: So following up on the last point first, my experience is that one of the issues that drives what you were just talking about is that in some states, maybe in most states, these programs are at least partially administered not by the single state Medicaid agency. They're administered by the DD agency. They're administered by, you know, other entities. And so depending on what the interagency relationship is and the flow of funds, those states may in their administrative structure lack the resources and the relationships to do some of the technical assistance that may be needed here.

I think also we have a great diversity across the

country of communities that have embraced integrated models and communities that have not. For me, it was a little bit of a culture shock to move to Massachusetts where there is still an incredibly heavy institutional bias amongst families and state agencies and the providers, having come from Pennsylvania where it was completely the opposite.

So I think that -- one, I think this is important work, and I think we should keep on top of it and not just sort of wait until it rolls out. I would be interested in hearing from stakeholders. I would be interested perhaps in hearing from the state DD directors. You know, are they getting what they need from the Medicaid agency? So do they feel like they're equipped? If you're the IDD director in your state, do you really feel like you have enough information about this? And do you have necessarily the relationship with CMS that you need in order to get this done, particularly if you've been delegated the administration of the 1915(c) waiver or some component of it? So I think that's an issue.

I would say another communication piece that I think historically has gone lacking is communication to everybody else. Right? A lot of these people are still in medical

models. So I don't know that we've talked to the health care community about what they can do, what they should be doing, what they should be asking about in terms of people who are being served in these settings. And health care is one of the most segregated silos, right? So you get a situation where the people who specialize in delivering health care to people with disabilities see segregated practices. This is why these things are located on the grounds of ICF/MR and why -- right? Because they're still, in fact, operating in a very segregated setting. And I don't think the health care community is as conscious of this as they need to be in order to be supportive. So I think that's -- it might be interesting to hear some feedback from there.

I wonder, actually, if there's -- if this might be a place where having one of your roundtable sessions and get a bunch of different stakeholders around and see what people are hearing -- does the health care community feel equipped to do this? Has there been enough guidance? Has it gone to the right places? Is it in the right jargon so that people understand -- you know, in many of these still quasi-medical models, there's a doctor's signature

required, but we haven't told, you know, the doctors what they have to do, that sort of thing.

So I think this is incredibly important work, and I would absolutely encourage us to continue to assess readiness for people to move into compliance with this. I certainly would like to get ongoing updates from staff about are we going to be ready. Any movement on this front is, in my view, welcome movement as long as it's not counterproductive. But there will be winners and losers, and, you know, so community living is not an 80-bed congregate, right? Massachusetts is very proud of the fact that we've just opened a brand-new VA home with 180 beds. It's like, "Huh?"

The one other thing I want to flag for us is a bit of the rocking horse that we ride all the time, which is this is easier to do in settings with reasonable provider density, i.e., urban and suburban settings -- although in the deepest inner city in fact not, because then resources and other things become difficult.

An important thing about serving people who come from rural communities is -- and Leanna can speak to this, right? Because her daughter has to go far away in order to

get the service, right? So if we want people to be integrated, they need to be integrated into their families, they need to be integrated into their faith communities, they need to be integrated into the places where they came. And one of the things that some states have done well and other states have not is when moving people from institutional care, repatriating people to the communities from whence they came. And so I think that's a critical issue.

And then I would like to explore, if we can, if we have time -- and, you know, maybe it's a year, maybe it's two years, maybe it's three years -- the issue of beneficiary and family choice and how much are people being given an opportunity to express what works for them and where they want to go and how it's going to be. Or are we getting around the table with a bunch of professionals and paraprofessionals doing person-centered planning and saying, "Hey, Mrs. Jones, you're going here"? And so I'd like to know what the experience is around beneficiary choice and whether they really feel like they've been involved in a process, because it would be terrible for the implementation of what is, I think, an enlightened rule to

end up being just another mechanism of oppression for people with disabilities.

CHAIR BELLA: Before we get to Bill, Leanna, did you want to say anything? I saw you nodding.

COMMISSIONER GEORGE: Well, this is like five miles away. Yeah. One of the biggest challenges -- I read this in the actual report as well -- is with the provision of services to an individual with home- and community-based services, especially in a very rural area -- is transportation. If you're providing supports to -- let's say my daughter, for instance, when she was at home, and the goal in her personal-centered plan was, okay, she's going to go to the library, check out a book from the library, and participate in a library activity. Then the library is 20, 30 miles away. Who provides that transportation and things like that?

So we're incorporating these goals already without really funding the resources needed to achieve these goals.

In general, I think this is going to be a good thing for most families, but with rural areas and just how scattered high-quality services are and programs are -- I know like, for instance, of the office in South Carolina,

we have a great program that provides in-home care providers and stuff like that through HCBS, but that's in Wake County. If you don't live in Wake County, you might get a care provider, but you don't have access to the other activities that those groups can provide because that's how they operate. But yeah.

CHAIR BELLA: Thank you. Bill?

COMMISSIONER SCANLON: I'm not sure of the importance of this, of what I'm about to say, but, I mean, it partly relates to the fact that I feel like the words are being used very imprecisely. And this happens all the time in LTSS.

In the example here, we talk about providers and the issue of whether providers are going to be willing to adapt, but we're also talking about home- and community-based services, which I think of most predominantly as services delivered to an individual in their home by someone from outside.

So the question is, when I now start to think about this rule in home- and community-based services, what am I dealing with? And I feel like there's a distinction between your residential services, which could be close to

institutional, and your support services, which could either be provided by the same entity that's providing your residential services or could be provided by someone else.

Now, this may be wrong, but way back, I thought the use of HCBS services for people in -- we'll call it group settings -- was a way of getting Medicaid funding for those services, where otherwise there would have been no services. And the individuals would have been left with dealing with their disabilities with no assistance beyond what that residential provider might be able to provide, and that may have been incredibly scanty, to say the least.

So there's this question of consequences, because I think there's a wide variation. I've been in multiple assisted living settings, and they vary all over the map. So there's this question of kind of like what are the consequences when we take these words and we have, in some respects, a uniform definition that we're going to apply, and it may not fit sort of all the different circumstances.

It's hard to deal with that because we don't know the prevalence of all these different circumstances. We can't tell you what the distribution is like of residential settings and what the consequences would be in terms of --

if we were to say you cannot provide HCBS services to these types of settings, then these are the people that are not going to be getting those services funded by Medicaid and whether the implication of that is they're not going to be getting these services. I mean, I think that's the big question that we sort of have to be asking.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: Kristal, thank you for this. I think it's going to be really important work.

The one thing I want to just reference is kind of the Olmstead driver behind a lot of this settings-based work. The Olmstead decision came out in 1999. it said that the ADA required integration into community. Integration means opportunities like people who live in residential communities, so a lot of the employment-related pieces, the transportation-related pieces, it was really, in the Olmstead decision, driven by a non-institutionalized approach to integrating people into communities where people without disabilities lived.

So then that led to if somebody is in an assisted living facility that has 200 units as opposed to a nursing facility that has 200 units and they're similar campuses,

just as far away from churches and jobs for younger people with physical disabilities and all the rest -- or developmental disabilities, is it really integrated? Is it just a facility by a different name?

I think what you've described here is really capturing, once you get down to the details of it, what does it really mean to be in a community-based setting, what does it really mean to be integrated into a community setting in the spirit of the Olmstead decision. And I think it gets really complicated.

I mean, as Leanna said about transportation, there's other issues around how do we know it when we see it.

So I just want to say I think this work is really important. I think it derives a lot from Olmstead plans and Olmstead decisions and how will we know when we see it that it's not a facility by a different name.

So I do think that it's partly, Bill, to your comment, not just based on what services are delivered into the home, because if that home is just as isolated from an integrated setting as a nursing facility, it doesn't meet the spirit of Olmstead, but it's incredibly complicated, as you noted.

I don't have a question here. I just want to say I think the right way to locate this work is how will we know it when we see it in the aftermath of compliance with the Olmstead decision and the ADA.

CHAIR BELLA: Sheldon?

COMMISSIONER RETCHIN: I acknowledge Chuck's framework as well. I believe that I may be adding, Kristal, the context of the Olmstead decision and the ADA as well in terms of the spirit of the rule.

I know it will be a shocker to everybody, but as I thought about this and was looking at the end of the memo, it was the unintended consequences on, yes, workforce. So this is an entry-level workforce for many of the services in HCBS. There's a terrible shortage, as it is, and since there are no payments, additions, or at least none proposed on this, that my fear is it will squeeze the ability for wage increases at an entry-level workforce that's already strained.

So I don't know how the stakeholders, particularly provider associations, will probably bring this up, but I think it is something important to keep in mind.

CHAIR BELLA: Other Commissioners?

[No response.]

CHAIR BELLA: I'd like to see if anyone in the public would like to comment.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: We have zero takers. All right.

Thank you, everyone, for the feedback that you have given her. I think that there is an interest in continuing to convene stakeholders, whether that's one of our sort of small group sessions or whether that's at a public meeting with a panel. I think we'll kind of leave it to you to look at who you've talked with and kind of how to augment what we've heard with a cross-section group of those folks, but I think, definitely, that would be something of interest, and it would be helpful.

I'm happy that when we got the book, there were 15 approved, and now there are 17 approved. Maybe next time we come together, there could be 27 approved. But I think it would be helpful to know how that progress is tracking as well.

UNIDENTIFIED: [Speaking off microphone.]

CHAIR BELLA: What's that?

UNIDENTIFIED: [Speaking off microphone.]

CHAIR BELLA: You do? Would you like to make a comment?

MS. NELIS: Yes, please.

CHAIR BELLA: Oh, go ahead and please come to the microphone.

* MS. NELIS: Hi. My name is Tia Nelis, and I work for TASH, which is a national advocacy organization and as a person with a disability also.

HCBS ruling, we also have to remember that there has to be monitoring in order for this to work because a lot of times when it doesn't have anybody monitoring what's going on and what's happening, it's the same crap, different day, when nobody is there watching.

So like if you're going to make sure that people are getting choices also about where they live and if you're making that kind of choices, that also people have to have an informed choice. You can't just have somebody who's been stuck in an institution all their life and say, "Hey, do you want to live in the community today?" That's not fair to the person.

Also, you have to make sure that they are able to have

an informed choice, have opportunities to go see things, to be a part of the community, because then they can really make some informed choices. People don't know all the time what is available and what could happen with those things, and we need to again educate people.

As far as going to different places, there's also natural supports out there. It doesn't always have to be paid supports. You can think about supporting a person with a disability around "Hey, is somebody going to this place or that place today?" Maybe they want to pick up that person and take them to the library with them, or maybe they're going to church. And maybe their service provider can't take them to church, and somebody at the church is willing to take them to church.

But I think we need to also be very creative and to think about those things, natural supports as well as paid supports, and to think about how people aren't getting supported. And then when something is not working, who do people go to, to say, "Hey, I have an issue, and I'm not getting the supports and rights we need"?

And for the HCBS rule, we're coming out with -- ASAN is the Autism Self-Advocacy Network -- is coming out with a

toolkit to make things easy to understand for the HCBS rule, so that people with disabilities can really understand the rule. And that's part of the problem. If it gets written up in so much bureaucratic language, how do you expect people with disabilities to understand what their rights are and what the rule says and what they need to be available in, good or bad?

And then the other part, again -- so, again, community, direct-support care workers really need more money. We need to figure that out because you can work somewhere else in less hours and get a lot more money than having to do caseloads and caseloads of helping people that, you know, they don't get any breaks and they don't make a lot of money. And that's where we lose our good people. That's where we lose people who are good supports to us because they don't get enough money. They can go somewhere else and make a lot more money, and I think that and educating people around disability also is another thing that you have to really put into making sure that happens.

But I think that people can live in the community with the right supports that they need and can make it really

good if everybody is on board trying to make it happen. Thank you.

CHAIR BELLA: Thank you for coming.

A quick question back for you. When will you have your toolkit? When will that be released?

MS. NELIS: Oh, it's not me. It's ASAN's. It's very close to being ready. It's in the final stages. Julia Bascom, the director of ASAN, you can contact her, and she can tell you when it will be totally ready.

CHAIR BELLA: Okay.

MS. NELIS: That would be great because it's going to explain in plain language, hopefully, so that people can understand it and be able to do that, because if you want people to be a part of this and understanding it and be at the table to be included, they have to understand it first.

CHAIR BELLA: Thank you. Thank you for taking time to come.

All right. Any last comments from the Commissioners?

[No response.]

CHAIR BELLA: Kristal, anything you need from us?

DR. VARDAMAN: No. I think we'll add a little maybe to the setup about Olmstead, and otherwise I'm good. Thank

you.

CHAIR BELLA: All right. I would like -- I think making the concept of informed choice, making sure that that comes through in the chapter as well.

Okay. We have finished for the morning. We are going to take a break for lunch. We will reconvene at 1:00 p.m., and we will be talking about Medicaid enrollment trends.

So thank you, everyone. Please be back here at one o'clock.

* [Whereupon, at 11:49 a.m., the Commission was recessed for lunch, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[12:59 p.m.]

CHAIR BELLA: Okay. We are going to go ahead and reconvene. Thanks to those of you that have rejoined us. We are going to kick off the afternoon with a session on Medicaid and CHIP enrollment. Martha, there is great interest in this topic, so please take it away.

MEDICAID AND CHIP ENROLLMENT: ANALYSIS OF NATIONAL AND STATE TRENDS

* MS. HEBERLEIN: Thank you, Melanie, and good afternoon, Commissioners.

The December 2018 version of MACStats documented Medicaid and CHIP enrollment changes between July 2017 and July 2018, and this was the first time since implementation of the Affordable Care Act that we reported a decline in enrollment. Since those numbers were reported, enrollment declines have continued, so today I'm going to present an updated analysis of the trends in enrollment, at both the national and state level, as well as some of the possible drivers of these changes.

Overall, Medicaid and CHIP enrollment has been declining for much of the past two years, although there were increases in certain months. Specifically, total

Medicaid and CHIP enrollment declined from 74.6 million in May of 2017 to 72.8 million in May of 2019. This is a decline of approximately 1.9 million enrollees, or 2.5 percent. This figure includes a decline of almost 930,000 children and 787,000 adults.

As with all things Medicaid, there was variation across states during this time period. Fifteen states saw increases in enrollment while the remaining 36 including D.C. reported declines.

This figures shows the monthly change in enrollment between May 2017 and May 2019. As you can see, the month-to-month change at the national level is fairly minor. While the majority of states hover around this mean, a few state-level changes were more dramatic. For example, the two spikes on the right-hand side of the figure show a 17 percent increase in Virginia, when the state implemented expansion in January of 2019, and a 7 percent increase in Utah following its more limited expansion to 100 percent of the federal poverty level in April 2019.

So focusing on the states with the largest declines in enrollment shows a diverse group in terms of geography and adoption of the Medicaid expansion. Missouri had the

largest decline in total enrollment at almost 13 percent, as well as the largest decline for children, at about 15 percent. Wyoming had the largest decline among adults, at almost 18 percent.

Commissioners, there is additional state-by-state data for total Medicaid enrollment, as well as among adults and children included in your appendix tables.

So the declines in enrollment have raised questions about whether those losing Medicaid are securing other coverage or are becoming uninsured. While we are not able to track the outcomes of particular individuals, survey data can provide overall trends in coverage patterns during some of the time frame that we looked at.

I want to take a moment here to describe the two data sources that I will be discussing. The first is the Annual Social and Economic Supplement of the Current Population Survey, or the CPS ASEC. This survey provides health insurance information for the nation as well as demographic groups, and was released on September 10th. The American Community Survey has a much larger sample size, making it possible to examine health coverage by state.

The state-level uninsured data from the American

Community Survey were released, along with the Current Population Survey on September 10th, and those are the basis for the state-level data that I will share. Additional data were released today from the ACS, and there will also be more tables coming out on October 17th, so we will be taking a look at those data as well, but they are not included in this presentation.

Data from both sources indicates that the percentage of uninsured individuals increased nationally between 2017 and 2018. The American Community Survey data shows that the percentage of uninsured individuals also increased in eight states but decreased in three. Again, Commissioners, the state-level changes are in your appendix.

As I mentioned, while additional state-level data are being released, the national-level data from the Current Population Survey provides some indication of what those data might say, and those are listed on this slide. Those data indicate that the percentage of people covered by Medicaid decreased while the percentage of people with private coverage did not statistically change between 2017 and 2018.

At the same time, the percentage of children who were

uninsured increased, the percentage of children with private coverage did not change, and the percentage of children with public overage declined. And most of this decrease in public coverage was due to a decline in Medicaid and CHIP.

Medicaid is often described as a countercyclical program, meaning that Medicaid enrollment increases during economic downturns as individuals lose jobs and incomes decline. As the economy improves, enrollment growth slows and typically stabilizes, although it has historically not fallen back to pre-recession levels. The number of unemployed individuals has increased nationally over the last few years, with all but seven states experiencing an increase in the number of employed individuals. However, the gains in employment in states do not necessarily align with the declines in Medicaid and CHIP enrollment.

Additionally, it is not possible to understand from the existing data whether individuals who are dis-enrolled from Medicaid did so because of a change in job status or whether that employment change was associated with an offer of employer-based coverage.

So in order to gain a better understanding of the

factors that might be contributing to enrollment trends we reached out to states to discuss these changes. There was not one single explanation across the states for why enrollment may be declining, but they listed several possible explanations, which are included on this slide.

One contributing factor were systems issues. When states launched new eligibility systems in response to changes required by the ACA, technical issues were common and a number of states delayed renewals. This was a mitigation strategy that was approved by the Centers for Medicare & Medicaid Services as a way to help states transition to their new systems as they were dealing with an influx of applications.

As these systems have matured, states have been able to return to processing renewals, possibly accounting for some of the declines in enrollment, as individuals were no longer eligible or did not respond to renewal requests.

Other states mentioned eligibility processing changes. Given the complexity of some of the changes mandated under the ACA, confusion regarding the interpretation of the rules, or difficulty in implementing some of the changes, may have led to enrollment declines in some states. For

example, producing notices that informed individuals of their eligibility determinations, especially in families who had mixed coverage, was found to be difficult.

A number of state officials also cited the improving economy over the last several years as a contributing factor, while some states mentioned that various policy changes at the federal level may have had an effect. For example, the removal of the financial penalty for not having health insurance and the proposed rule that would change the definition of public charge may also have had effects on enrollment.

So while declines in Medicaid enrollment have been found both at the national and state level, there does not appear to be a single explanation for these changes. I also want to note that it may be too early to know what the enrollment baseline should be following the Affordable Care Act. Implementation was expected to, and did, in fact, increase enrollment in Medicaid for a number of reasons, including the Medicaid expansion, heightened awareness of insurance options, and simplified enrollment and renewal processes. The multiple policy changes that encouraged enrollment, as well as delayed renewals in a number of

states, and the simultaneous economic growth make it difficult to determine what constitutes an appropriate number of enrollees and level of churn.

So staff is going to continue to monitor the changes in enrollment as well as the state-by-state estimates of coverage that I discussed earlier. This ongoing analysis may provide more information on the trends in states and whether the declines in enrollment are an anomaly or a continuing issue, especially as the recent increase in the uninsurance rate was the first following implementation of the ACA.

CMS has also been looking at this issue very closely and is trying to discern what the drivers of these changes are. This work is expected to be completed soon and staff will continue to monitor these efforts and report back.

Staff has also recently started a follow-up project to the Medicaid eligibility enrollment and renewal case studies that we presented last fall. This new project is going to look at the risks that remain for both states and individuals in the process, and how states and others, such as application assisters, are trying to mitigate those risks.

Finally, the first results from the revised Payment Error Rate Measurement, or PERM, eligibility reviews are expected to be released in November. These data will be the first publicly reported information on eligibility errors following implementation of the Affordable Care Act, and staff plan to bring these findings to the December meeting.

So thank you, and with that I will leave it to you for questions and discussion.

CHAIR BELLA: Who would like to start? Peter.

COMMISSIONER SZILAGYI: Thanks, Martha. This is really disturbing. So that's a generic comment, but I do have some questions.

So in terms of the monthly drop, there were several months where the drop spiked to like 0.3 percent, which one may think that's not very different than 0.1 percent. So in April of 2018, June of 2018, September, and November. Do we know whether anything happened during the month prior to that, or during that month? I don't know enough about the various different rules. So, anyway, that's just a suggestion, to potentially take a look at those, because that's triple the loss. Typically it was 0.1 percent per

year, and then for several months it was 0.3 percent, so that's one question.

The second is, because CPS has this, and I think ACS as well, can you look at the loss by race and ethnicity?

MS. HEBERLEIN: Yes.

COMMISSIONER SZILAGYI: And is that in the plan? Because I would be very interested to see whether Latinos were more likely to --

MS. HEBERLEIN: Yeah, and they were.

COMMISSIONER SZILAGYI: -- to drop off of Medicaid.

MS. HEBERLEIN: Well, there was an increase in the uninsurance rate among the Hispanic population, in the CPS. The ACS does allow for that, but those data -- I am not sure if they were released today or if they are coming, there are more tables coming October 17th. But we can certainly look on a state-by-state basis.

COMMISSIONER SZILAGYI: Because I think looking at the different groups, by age, by race, and by ethnicity, or sort of by the different classifications would be important.

A third point is, if you look at -- half of the losses were from three states, and two-thirds of the losses were

from four states. That makes sense because some states are enormous. But I'm just wondering whether it would be kind of worth looking -- you know, kind of combining those states and try to figure out, are there some commonalities. That is qualitative. You are not going to be able to do that quantitatively.

So I have about 13 more questions but I will stop and let others take over.

CHAIR BELLA: Tricia, then Toby.

COMMISSIONER BROOKS: Okay. I probably have about double the number you have, Peter. So based on the first look at the ACS, the American Community Survey, uninsurance data, top line in the United States, kids' coverage dropped by 130,000 kids. That was about half of the drop that we saw in the prior year, but it is still considered statistically significant, and represents the second year in which we have seen a reversal of more than a decade of coverage gains for kids.

And, in particular, these data will lag even further behind the details that we need on a state-level basis from the ACS. But the Urban Institute also indicated that participation rates in Medicaid dropped for the first time

in 2017. And there is a correlation here, because we know the more we have done to reach eligible children and get them enrolled in Medicaid, that that has really been the driver of the decline in children with uninsurance. So that is another piece of data that we need to look at.

Just a couple of things, very specifically. I would say we know that CMS is looking at the states that had the largest declines, either percentage decline or number decline. We have certainly been tracking that at the Center for Children and Families. And yet I've heard that that particular study and report may or may not ever be released publicly. So one thing I think the Commission can do is really encourage CMS to make their analysis available to us as well.

The other thing, in going back and doing case studies, is a very specific recommendation, and that is that returned mail, I think, is a huge part of the problem, and looking at what states do with returned mail, how the process that, what they do to try to identify those families, I think would be enlightening, in particular. We also know that at application families have 45 days to provide documentation if it is needed. At renewal, they

have 30 days to provide documentation if needed. But with returned mail, the states are cutting folks off in 10 days.

And we know there are lots of issues where people have sent stuff in, it hasn't been processed, you know, people try to call in to call centers and they have long waits. They are working individuals and they are not able to get through.

So we are just not providing all the opportunities that families need, I think, to keep their information current. So those are some areas I would be interested in getting more details from the states.

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: Yeah, I just would caution that we have got to remember that there are so many different dimensions to this, and the responsibility of payment access and thinking through from a state lens of program integrity. And there are so many different levers, as Martha said, around what is going on, or dynamics. We don't know exactly. And states, on one side we want -- a lot of these states pushed quickly on system changes to get families and individuals on the coverage. What we could be seeing, we don't know, is just everything is catching up

and making sure that they are following all the rules that some states were not able to be compliance with, has caused these dynamic changes.

And so we just caution jumping to that -- you know, it's ill-intentioned, rather than falling within the program structure that states have to follow to keep the right people on the coverage. So I'm not saying that we shouldn't keep on looking at it, but we just have to know that there are so many different sides to this, in the eligibility and enrollment, that is beyond just fostering coverage.

CHAIR BELLA: So I have a question related to that, and then Kit, and then Chuck. The whole notion of having kind of turned off the renewal processing while the systems were getting up and running, so a couple of questions. Well, maybe three.

The performance indicator data that states self-report, like I went on the site last night and was trying to find -- a couple of things are reported but a lot of it is not, as you indicated. Can you just explain what is shared publicly and what else -- because processing time, for example, is a proxy for some of this, and states are

self-reporting and I think some of them are self-reporting that there are problems.

And so one of the questions is, what is happening on the performance indicator? What of that is transparent? And then what kind of ongoing monitoring is CMS doing, of the whole requirements around processing time frames, all those kinds of things?

MS. HEBERLEIN: Okay. So hopefully I can remember all of those questions at once.

The performance indicator data are a dataset that was really sort of started after the ACA to monitor things more quickly. And so there are a whole bunch of things that states are supposed to be reporting on, and my understanding is that CMS has been sort of working through those data reports over the years to get the data sort of clean and understandable and out as they can.

And so they prioritized the enrollment data, because this is the enrollment data we have, because there are other systems that aren't reporting enrollment data. So they prioritized those data first. They have also worked on the timeliness data, which you mentioned, and they issued a report last fall on the timeliness standards, but

they haven't released any additional data on those metrics.

There are denial reasons that states should be reporting, but they are very high level. So it's like ineligibility was found, or there was like process reasons, but it doesn't go further to say, like, mail was return, or, you know, more detail on those reasons. And those are not publicly reported, and my guess would be is that states are kind of all over the map in terms of what they can report. I mean, we know their systems don't necessarily track all of those things, and so what they are reporting to CMS, and how comfortable CMS is with those data and willing to share them.

I know, you know, MAGI versus non-MAGI is in there. Those aren't reported in terms of enrollment numbers. So I think, you know, there are more data here, and we can certainly follow up with them to see sort of what they are prioritizing next and what we might see in the future.

CHAIR BELLA: Is that mainly what they are relying on to do oversight of the states' processing systems and all of those things?

MS. HEBERLEIN: I think it's sort of a combination of things. I think that's definitely a piece of it. They are

looking at the data, and I know that the data people are talking to the eligibility people, to sort of be like, okay, this looks weird -- can you help us sort of understand this? There is a lot of TA going on with states.

At the beginning we saw more TA that was, you know, big calls, like SOTA calls -- SOTA, which I can't remember what it stands for. You know what I mean. There were big group calls. They were sort of walking through the guidance and this is how you need to do things, and it was a lot more formal outreach. And now, as states have gotten further along, there is more one-on-one TA with states as they encounter specific issues. So CMS is working more closely with them to try to address state-specific issues as they come up.

So I know that those efforts are going on, and so that, I think, is also part of the oversight, to see how the eligibility processes are working.

CHAIR BELLA: Thank you. Kit?

COMMISSIONER GORTON: Yeah. I just want to underscore what Toby said, and Martha pointed this out as well. So there are a lot of reasons why this could happen, and I was

actually running a health plan in Massachusetts during a portion of this period. Massachusetts has had a long-term commitment to full insurance. And so one of the things that they didn't place a lot of emphasis on, for a number of years, was redeterminations. And what happened, actually, in the year 2017, is that sort of all caught up with them.

And in Massachusetts, if I remember correctly, in 2017, we did seven waves of redeterminations, and to Peter's point, they weren't all the same size. There were little ones and there were big ones. There was a lot of returned mail. But Massachusetts gives us a nice sort of control case, because Massachusetts has its long-term commitment to full insurance. And it is my understanding that they did not see a jump in the uninsurance rate.

And that is just one state, when we start rolling together all of these states. So I think we should be concerned, and I think we should pay attention, and I think we should watch this closely. But I think that we need to keep front of mind that these are very complicated systems, that there were a lot of changes that have gone on over the course of the last five years, and I would just echo what

Toby said. We don't know what the right baseline is.

And, you know, if we want to run a cost-effective program, then one of the things we need not to do is pay managed care companies capitation for people who no longer live in the state, who are no longer alive, who, you know, if you can't get your correspondence from the state then you are not getting your card from your health plan or anything else. And so that's just money that's going out the door and buying no value for anybody.

And so I do think that while the redetermination process, the renewal process creates vulnerabilities, certainly for families who are mobile and may not have stable housing or stable transportation, or those things, we need to be cognizant of that. We also need to be cognizant that as we moved in the direction of a capitated system, that making sure we're paying capitation on only the people who are eligible for services and who are using services and can take advantage of services, that's one way to manage the cost-effectiveness of the program.

CHAIR BELLA: Chuck, then Stacey, then Darin.

VICE CHAIR MILLIGAN: I have a question, Anne. I'm not quite sure, Martha. I think it would be helpful for us

to identify kind of what our issue brief for publication approach is going to be. I do think there's a lot of good information in some of the tables in the appendices that we saw that you didn't have time to really present, that I think for us to just start identifying a publication approach that we can communicate publicly I think would be a good thing in a way that just is kind of putting the facts out there. And so I do think, for example, some of those tables would be good to just start pushing out. And I think my own view is that probably over time we're going to want to have, you know, number two, number three, number four.

I do think that, as you noted, there's a lot of potential factors. I do think that from an analytic point of view and kind of multivariate point of view, it would be good to have some approach to try to size the relative magnitude of is it, you know, potentially ineligible people and system redeterminations? Is it other policy factors? Is it other things? I know that that's a complicated analytic endeavor, but I think just trying to debunk some of the potential theories with kind of relative order of magnitude -- I'm almost thinking kind of like a waterfall

depiction of this, which I know is easier said than done.

I do want to mention a couple of other factors and then refer back to some I've heard, that -- so there is a descriptive piece, obviously, which you've done a really nice job, Martha, of just saying here's a list of things that could be going on and likely are going on. We don't know how they vary by state. We don't know how they vary by order of magnitude. I would just want to kind of become explicit about a couple of things.

One is I do think that the ACA impact of potentially parents no longer feeling obliged to enroll because of individual mandate-type issues and then kids who might have been in that same household not being part of Medicaid, I think that is a real issue. I do think that in some of the immigration-related and public charge pieces are real issues.

I do think that a lot of the Medicaid expansion adults in the states that did expand, there was a big dropoff if they tended to be non-utilizers early and didn't see the point of renewing, I do think that that's a related factor.

I do think that the systems piece that we've talked about has tended to be kind of catching up with

redeterminations and moving away from self-attestation kinds of things. But there have been some other system-related pieces, which is like deemed eligibility where, if you're eligible for food stamps, we're going to deem you eligible for Medicaid, and like how we use other subsidized programs to kind of be proxies for Medicaid eligibility. I think that's part of a systems and policy piece.

The other thing I want to -- and, Tricia, when you mentioned the direct mail, what occurred to me is one of the things that we have seen is people who are on income support programs of various kinds tend now to get more direct deposit, and that means we tend to have not as good addresses because people aren't looking for things to arrive in the mail. But, again, you know, we could all like throw 45 different theories out there. I do think how we can try to size order of magnitude and then come up with a publication approach to how we can release that, I think that is squarely within the role of this Commission. And thank you for your work getting us this far.

CHAIR BELLA: Stacey.

COMMISSIONER LAMPKIN: I'd like to thank you, too, Martha. This is really helpful, really useful. This

general subject is one that I and my colleagues are paying a lot of attention to because the order of magnitude of the change here is enough to affect the acuity of the population over time, and so we have to do our best to understand what the drivers are and what the implications are from a risk perspective for the MCOs. And so I love that we've done this, that we've laid this out, how complex the drivers are, and I think an issue brief is a great idea.

I did have one question, and I hope this is not a throwing 45 different theories out kind of question. But at least with a couple of the states that I've been studying more closely, one of the really dramatic patterns has been that while we see a distinct decline in Medicaid children enrollment, we see sharp increases in CHIP enrollment. And so I wondered if -- I don't know how widespread that is. That is, you know, an example of two. So maybe, Tricia, you have more intel as well. But I wondered if we had any kind of income slices of any kind that tell us whether these patterns vary by income level.

MS. HEBERLEIN: So I didn't look at -- when I looked at pooled enrollment, I pooled Medicaid and CHIP

enrollment, and so we could certainly do -- they do report it by Medicaid and they do report it by CHIP. So we could conceivably look at that a little bit more closely.

There are also income measures in the ACS, so we could do some sort of proxy. We've done that before with other work.

We did hear from one state that -- sort of the flip side of what you're saying is that they were not seeing the transfers that they thought. And that was one of their systems issues, that we built this new system and somehow kids from Medicaid are not necessarily getting into CHIP as we think they should. So I think there's also sort of that other question: As income goes up, are the kids moving from Medicaid into CHIP? Or is that handoff not happening? And I think that's sort of like another question that we could look at more closely.

CHAIR BELLA: Toby. You raised your hand. You forget? No, it wasn't you. You already spoke.

[Inaudible comments/laughter.]

CHAIR BELLA: Darin, for Toby.

EXECUTIVE DIRECTOR SCHWARTZ: Do you think if I move you to the other side of the table this is going to stop?

COMMISSIONER GORDON: I would think it would minimize --

EXECUTIVE DIRECTOR SCHWARTZ: Bring a wig to the next meeting.

COMMISSIONER GORDON: It would minimize the issue.

So I'm going to align myself with my dear friend Toby and Kit and Chuck and some of the other things that were said as well, because I think just listening to everybody, there's recognition that this is incredibly complex. And then when you try to look at it state to state, it adds even more complexity to it.

But Kit had something in particular that -- and you added some of the narrative as well -- that I don't know how you factor this in, but it's clearly an element that arose in your discussion with states. But, you know, Kit gave you a good example in Massachusetts and their prior history with redeterminations. I had heard from a fairly decent size state recently that had a lot of community -- these are county-based eligibility systems -- that one of their largest counties in the state, when they were going through the whole process of abating systems and processes to make sure that they comply, their system at the county

level did not have a redetermination function for decades in it. So they were not doing that properly before as well. And I do know, you know, we saw this in our state. When we in-sourced the eligibility function from the Department of Human Services, there was a remarkable lack of documentation and good process descriptions of how things were being done before, which then, you know, would lead one to believe that there wasn't high fidelity in the appropriateness of how they were doing things before, that one of the things that happens in the ACA really did bring an enormous hyperfocus to the rules and the policies that were being done, and yet new systems implementation, again, with systems that were decades old being replaced, that I don't know much of a factor that is, but I have enough of those examples adding to 46 and 47 of the theories, because you had 46, the 47th of the theories that Chuck's counting, that there's something there, too. And I don't know how you account for that, like, you know, because what we're looking at is this is abnormal compared to what we've known before, and we're making the assumption what was going on before was accurate. And I don't know if that is a safe assumption.

And, you know, one of the things that, you know, you look out there, you have -- similar to what you see on the MMIS side, you have a certain number of vendors -- there's only a few vendors doing the eligibility systems across the country, and that would be considered to be, you know, the experts in the field.

Again, I do think there was an elevation of consistency and rigor behind some of the processes and connecting that to the federal rules that may not have been there before. And, again, you noted in the narrative, but I do think that's something that we all just have to be cognizant of as we try to untangle this as best we can.

CHAIR BELLA: I'm going to take the Chair's prerogative for one second on that and then Martha. I think we can't assume that in the past was accurate, but we also can't assume it was inaccurate. And if we haven't -- you know, if people haven't heard for three or four or five or ten years to provide this information, or they may have moved, I mean, I think it's -- there's a lot of people that probably have no idea what's expected of them. And so if they don't know what is expected of them, then how can they comply with that?

And so I just think we should keep an open mind that there may have been inaccuracies, but there may have also been a lot of accuracies. And we have to figure out how to communicate to the people that legitimately should be on the program. So I just -- Martha?

COMMISSIONER GORDON: Point well taken.

COMMISSIONER CARTER: This may be theory number -- what are we at?

COMMISSIONER GORDON: 48.

COMMISSIONER CARTER: Well, I was looking at Table 1 and looking at the percent of total decline, and of the ten states that have the highest rates of total decline, four of them have lost population. So how does that -- I mean, overall obviously there's still a national decrease, but people moved from these states and went to a different state that wasn't an expansion state or didn't get re-enrolled quickly. So does that factor in? How does that factor in?

MS. HEBERLEIN: Yes, it would factor in, right, because if there's fewer people who are in the state, that's certainly, you know, a possibility. We did hear that as one thing from -- one factor from a state, thinking

that their overall population had declined. We also heard from another state that their population was aging and there weren't a whole lot of new people coming in, and so it -- no names, but it was -- so their population was moving to Medicare. So I think the population size and just the makeup of the population could also be a factor.

COMMISSIONER CARTER: Yeah, and that could actually be some -- you know, just looking at this list of states, that could certainly be a dynamic there. So it may be a national demographic trend, even. I mean, it is worth thinking about from that perspective as well.

CHAIR BELLA: Tricia.

COMMISSIONER BROOKS: So I think it's really important that we think about kids and adults separately here, and getting to Stacey's point about are these kids moving to CHIP, I know specifically in two states -- that maybe I shouldn't name -- that 80 percent of the kids that are losing coverage are in Medicaid, and you would think they would be making it to CHIP.

And so it's really important. I understand that a good economy might have put adult enrollees, you know, that are at 130 percent of poverty over the eligibility limit.

But I don't think that's happening for kids overall. But we'll get more data on who's uninsured, but I totally get the issue of program integrity and managed care capitated payments. Those are sticky issues. I don't know of a single children's advocacy organizations that wouldn't agree that all we care about is keeping eligible kids enrolled continuously so they get the care that they need.

And we certainly see that there is a push for stricter and more frequent reviews of eligibility, so not even just the annual renewal. It's going to quarterly or monthly reviews, and historically we know that a large percentage of families who have been reached out to are confused. They don't know. And to your point, Melanie, I thought you articulated that well, that we need to really educate families.

The other piece is income volatility. You know, 25 percent of low-income families experience a drop -- or, excuse me, maybe it's half, a drop of 25 percent in at least three months out of a year, and vice versa. So we have to come to grips with this idea: Do we really want to be churning people on and off simply because Mom and Dad worked three hours of overtime last month and that puts

them off the program, and then they show up at the doctor, they realize that they no longer coverage?

So it is highly complicated, but I definitely think that we have to address -- think about it differently for children than we do for adults.

CHAIR BELLA: Really, this time, Toby?

COMMISSIONER DOUGLAS: This is Darin.

[Laughter.]

COMMISSIONER DOUGLAS: To make sure I understand, I thought as part of the match, either they aren't -- I mean, they can be checking it electronically. So when you say --

COMMISSIONER BROOKS: I'm sorry. I --

COMMISSIONER DOUGLAS: Maybe just re-educate all of us on what's allowed under the new rules.

COMMISSIONER BROOKS: Okay. So they can't necessarily send a family -- a request for information to say you need to renew more frequently. What's happening is they do find some data behind the scenes that indicates a discrepancy. Then they are obligated to contact the family, and that's where every time you ask a family to produce information, you see the dropoff.

COMMISSIONER DOUGLAS: But that's the -- I mean, this

gets to the tension we have. That's a requirement of the rules, and they need to reach out.

COMMISSIONER BROOKS: Yes, that is -- well, they are -- there's no requirement for them to trawl for data. There is a requirement for them to react to data that they have available to them. But when you hear lots of anecdotes of families who say, "I never got that mailing," or, "That mailing told me I needed to do something in ten days. It was dated September 12th, and I didn't get it until September 30th."

So there are lots of internal issues that contribute to this that make it difficult for families to be responsive. And we learned that when we were much more proactive about providing good customer service and facilitating the process for families, we were able to increase coverage for children. And we just need to return to those roots and not necessarily, you know, be --

COMMISSIONER DOUGLAS: Yeah, I hear you. Just we have to remember -- and there's one big state that I know of where that occurred --

[Laughter.]

COMMISSIONER DOUGLAS: -- and, you know, we took and

we fostered -- more recently there's been many program and integrity of all the individuals who were not supposed to be on. So you've got to figure that states sort of this tension --

COMMISSIONER BROOKS: Yeah.

COMMISSIONER DOUGLAS: -- and so having to follow the rules knowing at times when we need to relax to make sure we're getting -- fostering the ACA and the -- but the rules are the rules, and we've got to figure it out. And then I think it is how do we learn from that to figure out how we better engage in families. But that doesn't mean I think that it's a bad thing that states are doing it. How do we continue to improve that?

CHAIR BELLA: Okay.

COMMISSIONER GORDON: I was just going to say I totally agree with you, Toby, but I would also say -- and you probably wouldn't disagree with this -- that there are process issues and things embedded all in there as well.

COMMISSIONER DOUGLAS: Absolutely.

COMMISSIONER GORDON: So I'd say that if -- I don't think we can say every state has optimized in a perfect way in regard to how they deal with this from soup to nuts,

but, I mean, your point's valid. I'm just saying there's stuff all in between there as well in complying with the rules, too, where there is some -- you know, there are some things going on that could be improved upon.

COMMISSIONER DOUGLAS: Yeah, or we just need to figure out what that steady state is.

COMMISSIONER GORDON: Yeah, exactly.

COMMISSIONER DOUGLAS: Because I think there was so much to increase enrollment, and we're now getting more to a steady state.

CHAIR BELLA: But, Martha, much of that -- I mean, some of this you're going to be uncovering or trying to uncover in the work that's going on that you'll bring to us later this fall, correct?

MS. HEBERLEIN: Yeah. So that project is just underway, so the plan is to bring it to the Commission in April. So, yes, you're talking about the enrollment renewal follow-up?

CHAIR BELLA: Yes.

MS. HEBERLEIN: Yes.

CHAIR BELLA: Switching from where you guys are, just one other question. When you talked to the states or any

of the stakeholders that you talked to along the way, did anyone talk about what the managed care plans are doing to try to help people maintain eligibility? Because it strikes me that in some of the other work we've looked at, like work requirements and various things, they don't seem to be as active as you might assume in trying to make sure that people that need to be doing renewals or -- what? Well, they can know when someone's eligibility is ending, and they can be making sure that they're getting them supports to get renewed.

COMMISSIONER GORDON: They can but in some states, because of past practices of health plans in dealing with eligibility, do not allow them to be involved with eligibility. I'm just telling you that's not they can do that on their own necessarily.

CHAIR BELLA: So I'll ask my question. Did anyone talk to you about what the managed care plans may or may not be doing?

MS. HEBERLEIN: No, and we didn't ask that question specifically. So it's possible that in some states the MCOs were, you know, following up with their enrollees when they knew that they had a redetermination coming up. But

we didn't ask and nobody offered that as an explanation.

COMMISSIONER GORTON: So I will say in Massachusetts we did try to do that, but a bad address and a bad phone number is the same for a managed care plan as it for anybody else. And the state was not always able to produce for the MCOs. The redetermination was enough in advance to plan a project like that. I mean, it's a big project. It's just a lot of work. And once they were no longer a member, then the window crashes down. You can't have any -- or then you're violating marketing rules and everything else. So it's trickier than that. I think even where states are supportive and plans want to do it, it turns out -- I mean, we didn't feel like we had a whole lot of impact on that, either during this wave of redeterminations where we were trying to do that or, for that matter, in the MMP in terms of finding people who are losing their eligibility for the --

CHAIR BELLA: Maybe I just get to see it like I'm living in La La Land, but in my other -- in my real life, we see each month, and there are -- those plans and those providers have people on the street. They're expected to be out there getting people's needs met. And when we talk

about social needs, like this is one of those social needs, is continuing to help people fulfill their eligibility.

And so I guess one thing I would be really curious -- and I understand there may have been bad actors and bad past practices, but if the world is moving to managed care and these are supposedly people that are developing relationships with these members in ways that the state doesn't have and developing relationships with a pharmacy and knowing what transportation claim they paid, then we should see if there's not smuggling that we could do to shine some light on a best practice about how you might allow this and/or figuring out where there's been abuses in the past and protecting against those abuses. But abuses in the past shouldn't -- doesn't mean that they're always going to stay abuses.

I know you -- you --

VICE CHAIR MILLIGAN: Yeah, me -- me. When I ran a local plan, we did exactly what Melanie is describing. Again, it depends on the state data. But it also depends on the model and the state and the rules. But part of it, to Stacey's earlier comment, was plans are seeing, you know, mix changes that -- and the rate issues, and not just

keeping people continuously enrolled for health outcomes and health benefits, but if you get -- if you're chasing a bad mix on and on, that creates a whole other incentive for plans, too.

COMMISSIONER GORDON: So, you know, when I think about this population and the plans rolling -- I mean, I think we had gotten comfortable. There are certain populations that have an incredibly high rate of, you know, consistency on the program, and those, you know, we felt a little bit more comfortable in drawing some very tight parameters on what the plans could do so that they couldn't cherrypick who they helped and who they didn't. And, again, there's been cases around the country in the past, and we had some experience in the early '90s where plans were doing some inappropriate things.

The thing is I think about this -- and you talk about like being -- you know, the plan being engaged in understanding this. To Stacey's point a little bit -- and we've seen this in states as well -- that, you know, we're seeing the risk mix is changing to who is staying as being high-risk, meaning lower risk, lower utilizing individuals are coming onto the program.

The plan isn't in constant engagement with the individual that doesn't use services all the time. I mean, when you have 500,000 members, you try to stratify them and focus on those that, you know, can have a big impact on it.

I think when you look at this, the ones that would be more puzzling to me is not, you know, the low utilizers. I mean, there's all sorts of -- we can add a whole series of theories around that, but those that have like chronic conditions and that were going to the doctor repeatedly month in, month out, you know, and what happened there, because that is one where there is the tie to relationships, where there is ongoing communication, is one that you would identify that there's been a drop in the coverage more quickly. And I know some states will do some additional outreach to those populations, however they define it to be able to do, but that's where -- you know, I don't know. If you're looking at the population as a whole, are we seeing it in those populations or are we seeing it predominantly in low to no utilizers. That, you know, makes a little bit more sense to me. Although everything else we've said is true, some of that still has some questions but --

CHAIR BELLA: That's a fair point.

Anne, for the wrap-up.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, I just wanted to say a little bit more about the project that Martha mentioned that we will be doing to follow up on the case studies we did last year on enrollment and renewal. And the purpose of that project was sort of saying it's been enough years after the passage of the ACA. What did different states need to make their systems work? And we also had another thread last year where we talked about -- I think it was Chuck who said, you know, what are the conditions that allow beneficiaries to be successful as their own advocates and take ownership for the things that they are responsible for?

And I think this next project is supposed to be taking the next step from the state side and the beneficiary side to say now that everybody's got their enrollment and eligibility systems working, how is that actually working now? How is checking of electronic sources -- what new problems are we coming up with that that we didn't know when we were working on that previously? And, similarly, on the beneficiary side, we keep hearing, you know,

beneficiaries aren't getting mail. What is an effective method for reaching beneficiaries? We don't want to be in a situation where it's like speaking to someone who speaks another language and you just speak louder in your own language and the message doesn't get through.

So, you know, what do we know about technology, what do we know about beneficiaries' lives so that we can sort of be in a situation where they can succeed and the state can also be upholding its obligations around making sure that people who are eligible are enrolled and the people who are no longer eligible are not?

So that's really what that project is about, and so it's supposed to present sort of the spectrum of things that we should be learning about now to get that right match.

CHAIR BELLA: We want that tomorrow.

MS. HEBERLEIN: On it.

[Laughter.]

CHAIR BELLA: I would invite anyone from the public, if there are any comments.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: No comments.

Any last words from any Commissioners? That's a risky offer.

[No response.]

CHAIR BELLA: Okay. Martha, thank you very much.

All right. Erin is back, this time to talk about part 2 and confidentiality.

PROPOSED RULE AFFECTING CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS (42 CFR PART 2)

* MS. McMULLEN: Thanks. Good afternoon.

As Melanie said, I'm going to be talking about the proposed rule on substance use disorder confidentiality of patient records, otherwise known as 42 CFR Part 2 or just Part 2 for short.

On August 26th, HHS issued an NPRM to further amend Part 2, and the proposal was issued to facilitate better care coordination for individuals with a substance use disorder.

Before I go into detail about the proposed changes, I'm going to briefly summarize Part 2 and its underlying statute. I will also provide a quick overview of the

commission's prior work in this area and noting where some of the commission's previous recommendations stand today and how they kind of play out in the proposed changes to the rule.

I will conclude today's presentation by highlighting areas where commissioners may want to submit comment. Just as a reminder, your statutory authority invites you but doesn't require you to comment on this proposed change. If you do decide that you want to submit comments, they will be due before our next commission meeting on October 25th.

So Part 2 governs the disclosure of substance user disorder treatment and prevention records. It establishes patient protections and sets conditions for disclosure of any information that would indicate that an individual has a substance use diagnosis or seeking substance use treatment.

The regulations were first promulgated in 1975 and implement statutory requirements intended to encourage individuals to seek treatment for a substance use disorder by addressing the general stigma around substance use and concerns that individuals receiving treatment could be subject to negative consequences.

You talked about those consequences at length in a June 2018 report to Congress. Specifically, you noted the disclosure of substance use-related information could lead to criminal arrest, prosecution, loss of employment, among other things.

So, as I mentioned, Part 2 draws from an underlying statute. I'm going to talk about the first and third bullet in a little bit more detail.

Statute requires Part 2-covered providers -- so those are providers that hold themselves out as providing substance use treatment -- to seek written patient consent when they're disclosing the records of a patient's identity, their diagnosis, or their treatment information.

There are some statutory exemptions that relate to that prior consent requirement. Some of the exemptions relate to medical emergencies, which we'll talk a little bit about later, scientific research, audit purposes, program evaluation.

So that brings me to your prior work in this area. You actually first noted the barriers that Part 2 presented to integrating care in the June 2017 report to Congress where we first talked about the opioid epidemic within the

Medicaid program, and then in the June 2018 report, we had a whole chapter dedicated to this that drew from a MACPAC roundtable that we held on this topic as well as some analysis around different comments that were submitted during -- prior federal rulemaking around Part 2.

So I've included the two recommendations that you all made on this slide. Generally, the chapter noted that there was great confusion around which providers Part 2 applied to, which information needed to be protected, how information could be shared in a way that was Part 2 compliant. So, therefore, you made these recommendations around providing some additional clarification, but you also recommended that HHS should conduct a coordinated effort to provide education and technical assistance to providers and other entities around Part 2.

The next few slides talk about the current Part 2 regulation and proposed changes. I just want to note from the outset that a lot of the changes that I am going to be talking about today are modest. A lot of them are not areas that the commission contemplated in its prior work. There are some areas where our recommendations might align slightly, but for the most part, these weren't areas that

you weighed in on previously.

The first change I'm going to talk about relates to the applicability of Part 2. As I mentioned earlier, Part 2 applies to federally assisted programs that hold themselves out as providing substance use care.

In the June 2018 chapter, we talked a little bit about kind of what does hold itself out mean. Do providers know if this applies to them? We cited a lot of confusion, a roundtable, about how providers just didn't know whether or not Part 2 applied to them, and if they did, what were they supposed to do to be compliant.

So the NPRM does not further clarify kind of what "holds itself out" means, but it does provide some additional clarifications for non-Part 2 providers and how they can keep their records that are based on their own patient encounters that aren't subject to Part 2 and how they should segment those records from anything they receive from a Part 2 provider in order to be in compliance with Part 2.

So the next proposed change relates to when patient consent is required. Generally, there's very few circumstances when information, substance use treatment

information can be disclosed or redisclosed without obtaining additional written patient consent. As I mentioned earlier, one of those being for medical emergencies. So there were a few proposed changes around kind of when patient consent is required.

One of the changes is amending or defining a bona fide medical emergency under Part 2 to include situations where a state or a federal national disaster has occurred. So that would mean additional consent wouldn't have to be obtained in those circumstances.

The regulation or the proposed regulation also brought in the disclosure exemption for research purposes and clarifies when information can be disclosed for audit and evaluation purposes.

These weren't areas that we really hashed out in your report, but it does try to make some clarifications when information can and cannot be shared.

The next proposed change relates to consent requirements. Under the current regulation, it's very specific what needs to be included in a consent before information can be shared by a Part 2 provider.

Among other things, patients have to specify who can

receive information, and they have to identify one of the following individuals or entities listed under the bullets under current regulation.

Right now, if you don't have a treating provider relationship with a patient, you can't just name an entity. The proposed change would allow patients to consent to the disclosure of their information to a wider range of entities without naming a specific person who would be receiving that information.

So, in the proposed rule, SAMHSA gives the example of someone who wants to disclose their information to the Social Security Administration to apply for benefits. This change would allow for that facilitating of information should the patient consent to it.

Again, we didn't opine on this specific issue, but we did talk about in the 2018 report that SAMHSA needed to further define when general designations can be used.

We also indicated additional guidance would be helpful around when that treating provider relationship exists.

Another proposed change relates to the redisclosure of information. Redisclosure of Part 2 protected information is only allowed in certain circumstances, and often patient

consent is required.

The proposed change is not material. Rather, it takes a list of -- I want to say 17 payment and health care operation activities that were identified in the preamble to the 2018 rule and moves it into the regulatory text. SAMHSA indicates that there was still some confusion around when this information could be shared. It's not an exhaustive list but meant to be illustrative. Again, this was not an area that we looked at in the 2018 report.

Then there's three other provisions I'm going to highlight. I'm only going to speak to the second one because it's an area that the commission has brought up in a few of its different reports. That relates to the disclosure of Part 2 protected information to prescription drug monitoring programs, specifically information from opioid treatment programs.

So the NPRM proposes to allow opioid treatment programs to disclose dispensing and prescribing data to PDMPs subject to patient consent. This is a reversal from SAMHSA's previous guidance that was issued in 2011.

In the same vein, the NPRM also permits non-OTP providers to query certain central registries to determine

whether their patients are already receiving treatment. Some states require their OTPs to check a registry before enrolling someone in an opioid treatment program to make sure there's not duplicative treatment occurring.

So that leads me to potential areas for commissioner discussion and comment. The commission may wish to comment on areas where the NPRM does seek to improve care coordination and sharing of Part 2-covered information.

In a number of our reports, you have previously noted that PDMPs do often lack complete prescribing information because OTPs are not sharing data with the PDMPs. Moreover, in the June 2018 report, you noted that Part 2 doesn't adequately address data sharing limitations by most opioid treatment providers with PDMPs.

You might also want to reinforce recommendations made in the June 2018 report to Congress that remain unaddressed by the proposed rule.

You cited a number of areas where there might need to be additional sub-regulatory guidance. That included which information must be protected under Part 2, what providers are covered by Part 2, including further defining what it means to hold one's self out as a Part 2 provider.

We also discussed kind of additional issues around sharing information within a Part 2 program.

You might also want to think about reinforcing your second recommendation, which was around additional education and technical assistance around Part 2.

I should note that when the June 2018 report did go to print, right around the same time, SAMHSA and the Office of the National Coordinator for Health IT did issue two fact sheets illustrating some different situations of when information could be shared in different settings and how information could be shared through intermediary entities electronically. So there has been some additional assistance through those FAQs, you could say, to providers, but there are a number of areas that kind of remain unaddressed.

So, with that, I'll turn it back over to you for additional discussion.

CHAIR BELLA: Fred, then Martha.

COMMISSIONER CERISE: Thanks, Erin.

I appreciate the review. It does appear, like you said, there's a lot of the same recommendations in the discussion we had in the past that didn't get picked up in

any of the rule clarifications and changes. So I would, at the opportunity, try to reinforce the comments that we made in prior discussions.

Particularly, I'll tell you the multispecialty issue is a -- practice has changed. These are old regs. There's new treatments. There's new delivery system models, and it's very difficult to imagine effectively segregating. When you've got a -- in our place, a hospital-based setting where you've tried to embed treatment providers within a big multispecialty group and they're necessarily embedded with many other providers there with an electronic health record and to attempt to segregate that out is very difficult to imagine. And I think it serves as a deterrent for people that would want to get into doing those services.

I would certainly want to reemphasize some of the comments that we made last time, particularly around clarifying what holds itself out. Some of the information that came back seems to say hold yourself out means if you're doing these services, which means if you're an addiction program within a larger group, then that applies.

But to effectively coordinate care like we all talk

about now, how you want to integrate care and not segregate care and coordinate services better, it's very difficult then to start piecing out what you can share with the partners in the group.

CHAIR BELLA: Martha?

COMMISSIONER CARTER: Like Fred, I think that the commission should support, I'd say, these recommendations; in particular, the one that allows sharing of information to an entity rather than individual providers. I read this very carefully, read some of the comments online, spoke to MAT providers and primary care association. The requirement to list a specific provider to whom one can release records winds up with delays in referral processes. For example, if you want to refer to XYZ cardiology group and there are 10 cardiologists there, how do you pinpoint which cardiologist the patient is going to be able to see?

Let me just say that the whole reg is just not very friendly to integrate care, as you were saying, Fred. The patient may be in for substance use disorder, but they're also seeing primary care and dental and behavioral health and maternity care, and their kids are seeing the pediatrician. That information to be good care, the best

care for this population, needs to be well communicated and well integrated.

So I understand the concerns of privacy, and I think the public is very touchy on this subject, but I think in order to provide the best care, we have to loosen these regulations and, like I said, at least support the recommendation, the proposed rulemaking that would allow disclosure to an entity rather than a specific person.

I think the regs have a chilling effect on clinicians who may be considering being an MAT provider. First, they've got to make sure they don't exceed their 30 or 100 limit that they've got a waiver for, and they've got to be real careful about that. Then they've got state laws, and then they're worried about whether they're going to run afoul of Part 2. We're trying to get access, and there are a lot of folks that just won't become an MAT provider because it's too scary. And then you can put an undercover agent in your practice for 30 days. Yeah.

So I think that I would really support anything we can do to make it easier to provide coordinated care for people on SUD treatment.

CHAIR BELLA: Kisha.

COMMISSIONER DAVIS: Thank you again, Erin, for the summary, and I want to echo everything that Fred and Martha have said about just the ease of being able to, you know, release to an entity rather than a provider. That can be really complicated once you get into big groups.

I also wanted to bring us back a little bit. When we talked about this last time we talked a lot about HIPAA and the benefits of HIPAA versus Part 2, and having to comply with both of those. You know, we, as a body, weren't ready at that time to go and, you know, fully say, maybe we should just do HIPAA instead of Part 2, but continuing to bring that up as part of the conversation, of why are we forcing folks to comply with these two very strict regulations, and is there benefit of just taking one that can supersede all of that.

CHAIR BELLA: I actually had a question on that, because I wasn't here during that discussion. But, I mean, do we agree that the statutory authority does it exist. Do we agree that the agency couldn't go that far, if they wanted to go that far? Because that's what they appear to say. I'm just curious. In our deliberations in the past, is that where we came down, as well?

MS. McMULLEN: No. I mean, so if you look back at the 2018 report, we indicate that it's an area that we would need to do more work on, to see if there is -- where there could be further alignment with HIPAA and Part 2. I mean, if you go back to, yeah, a lot of the Part 2 requirements are in statute. Our chapter did look at different areas where HIPAA and Part 2 differ, but we didn't get into the weeds of a legal analysis. But, you know, a lot of the regulatory text is drawn from, you know, these statutory requirements.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, if I can just add to that, obviously both Part 2 and HIPAA are bigger than Medicaid, but I think it's legit for us to talk about them in the context of how that affects the delivery of care for Medicaid beneficiaries. I think for the purposes of this reg, it's not appropriate, because the Secretary can't do something about HIPAA.

I think, also, going back to when the decisions were being made on those recommendations, that is something that the Commission could have weighed in on, in which case the recommendation would be for a statutory change, not for a regulatory change. And I think there was a lot of backing-

and-forthing among the Commission at the time, and then I think sort of more interest in that, at kind of the 11th hour, at a point at which we sort of knew where we were headed on the recs to the Secretary, and then we just haven't come back to it.

So, you know, to the extent that there is an appetite to bring that up again, I mean, we could certainly do it. It's just I don't think that -- it wasn't that we made an affirmative decision at that time not to do it. We just sort of didn't get all the way to the finish line for the purposes of that report. So that's a little bit of recap on where we were.

CHAIR BELLA: Thank you. Chuck.

COMMISSIONER MILLIGAN: Thanks, Erin. I want to align myself to the comments I've heard. I think we should commend the proposed aspects that are in line with our previous recommendation. I think we should reinforce the absent parts of our previous recommendation. I do think that part of it is, you know, there still is -- and you referred to the FAQs, Erin -- I still think there is a gap among the provider community about who is subject to what, whether they are a covered program, and what the rules

about sharing are. And I think that other aspects of our previous recommendation we should take this opportunity to reinforce.

And depending on whether we end up taking that action about commenting, and, Melanie, and maybe for a couple of others who weren't here, when we got to that point there were -- you all had reported out on the panels. We got really good public comments. I became much more sensitized than I had been at the time around the risk of inappropriate data sharing, around things like loss of child custody, loss of Section 8 or subsidized housing because of rules like, you know, not using substances, and I became sensitized to that.

I do think that where we came to -- and we can revisit all of those previous recommendations -- but where we came to, at least that far, we should continue to support pushing on the Administration to go beyond what they've proposed here and to get to the extent of our previous recommendations.

CHAIR BELLA: Yeah. So I agree. I would like to see us comment. I guess -- and again, not having been part of the prior discussions, and, of course, we want to be

thankful for what they have put forward, but this, to me, doesn't feel like we're doing much to advance care coordination. And so if the example of advancing care coordination is being able to share it, to be able to close to the PDMPs, like that's actually not getting helpful information in the hands of caregivers, all of whom are touching this person.

And so I --

COMMISSIONER CARTER: It's actually pretty big. I mean, it's a little thing but it's actually pretty big, because you've got to know whether your patient is getting medication from other places, and right now you don't actually even have that information.

CHAIR BELLA: Sure, but it's still with consent. And so if it's with consent, then why couldn't we give people the opportunity to give sent to share for treatment purposes and not just health care operations?

COMMISSIONER CARTER: Got it. Right. Right. No, no.

CHAIR BELLA: That's what I -- that part is missing to me.

COMMISSIONER CARTER: Of course. Right.

CHAIR BELLA: And so if we have an opportunity to

reinforce what we said, and certainly to be thankful that we're going in this direction, but I think that there is still a big piece missing here. Absolutely, it can't get in the wrong hands, but it's also like -- it's dangerous when it's not in some of those hands, when you need it for care coordination purposes as well.

COMMISSIONER MILLIGAN: Yeah, and I completely agree. And, to me, one of the items that we identified before that, I think we have providers that are not sharing because they're afraid of legal risk, when they aren't even subject to Part 2. And so HHS has a better job to do to educate providers about what the rules of the road are, and to advance the care coordination that's permissible in all of those dimensions.

CHAIR BELLA: I'm going to turn to the public and then come back to any of the Commissioners who want to speak yet on this topic. Do we have any public comment on this issue?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. How about any additional comments? Kit.

COMMISSIONER GORTON: So going to back to what Anne said, we really got to this piece of the conversation fairly late last time, and there simply wasn't time and a thoughtful, careful way for the process to move forward.

I would be supportive of, in the next year, picking up that thread and seeing if we can't get another step further down the road. I do think that we can't shoot from the hip and put out a recommendation to Congress without some serious revisiting of some of these other issues. I mean, we did hear, at the roundtable, clinics that had been accosted by law enforcement, and we heard stories of displaced families from Section 8 housing and people who lost custody of their children.

And one of the question that I recall, we talked about it last time, is were we confident enough that HIPAA could provide the same level of protection, or would there be a need, if we were going to move, as Kisha and others have said, to a single standard? Do we need to revisit that other standard as well?

So I would be open to picking up the thread of the conversation and seeing if we can move it forward, but I don't think we're there yet, at least not in my head.

COMMISSIONER CARTER: Yeah, I agree, Kit, or is there a different regulation that would prohibit use of this? I mean, there's already some protection in here, but prohibit use of the data for all those purposes -- housing, et cetera. Rather than prohibit sharing in a manner that promotes best care, prohibit use of data outside health care.

COMMISSIONER GORTON: Yeah, I think that's a potential solution, but we really need to look at that and hear from people who are expert in this topic, again, about whether that is something we would want to recommend.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I mean, if there is an appetite for that, it's something that we can take on. We would have to figure out how to work it into the work plan. You know, this morning you said you wanted to talk about parity, and Erin is going to be working on parity, so we have to figure out how to sort of queue it up. But I think we could do a thoughtful analysis on it. It will take us a little time.

CHAIR BELLA: Other comments on this, and do the Commissioners -- so the rest of you, like there's comfort in submitting comments on this? Okay.

Erin, do you need anything else from us at this time?

MS. McMULLEN: No. I don't think so. I think you guys are pretty clear in how you want to reinforce our previous recommendations, and that sort of thing.

CHAIR BELLA: Okay. Thank you very much.

I believe we are now taking a break. Is that right?

We are getting ahead of ourselves today. We are going to take a break and come back at 2:45. Thank you.

* [Recess.]

CHAIR BELLA: All right. We are going to reconvene shortly, if everyone could take their seats, please. Chris is ready to go, and Chuck is actually going to lead this session.

VICE CHAIR MILLIGAN: So, Chris, we've missed you.

MR. PARK: Thank you.

VICE CHAIR MILLIGAN: But we knew that on our first day, we would hear about pharmacy. So we're ready to hear about pharmacy.

FINDINGS FROM PHASE 2 OF ANALYSIS ON MEDICAID DRUG FORMULARIES: EFFECTS ON UTILIZATION AND SPENDING

* MR. PARK: Okay. Thank you.

Today I'll present findings from a project that we've conducted with IMPAQ International to compare Medicaid coverage of drugs with Medicare Part D and commercial payers.

I presented findings from the first phase of this project last October, where we found Medicaid generally offers coverage for more drugs than the other payers, but they also may place restrictions on more drugs.

Over the past few months, we've conducted a second phase of this analysis, which looked at three particular policy questions. The first is, what is the effect of formulary coverage on utilization, and does this effect vary by payers? The second, how do payers vary in providing formulary access for new drugs, and does this change over time? Then, finally, how do payers vary in the use and cost of drugs?

This slide is just a quick refresher. For the most part, Medicaid must generally cover all drugs, where other payers generally have the ability to exclude coverage of a few drugs.

For the analysis, we used two different data sources. For formulary information, we looked at data from July 2017

to June 2018 from Managed Market Insight and Technology. This dataset included formulary information for about 2,000 plan formularies and covered over 290 million lives.

For spending and utilization data, we looked at information from Symphony Health Integrated Dataverse. This dataset included 92 percent of prescriptions filled at retail pharmacies and included claim-level information.

During our analyses, we used a few different measures. When we talk about formulary access, we grouped beneficiaries into three different groups. First, no formulary coverage, which means that the drug was not placed on the formulary; restricted coverage, which means the drug had some form of prior authorization, step therapy, or quantity limits placed no it; and unrestricted coverage.

When we looked at utilization, we used a 30-day supply, and we used a 30-day supply to normalize utilization so that like a 90-day prescription would be the equivalent of three 30-day prescriptions.

When we looked at cost, we looked at the average drug cost for a 30-day supply within the drug class.

Going back to drug utilization, I will use the term

"relative utilization," which means essentially the market share, so what portion of the therapeutic class' prescriptions were for a given drug.

To assess how formulary coverage and restrictions affect drug utilization, we ran linear regression models on seven drug classes, which covered 52 drugs, and these classes were selected because they had at least one drug with a wide variation in coverage across payers.

We used formulary coverage information as of December 2017, and then we aggregated utilization from July to December 2017.

We ran two models. The first model was to look at how relative utilization of a drug between enrollees with no coverage compared to enrollees with either restricted or unrestricted coverage, and the second regression model was focused on the variation between payers. So we compared relative utilization of a drug between Medicaid enrollees with Medicare and commercial enrollees that had a similar level of formulary access.

This table shows the result of that first regression model, where we looked at the relationship between relative utilization and formulary coverage. As one would expect,

we did see that formulary coverage for a drug, either restricted coverage or unrestricted coverage, did lead to an increase in relative utilization for a lot of drugs.

Across all payers for 29 drugs, we saw that no coverage led to lower utilization compared to either restricted or unrestricted coverage, and that's shown with that blue circle right there.

These results were similar for both groups for restricted coverage or unrestricted coverage. Out of the 29 drugs in these two groups, 26 were the same between the two groups. So, for the most part, it was the same drugs that had lower utilization when there is no coverage.

Then when we looked at Medicaid alone, we did see a bit of a difference between the two comparison groups. So unrestricted coverage generally led to higher relative utilization for more drugs than restricted coverage, and this indicates that in some cases for some drugs, the level of restrictions may have a similar effect as not covering the drug at all.

So the next few slides, I'll be going through the results of the second regression model, which was looking at the effect of formulary coverage on relative utilization

across payers and seeing how this varies.

This slide shows the effect for the no formulary coverage group. As you can see for the comparison between commercial enrollees and Medicaid, Medicaid had higher relative utilization for 5 drugs and lower relative utilization for 17 drugs. When compared to Medicare enrollees, Medicaid had higher relative utilization for 5 drugs and lower relative utilization for 14 drugs.

In most cases, the difference in relative utilization was actually fairly small. It was less than 5 percentage points. So while these differences were statistically significant, the practical effect was not very strong. And where there were differences greater than 5 percentage points, all of these drugs had less than 10,000 Medicaid users. So these results may have been influenced a bit by a smaller sample size, since not many Medicaid beneficiaries actually had no formulary coverage for a drug.

This slide looks at the group of enrollees with restricted coverage for a drug, and this was the predominant formulary status for most enrollees in each of the three payer groups.

Compared to commercial enrollees, Medicaid had higher utilization for 20 drugs and lower relative utilization for 19 drugs, and against Medicare, Medicaid had higher relative utilization for 11 drugs and lower relative utilization for 24 drugs.

The higher relative utilization among Medicaid enrollees may indicate that there are more stringent restrictions for either commercial and Medicare beneficiaries or it may reflect the level of cost sharing that commercial beneficiaries or Medicare beneficiaries may face.

Similarly, the relative effect was not very strong in these cases where there is a difference. For the most part, it was less than 5 percentage points. Of the 22 unique drugs where Medicaid had higher utilization compared to one of the other payers, only seven had a difference between the payers of greater than 5 percentage points. For six of those drugs, they were either hepatitis C drugs or the drugs that were used to treat diabetes.

Similarly, for the 29 drugs where Medicaid had lower relative utilization to one of the other payers, only 7 drugs had a difference of greater than 5 percentage points.

Again, four of the drugs were used to treat hepatitis C or diabetes. It does seem like there might be some significant differences between Medicaid and the other two payers in the utilization in these two classes.

These classes have very few generic options available. So that may be a reflection of the cost sharing required by either Medicare or commercial beneficiaries.

This slide shows the payers among the unrestricted coverage groups. Again, Medicaid had higher relative utilization versus commercial enrollees for 22 drugs and lower relative utilization for six versus Medicare beneficiaries, Medicaid had higher relative utilization for 19 drugs and lower relative utilization for 7 drugs.

The higher relative utilization here may be another reflection of cost sharing. If the cost sharing is significant enough for commercial and Medicare beneficiaries, it may lead to lower relative utilization, even though there are no restrictions on that drug.

Similar to the other groups, we showed, for the most part, the differences are less than 5 percentage points, and in the cases where the differences were greater than 5 percentage points, like the no coverage group. Generally,

those situations, there were less than 10,000 Medicaid beneficiaries, and in some cases, the majority of enrollees were isolated in a couple of states.

This slide kind of summarizes the results of that particular analysis, and for the most part, no specific pattern emerged in the effect of formulary access on relative utilization across the payers.

For most drugs with a significant difference, the difference was less than 5 percentage points, as highlighted and circled there.

Overall, the practical effect of the differences were not very strong, and when you combine that with the amount of drugs with no significant difference, there are only a small difference in the relative utilization between Medicaid and other payers for most drugs.

So this next analysis looked at formulary coverage for new drugs over time. One area where Medicaid is different from other payers in terms of formulary requirements, Medicaid is required to cover a drug immediately as soon as it's approved by the FDA where other payers generally have at least 180 days to kind of determine their formulary coverage criteria.

To look at how Medicaid may differ from other payers, we identified 10 drugs that were approved in either 2017 or 2018. We used the formulary information to look at the percentage of covered lives for each payer that had coverage in each month between July 2017 and June 2018.

Overall, Medicaid did seem to provide coverage earlier than the other payers. For 6 of the 10 drugs, Medicaid provided broader formulary coverage during the first few months after FDA approval. However, commercial coverage did end up being comparable to Medicaid over time for most drugs. The coverage usually equalized around 3 to 6 months afterwards.

These next few slides, I'm just showing some examples of the patterns of coverage across the payers. Here, you can see for Emflaza, which was approved in February 2017 and is indicated for treatment of Duchenne muscular dystrophy, that Medicaid initially had higher coverage and maintained higher coverage throughout our study period over commercial beneficiaries. Medicare beneficiaries had low rates of coverage, but that's probably a reflection that this drug is usually used to treat children.

Symdeko is a drug that was approved in February 2018

for the treatment of cystic fibrosis. You can see that Medicaid had higher coverage, covered more lives, a greater percentage of lives in the initial month of approval in February 2018, but within 3 months, commercial payers had similar levels of coverage. Again, here Medicare coverage is probably low because this drug would primarily be used to treat children.

Mavyret is a hepatitis C drug, which was approved in August 2017. Here, you can actually see that commercial payers had a pretty rapid take-up of coverage for this particular drug and actually had higher coverage early on compared to Medicaid, but over time, Medicaid actually ends up with higher rates of coverage.

This is kind of the reverse case. Bevyxxa is another hepatitis C drug that was approved in July 2017. Here, Medicaid had higher rates of coverage early, but then commercial payers seemed to increase coverage pretty rapidly over time. So that after several months, they actually had slightly higher coverage than Medicaid. For both of these drugs, these hepatitis C drugs, we see an interesting pattern with Medicare in that we see a rapid take-up of coverage around January 2018. So this may

indicate for some of these drugs, they may wait until a new contract cycle to actually make the formulary coverage determination.

This chart shows variation in coverage of new drugs across the states, and so despite federal rules that require Medicaid programs to cover a new drug immediately, we do see that states do not necessarily provide broad access to the drug immediately. Within 3 months of approval, you can see that for the most part, for a lot of these drugs, 20 to 30 states provided coverage to over 75 percent of their population.

I will note the bottom two drugs, Bevyxxa and Zypitamag, they have lower rates of coverage, and I think this is probably a function that while they were approved, they had some delays coming to market, so they may not have put them on the formulary immediately until they actually did hit the market.

So this last analysis that we did looked at the difference in utilization and cost by payer within a few drug classes. We looked at six classes with large variation in the median number of covered drugs across payers. We calculated the number of 30-day prescription

fills and gross cost for each drug from January to June 2018, and we looked at the difference in brand/generic mix and the average gross cost of the drugs within that class for each payer.

This was looking at whether or not each payer actually was able to kind of control the mix through the formulary and what results they actually achieved.

Here in this table, we show the average cost per 30-day fill by brand and generic payer. Highlighted in blue circles are where Medicaid actually had the lowest average cost within the class compared to the other payers, and so for these four classes, there are different factors kind of driving this lower average cost. Within the antidiabetics GLP-1 agonists, and the SGLT-2 inhibitors, there were no generic drugs. So this was primarily a function that Medicaid was paying the pharmacies a lower cost, a lower amount for these brand drugs.

For the inhaled corticosteroids, this was a function of both generic use and the lower brand cost, depending on whether you're comparing it to Medicare or commercial payers. And I'll show that on the next slide.

Then for the antidiabetic DPP-4 inhibitors,, this was

actually a function of Medicaid having a higher generic utilization rate.

Here for the antipsychotics shown in kind of the red dashed circle, Medicaid actually had the highest average cost per 30-day fill compared to the other payers. This is a function of the generic utilization rate.

On this table, we showed the kind of share of the fills by brand and generic status. As I mentioned earlier, for the inhaled corticosteroids, this helped. There's a difference between Medicaid, which had a 6.3 generic rate versus Medicare, so that explained some of the difference between those two payers. Compared to commercial payers, where they had a 6.4 generic fill rate, which is pretty similar, the reason Medicaid had a lower average cost was because the payments to the pharmacies were lower for those particular brand drugs.

For the antidiabetic DPP-4 inhibitors, we see that Medicaid actually had a much higher generic fill rate, around 14 percent, compared to about 1 percent for the other payers, and so that explains the difference in average cost there.

Then for the antipsychotic, second generation atypical

drugs, we see Medicaid had the lowest generic fill rate, and that helps explain why they actually had the highest average cost within that drug class.

The one thing I should caution about this particular cost analysis is that it was done in gross cost. We do not have rebate information in terms of what the manufacturers may have given in rebates to each payer. So while this is informative, it doesn't necessarily lead to like the ultimate conclusion as to whether any of these payers were able to drive utilization to the lower net cost.

So this analysis revealed that there is really no specific pattern that emerged in the effect of formulary access on relative utilization across payers. There were some differences that were statistically significant, but for the most part, those differences were relatively small.

Medicaid generally did have to cover new drugs earlier, but commercial coverage was comparable over time.

Medicaid also had lower average gross drug cost; that is, before rebates in four out of the six classes. So this indicates that they do have some ability to steer utilization toward lower-cost products.

Our analysis did have some limitations. We did not

control for other factors such as cost sharing or any population-specific prescribing preferences. We also treated restrictions equally so that the degree of prior authorization or quantity limits were treated equally, even though one may be more restrictive than the others.

Finally, we do not have rebate data to look at net average cost.

But, overall, these results do seem to indicate that Medicaid generally had the ability to manage drug utilization in a similar manner as Medicare Part D or commercial payers.

So, overall, these results do support the commission's prior discussions to not completely blow up the Medicaid rebate program and to focus on particular drugs or classes that may require -- present unique challenges and require special treatment.

We are focusing our work this year, looking at high-cost specialty drugs and trying to identify potential payment or rebate models that could address the particular challenges that these drugs present, and we should have more information to share with you in a few months.

Also, if you have any thoughts as to whether you would

like to pursue additional work on this particular topic about the differences in formulary coverage, I would definitely appreciate any feedback you have on that.

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

VICE CHAIR MILLIGAN: Thanks, Chris.

So I wanted to actually sort of break this into two sections for questions for Chris, and if we could maybe start with just questions people have maybe about methodology, process, how to interpret, and then maybe pivot after that to kind of next steps and those sorts of things.

I did, Chris, want to just lead off with a couple of quick questions about methodology and process, and forgive me if I missed this. Is this inclusive of fee-for-service and managed care? Or is this limited?

MR. PARK: It's inclusive of fee-for-service and managed care.

VICE CHAIR MILLIGAN: Okay. And the second is you've mentioned that the rebate data wasn't incorporated in this. Do we have a sense of when rebate data might be available to help advance the analysis here?

MR. PARK: Certainly. There are provisions in recent

legislation that would provide MACPAC with the Medicaid rebate data. However, I don't think we would be able to get rebate information necessarily for Medicare or commercial payers, so it would still be difficult to make the cross-payer comparisons.

VICE CHAIR MILLIGAN: In terms of that, but on the Medicaid data side, do we have a sense of when that might become available?

MR. PARK: It depends on if the legislation passes. We don't know when that might --

VICE CHAIR MILLIGAN: Okay. So let me first look for folks who might want to ask questions about just the methodology approach. Toby.

COMMISSIONER DOUGLAS: Well, just on that question about managed care versus fee-for-service. So is there a way on the methodology to understand the differences? Would it be similar in terms of these if we broke it apart? I'm just thinking given where states are -- a lot of states moving with a carveout or --

MR. PARK: Yeah, we didn't necessarily look at that level, but the information is available at the plan level, so we would be able to look at any differences between

Medicaid and -- fee-for-service and managed care plans.

VICE CHAIR MILLIGAN: Peter.

COMMISSIONER SZILAGYI: Yeah, great analysis, Chris. This is really interesting. Two questions.

Since these were regression analyses, did you adjust for severity in some ways?

MR. PARK: We did --

COMMISSIONER SZILAGYI: Or are these just unadjusted?

MR. PARK: We did do a little bit of adjustment for severity by looking at how many drugs, classes each beneficiary used. We didn't have enough information to do like a true diagnostic risk adjustment type of, you know, severity control.

COMMISSIONER SZILAGYI: And whether you unadjusted or adjusted, did that change the findings in any way?

MR. PARK: I don't know if we actually ran it without that adjustment in place, so I would have to check with IMPAQ to see if they had those results.

COMMISSIONER SZILAGYI: And then the other question I had, it looks like some of these outcomes are number of drugs.

MR. PARK: Right.

COMMISSIONER SZILAGYI: Which isn't really the same as sort of the total drug utilization. Do you know what I mean?

MR. PARK: Right.

COMMISSIONER SZILAGYI: Because some of these drugs are for rare conditions, some for diabetes or, you know, much more common --

MR. PARK: Sure, and one of the reasons why we looked at kind of like if -- we wanted to get a sense of how a payer may be able to shift utilization to a particular preferred product within a drug class, and we didn't look at like total utilization because that may be driven by differences in the population's characteristics. You know, maybe more kids in Medicaid have cystic fibrosis than in commercial payers. And so we wanted to get a sense of whether or not like, you know, if a drug -- if a class had like ten drugs, you know, were commercial payers shifting utilization to these five drugs and Medicaid shifting it to these five drugs? And for the classes that we've reviewed, the seven classes, we looked at a couple of larger classes like antidepressants and antipsychotics, which would be generally utilized by all payers and enrollees pretty

heavily. We had a couple of specialty classes, hepatitis C drugs and the biologic immunosuppressants like Enbrel or Humira. And then we also had three different types of antidiabetic drugs.

And so I think, you know, we wanted to kind of see not necessarily whether Medicaid beneficiaries are utilizing these drugs more, but whether that mix between payers were different, because that would be kind of an indication that Medicaid had similar ability to control mix like other payers, because that's where the formulary decisions kind of come in. And when you compare kind of those -- like how many drugs had differences in relative utilization and marry that to some of the results you saw from the cost analysis. I think, you know, looking at that, even though Medicaid had differences in the antidiabetic drugs, that didn't necessarily lead to like higher average costs within that class.

So I think, you know, this was a challenge that, you know, we worked through and, you know, tried to kind of look at kind of the share of the drug use within a class by payer.

VICE CHAIR MILLIGAN: Kit.

COMMISSIONER GORTON: So just to follow up on Toby's question, if you can differentiate between the plans and fee-for-service Medicaid, two things. One is it might be interesting to see if there are regional variations. And a second is within the managed care plans it might be interesting to see whether there's variation between the national plans, which in theory have huge reach and are using the mega PBMs and so should have as much leverage in the market as anybody, versus the regional/local Medicaid plans. And it would be interesting if it could be done with any degree of rigor, if you could look at fee-for-service versus regional managed care versus national Medicaid managed care, whether that changed anything. I would wonder whether the area under some of these curves shifts depending on the nature of the pair. Now, you may not have enough data to know that, but if we could get to that level of detail without breaking the bank and, you know, busting the computers, it would be -- I think that might be interesting.

EXECUTIVE DIRECTOR SCHWARTZ: Can I ask a question about that? I mean, beyond that that would be interesting, like why do you want to know that? What would be the

implication of that for policy? I'm sort of mystified.

COMMISSIONER GORTON: So I think there are two, maybe three potential implications. One is we've supposed that there are different kinds of behavior, like when stuff gets added to a formulary. So are there regional differences in terms of who's adding early like the law requires and who's adding later or never in the face of the law. But there are -- these are expressions of behaviors, and I just wonder if the behavior is different if you're a national PBM supporting a national health plan versus if you're a mom-and-pop PBM supporting a local health plan versus you're a fee-for-service program without a PBM at all.

So I think it just seems to me that there might potentially be efficiencies in one or another of those buckets that would be worth shining a light on in terms of, you know, the fee-for-service program is not doing a very good job here. It's not that the managed -- because two-thirds of the program is in managed care, Medicaid looks like a commercial because, in fact, it's being managed like a commercial product. And it's the fee-for-service program where we're seeing the inefficiencies. It just would strike me that because those buckets function differently,

we may see different behavior, and I would worry that the aggregate numbers cover an addressable opportunity.

VICE CHAIR MILLIGAN: Toby, did you want to get in on this conversation?

COMMISSIONER DOUGLAS: Yeah, I mean, I think the fundamental -- there's a lot of movement in states on the belief that fee-for-service -- that actually consolidating rather than having the plans doing it individually can drive better formulary management, utilization, and spending. And so I think if we could look at the data to better answer that question, it would -- it needs the underlying rebate information, too, so that would be important. But it's a big question of purchasing power as well as to drive both the right formulary and then the right level of cost. Does that make sense?

VICE CHAIR MILLIGAN: What I'm picking up from this last bit of conversation is to the extent that a Medicaid program is managed either at scale or by entities that manage commercial, does it look more like commercial because of how an MCO or a large purchaser in Medicaid might have behaviors that are similar to commercial inside of the Medicaid rules? That's what I'm hearing. So less

really regional, more attributes around managed, scale, those sorts of things.

COMMISSIONER DOUGLAS: Yeah.

VICE CHAIR MILLIGAN: Are there other comments or questions about methodology? Tricia.

COMMISSIONER BROOKS: Maybe not really methodology. Maybe it gets into the next area. But I'm just curious. You know, you look at utilization and you look at spending. But what about outcomes? How do we look at that in relationship to better health outcomes -- if it's even possible? That's where it's a methodology question.

MR. PARK: Yeah, we don't have the information right now to be able to do that analysis.

VICE CHAIR MILLIGAN: Fred.

COMMISSIONER CERISE: A question again about the rebate, lack of rebate data. Chris, how much do you think -- is the financial analysis, is it useful at all without that piece? I just worry --

MR. PARK: Yeah, some of it is useful in the sense of particularly like the branded -- if you see one payer, you know, prescribing more generics, that is an indication that they are trying to use lower-cost products. And for the

most part, you know, generics are expected to be lower cost than the brands. But that's not always the case depending on the rebate.

It also can give you a sense of whether or not, at least from that gross cost perspective are they using higher-cost brands or lower-cost brand drugs. And so, you know, it does give you a sense, and particularly if you see vast differences between the payers, it might give you a sense that one is maybe managing it better, but you're correct in that you can't make an ultimate determination until you kind of see, you know, what the net cost is to the payer.

VICE CHAIR MILLIGAN: I do want to now open it up in terms of kind of what are the implications of this work. Where might we want to take it next? I do think, Chris, one of the things that is useful in just building this framework is, as we made recommendations a few months back around approaches for Medicaid to integrate into the formulary new-to-market drugs, and we looked at benchmarks like Part D and health exchanges, it was -- it's helpful to really get deeper around those comparison points, because I think that that validates using those comparison points for

Medicaid pharmacy policy recommendations the Commission might want to make. But I want to open it up now to ask whether folks have direction that might be helpful to Chris and Anne in terms of where this framework and background data can be taken to help drive the Commission's future work.

Anybody want to come in on that?

[No response.]

VICE CHAIR MILLIGAN: Then let me ask a couple of questions, Chris. You know, one of the things that we've talked a lot about is that there are a lot of breakthrough medications coming up through the pipeline that are going through various stages of approval process, and some of them are quite expensive. Some of them are, you know, really getting into genomics and all kinds of -- do we have a sense from any of the work that you've done to date whether different payers might be developing different approaches to how to address some of the biologics and others that are coming to market? You did talk about -- and you showed some good slides around -- adoption rates, but do we have a sense of how those adoption rate policies in the different payers might be anticipating the coming

drugs that are in the pipeline now?

MR. PARK: Yeah, I mean, one thing we do have are some like technical notes with the prior authorization criteria, so we could take a closer look as to what are the particular nuances of each prior auth policy to see if there are differences in how each payer is handling those.

Some of our upcoming work is, you know, focused on trying to learn more about all the various options that payers may be considering or may be out there for Medicaid to look at in terms of how we handle either utilization payment, or rebates of these particular high-cost drugs that have, you know, maybe unique characteristics where we could consider like a different way, a different model to, you know, handle those drugs.

VICE CHAIR MILLIGAN: I had two other questions. and then I will ask folks if you want to come back in.

You know, one of the ways in which a lot of commercial payers and other payers manage is they do have an exceptions process. I mean, they might have a formulary. They might not list a drug on a formulary, but they might create an exceptions process by which a prescribing provider who thinks that an off-formulary drug is really

necessary for that patient can access an exceptions process.

Do we have a sense of whether there have been changes in that exceptions process that may kind of regulate access to medications and whether that is changing over time as some of these new and expensive drugs also come to market for those other payers?

MR. PARK: I do not know if that has been changing over time.

VICE CHAIR MILLIGAN: So I do think that that is -- just a qualitative exercise would be helpful in terms of the notion, you know, Medicaid has more broad coverage, even if there is PDL.

And then you did comment early on in your presentation that we couldn't really take into account the effective co-pays in kind of utilization rates, utilization levels. But I do think that as co-payment approaches change both in Medicaid but also in other payers, how that becomes an increasingly important tool in kind of directing individuals toward a payer's preferred drug. And so I think sort of monitoring changing payment policy and the effect on all that would be useful just qualitatively.

Have other folks kind of had second thoughts about jumping into this conversation at this point? Tricia.

COMMISSIONER BROOKS: So I wasn't here when you did Phase 1, so you may have already looked at this, but do we -- this is more on the qualitative side as well -- have a better sense of the criteria that states are using to establish their preferred drug list? Is there any value in looking at that and then comparing that to the cost and utilization in a way to better understand, you know, where there's an opportunity for improvement?

MR. PARK: Certainly. We don't have good information on -- like all the information the states may be reviewing to establish their PDL, but we can certainly, if the Commission is interested, try to take a closer look at some of those specific notes on the prior authorization criteria and to see where they've established the criteria and see if the requirements, you know, vary significantly across states.

VICE CHAIR MILLIGAN: Melanie, did you have anything, a question or comment, before I -- anybody out in the public have anything you want to contribute to the discussion?

PUBLIC COMMENT

* [No response.]

VICE CHAIR MILLIGAN: Okay. Chris, thanks as always for helping build the framework. I do think that as various congressional initiatives advance and as more of these kinds of pharmacy-related things get debated in Congress, it is helpful for us to stay current with the analytics. And for everybody's interest, I think certificates for Chris Park continuing education are available on your way out.

[Laughter.]

VICE CHAIR MILLIGAN: And I think we'll be taking up nursing facility payment policy now. Thanks, Chris.

MR. PARK: Thank you.

CHAIR BELLA: Welcome, Kayla and Rob. We are ready when you are ready.

NURSING FACILITY PAYMENT POLICY: PAYMENT METHODS AND RECENT DEVELOPMENTS

* MS. HOLGASH: Good afternoon, Commissioners. For our final session of the day we are going to discuss methods and recent developments in nursing facility payment policy, including findings from our recent update of the nursing

facility fee-for-service payment policy compendium.

I will begin by first providing some background information and then discussing base payment methods and adjustments. Then, I'll turn it over to Rob to discuss his favorite, supplemental payments, policy developments, and policy questions, before receiving your feedback on possible next steps.

Nursing facilities are institutions that provide long-term services and support, or LTSS. They are certified by the state to offer 24-hour medical and skilled nursing care, as well as rehabilitative and other health-related services. Nursing facility services are a required Medicaid benefit and are the second-largest category of Medicaid spending, amounting to $56.7 billion spent in fiscal year 2016, which was 10 percent of all Medicaid spending and 34 percent of Medicaid LTSS spending.

In 2017, 62 percent of all nursing facility residents relied on Medicaid as their primary care, and most of those residents were also eligible for Medicare.

Some of the key differences between Medicare and Medicaid are listed on this slide. While Medicare only covers skilled nursing care following a hospital stay of at

least three days, Medicaid covers both skilled and long-term care, regardless of whether or not the individual was hospitalized first. Medicare pays for up to 100 days per spell of illness, but Medicaid does not have a limit on duration. And, lastly, Medicare pays for nursing facility services based on a national formula, while Medicaid payment varies by state, of course.

To better understand Medicaid nursing facility payment policy, we are using MACPAC's provider payment framework, which we also use to analyze hospital payment. So as a reminder, our framework is based on the statutory principles of economy, access and quality, and efficiency. And to evaluate policies based on these principles, we need data on payment methods, amounts, and related outcomes.

As this is one of our first looks into nursing facility payment policy in a while, we began with an analysis of payment methods, and we can look more into the other two categories in the future.

Our review of payment methods began by updating our nursing facility payment policy compendium that was originally published in 2014. In July of this year, we finished gathering the data for the updated compendium, so

we plan to publish it shortly.

As with our other payment policy compendia, this review does not include information on managed care payments to nursing facilities. It is just fee-for-service. And, overall, not much has substantially changed since 2014.

Before we go further, and to give you an idea of scale, this slide shows the distribution of types of payments to nursing facilities, and as you can see, most payments are made under fee-for-service, and a vast majority is in the form of base payments.

These base payments are typically in the form of a per diem, or a daily rate, and they are based on either costs or price, for the most part. Thirty-one states used a cost-based system, which uses cost reports from an established rate-setting year. Facilities are paid on their actual costs, generally up to a predetermined ceiling.

In price-based systems, states establish a fee schedule, generally for certain peer groups of facilities, and 14 states use this methodology. Four states use a combination of both methods, meaning that certain service

categories are paid based on costs, while others are paid based on price.

After the base rates are set, states provide various adjustments, and some of the common adjustments are based on acuity or case mix, which measure residents' level of need, and facilities may also adjust based on care provided for patients with high needs conditions, such as requiring the use of a ventilator, and they often adjust based on peer groups, such as the physical location or the number of beds in a facility.

In addition to adjusting the base rates, states also provide supplemental payments to nursing facilities, which Rob will discuss now.

* MR. NELB: Thanks, Kayla. While supplemental payments are a relatively small share of Medicaid payments to nursing facilities, the use of supplemental payments is growing, particularly for government-owned facilities. Based on our review this summer, 24 states made some sort of fee-for-service supplemental payment to nursing facilities, and 18 of those targeted government-owned facilities. The payments to these public providers are often financed by local governments through a form of an

intergovernmental transfer.

One particular arrangement we thought we'd highlight, that seems to be growing in use, is where the nursing facility will work with a public hospital, and the public hospital will lease the privately-owned nursing facility and put up the IGT so that that facility can get the supplemental payment for the facility, which would then be considered to government-owned.

Overall, base and supplemental payments to nursing facilities cannot exceed the upper payment limit, known as the UPL. Similar to how UPL works with hospitals, the UPL is based on a reasonable estimate of what Medicare would have paid for the same service in the aggregate for a class of providers. And states are required to demonstrate their compliance with the UPL annually.

To better understand nursing facility UPL payments, we examined state fiscal year 2016 UPL data, and compared them with actual spending, similar to what we had previously done with hospital UPL payments. Similar to our prior analyses, we found some pretty large discrepancies between the payments that states reported in their submissions to CMS versus the actual amounts that they claimed on the CMS

64 expenditure reports. This raises concerns about the accuracy of the data that CMS has to inform its review of UPL compliance, and also just raises concerns about the transparency of data overall. The Commission previously recommended better data on all of these UPL payments to providers, and the data we have now is just not very reliable.

However, unlike our previous analysis of hospital UPL payments, the discrepancies that we observed with nursing facilities didn't raise quite as many concerns that actual spending may have exceeded the UPL. And one reason for this is that most nursing facility base payments are much lower than the Medicare estimate to begin with, so there is a much larger sort of UPL gap that states have. And so even with some of the discrepancies we observed, the total payments were still below that upper limit.

Last but not least, managed care is an important source of payment for many nursing facilities. Twenty-four states currently use managed long-term services and supports to cover some or all nursing facility services in their state. As Kayla mentioned, we don't know much about how managed care plans pay nursing facilities. However,

payments are likely somewhat similar to fee-for-service, since fee-for-service rates are often used in the development of managed care capitation rates.

In addition, we do know that some states require their health plans to pay no less than the Medicaid fee-for-service rate, using that directed payment option that I talked about this morning.

So as the Commission considers potential future work related to nursing facility payment policy, we thought it would be helpful to make you aware of several recent policy developments. Most notably, beginning in October of this year, Medicare will be adopting a new payment method for nursing facilities, which is referred to as the Patient Driven Payment Model. This payment methodology will replace Medicare's previous payment method, which adjusted payments based on acuity, using resource utilization groups, known as RUGs.

As a result of this change, by next year CMS will stop supporting RUG classifications, which has implications for state Medicaid programs, since currently 34 states use RUGs when they are making Medicaid payments to nursing facilities. And, in addition, 33 states use this RUG

classification to calculate the UPL.

We are not exactly sure how states are going to respond to this change. On one hand, they could choose to adopt Medicare's new payment method and no longer use RUG payment methodologies in their system. On the other hand, if states want to continue with their current methods, they would need to figure out a way to get information to classify stays according to the RUG classification, most likely by administering a state supplement, getting supplemental data from nursing facilities to calculate these classifications.

Two other issues to be aware of are nursing facility quality and nursing facility closures. There are a number of cost-cutting issues to consider with nursing facility quality and safety. But as we think about Medicaid payment policy, we thought it was worth noting that facilities that serve a high share of Medicaid patients generally have lower quality ratings than other facilities.

This year, CMS put out a plan for improving the quality of care in nursing facilities by developing some new measures and improving its guidance to state survey agencies, but the strategy didn't identify many approaches

that were specific to Medicaid.

Another area to consider is nursing facility closure and the effects of closure on access, particularly in rural areas. Prior research had suggested that some nursing facility closures may be related to low Medicare payment rates, but, of course, there are many other factors at play as well, including local market dynamics and the broader shift of patients from institutional care into the community.

So to help facilitate your conversation today about potential next steps, we just thought we'd throw out some potential policy questions you may want to consider. First, we could look at more about how Medicaid payments to nursing facilities compare to Medicare, especially since so many residents are duals. Second, we could look at how the upcoming changes to Medicare payment policies will affect Medicaid. Third, how does the use of IGTs and provider taxes to finance nursing facility payments affect Medicaid payment policy? And finally, exploring the role of Medicaid payment policy in nursing facility closure.

Later this fall we plan to publish that updated nursing facility payment compendium with the findings that

Kayla shared today. This compendium will also be accompanied by an issue brief that summarizes some current issues in nursing facility payment policy. We welcome your feedback on various issues we may highlight in that brief.

This fall, as I was mentioning earlier this morning, there may be an opportunity to comment on supplemental payments as part of this larger rule that is expected. It will likely address supplemental payments more broadly, but the Commission could comment about nursing facility supplemental payments as part of that.

But really, as we look further ahead, we are looking for your feedback on areas for future work, and it would be particularly helpful to get your thoughts on what policy questions we should prioritize and what types of analysis would be most helpful for your decision-making.

Thanks.

CHAIR BELLA: Thank you. Bill, and then Stacey.

COMMISSIONER SCANLON: Today is my day to talk about precision, and this has been a frustrating thing forever, which is that talking about Medicare and Medicaid in the same context when it comes to what is the building that the nursing home, it is like apples and oranges. The Medicare

patients, they are post-acute, they require daily skilled care, and their average stay, and coverage, is probably around 30 days. And they are not dying there. They are going home, for the most part. So it is a very, very different population than who ends up sort of being on the Medicaid side.

That makes comparisons for any purpose really very, very difficult. I mean, when you talked about sort of the UPL and sort of that there are adjustments of the Medicare rate, I'm trying to think about how do you actually do that, because that is an incredible sort of challenge.

And so I don't know what I'm sort of raising here as a fundamental issue in terms of what should change, in terms of how we think about this, because what are the issues that we should have with respect to Medicaid nursing facility payment? The one that has historically been the case is the issue of the adequacy of payment, which may relate somewhat to the closures, but I don't know whether that is the case. Because historically, Medicaid has always been paying relatively low rates, from the nursing home's perspective, but we still have had this industry exist for, you know, well over 50 years.

And what has changed in terms of the use of what I'll call institutional sort of care is we eliminated the intermediate care facility, and we have created an assisted living facility industry. And the issue from a state perspective, as well as from a resident perspective, is the difference in the type of services that are being provided, and the differences in the type of regulation and financing that are available in those two different sets of circumstances.

So what's happening, it's very hard to disentangle all of this and then when look at it across states you've discovered that the states vary more here than maybe they do in virtually any other part of Medicaid. And, you know, what are they doing?

We talked this morning about HCBS and sort of how it's become a more important part of Medicaid and it's better in the aggregate than sort of nursing facility care. But there are some states that have neither nursing homes nor home and community-based services that are commensurate with the size of their population that likely has needs. So what is happening in that kind of a state? That would be a policy question that one would really want to know,

because what I'm thinking is happening, and we don't have the direct evidence on it, is there is an incredible amount of unmet need for people with disabilities, in a state that is providing neither of those kinds of things.

One of the disturbing things that was in the write-up was the idea that the minimum dataset is being changed, and the question is, is it being changed in a way that compromises the use of the data not just by states, but these data have been used for years to monitor what's happening in nursing facilities. And if we are starting to lose that information, which has been critical in terms of understanding a bit about what's happening in nursing facilities, that is really sad.

Because we have had a different approach with respect to nursing facilities than other entities, because we have cared about everybody that is there. The minimum dataset applied to every resident, and we were able to look, and when we do quality inspections, although we don't do a great job there, we looked at the care for everybody that's there. It wasn't an issue that we said these are our people, we pay for them, we are going to care about their care. No. It was we care about the residents of the

facility.

And so I think that is an issue in my mind that we would want to sort of not have the ability to observe and monitor what is happening in nursing facilities be compromised by the changes that are happening with the minimum data set and why Medicare is making its change is more of a testament to how much divergence there's been between Medicare and Medicaid. Maybe there will be some more convergence after this change because the thing that has driven some of the differences between Medicare and Medicaid is therapy, and the fact that for Medicare, while it had a prospective payment system, it was retrospective in terms of "we will pay you for whatever therapy people were getting". And so we saw that incentive result in more therapy and higher rates.

Again, it's a struggle in terms of thinking about in this world where there are so many things that are imprecise as well as variable, sort of exactly what we should be doing in terms of oversight.

CHAIR BELLA: Stacey, then Fred, then Chuck.

COMMISSIONER LAMPKIN: Thank you. This was really interesting and helpful, and thank you, Bill, because I was

also going to raise a confusion about how Medicare was a comparable benchmark for a UPL calculation, so setting that aside.

I think what I would be more interested in, not that the questions that you posed aren't interesting, but really how does the reimbursement mechanism fare versus an alignment of incentives for the quality and outcomes that we want to see?

So, for example, you talked about the fact that some states still use a cost-based reimbursement methodology, where other states use price. So with other kinds of providers, we have moved away from cost-based, thinking that wasn't an alignment of incentives that we liked.

But nursing homes have lagged behind. So is that because there is a difference in nursing homes as an industry, and such that we think cost-based reimbursement is still an approach that aligns things the way we want them to, or is there a political barrier to changing that structure to something that's more prospective, price-based structure? The base versus any kind of adjustments, you talked about different per diems for ventilator care and other kinds of things. But is that aligned with the

incentives we want? So I have a set of questions around that.

And then related to that, what kind of pay-for-performance or value-based purchasing, what's happening in the nursing home industry with respect to paying for performance? We also heard you say that the quality of care in the nursing homes that have the largest proportion of Medicaid recipients is the poorest, on average. So is there something that could be done in the reimbursement mechanisms to improve the quality for the Medicaid recipients? So that's what I'd like to see more about.

COMMISSIONER SCANLON: Actually, I may have misinterpreted sort of the cost versus price, because, I mean, historically, I would say all the states were paying on the basis of -- had prospective rates, and even when they were using cost there was an issue of whether it was an individual facility's cost but it was a prior cost, not their current cost. It wasn't retrospective sort of payment, which there is less of an incentive to be efficient when your own costs, even though they’re lagged, are going to affect your rate. But it is better than retrospective. Okay.

And then I interpreted price a bit as what we sometimes call class rates. And there are a group of facilities, and we pay them all the same. And it is not their own individual costs, but it could be cost-based. It could be that that group of facilities costs are monitored.

I mean, historically, the states gave us a lot of good information about how to set rates through their nursing home rates, because they were the ones that were the most innovative because they had the biggest stake there. And so they did these things in terms of trying to create the incentives for cost containment. They did the things in terms of trying to change access. They were the ones that led the world in terms of case mix adjustment. And there used to be a real problem in terms of getting heavy-care patients or heavy-care residents out of the hospital. When they introduced case-mix, the response was immediate, and, you know, the access problem was considerably eased.

We never have done much on the issue of creating good incentives for quality. That has been the area where there hasn't been a great investment.

COMMISSIONER LAMPKIN: So do we still think that we have state-of-the-art or progressive reimbursement

structure in our nursing home industry today that is aligned with incentives that we want? And questions about how do we pay for days when the resident is in the hospital, and is that aligned with what we want?

CHAIR BELLA: I think that that's something that we can have on the list of things. I mean, you're talking about bed holds and managed care plans and P4P and managed care plans and what the states are requiring, all that stuff.

I think I saw you dutifully writing those things down.

Okay. Fred.

COMMISSIONER CERISE: So, Rob, you get all of the creative Medicaid financing business, and this is another one. When you see the pie graph and you see --

MR. NELB: [Speaking off microphone.]

COMMISSIONER CERISE: Right. And I know a little bit about this one. But you see 5 percent supplemental funding, and then you look on the hospital side and you see where -- in Texas, over 50 percent is supplemental funding, and what a lot of people see with that graph is opportunity. And I think that's what you're trying to sound off on is that when you talk about there's a lot of -

- they're not at risk in aggregate of hitting that UPL cap because there's so much room there. The flip side of that is there's so much room there that there's a lot of potential activity.

The thing that is, I guess, relatively new is -- like these supplemental payment programs, you are recruiting an IGT, and so you run the risk of expanding the program in a way that the states are able to enhance payments with a provider group that is traditionally low payment, and there's a lot of pressure. And if you can do it without using state share, but you can recruit IGT in to do it, then it becomes an easier move.

As you see that develop, the issues of outcomes and what are the expectations and can you build some of that stuff in the program -- and I know that's an issue people are looking at right now, and there are outcomes that you can build in. You're seeing some of that. In the Texas program on the nursing facility side, things like the traditional quality outcomes, falls, and pressure ulcers and use of antipsychotics and things like that are sort of built into the program for performance.

I would throw in things like access to services where

you have these complicated patients in the hospital. You still get a lot of those patients move timely; Medicaid pending, for instance. If you're doing this program, you could incentivize some behaviors to take some of those cases, and heaven forbid, some uninsured as well, but you could build into that with expectations. I would look heavily on that side and see what those expectations are.

Staffing ratios is another very easy one. If you're going to get a supplemental payment, then you could expect better staffing ratios. So there's a lot that you could do there, but there is the potential, this being another financing mechanism, that could grow quickly and without a lot of expectations on what are you buying for the extra financing.

CHAIR BELLA: Chuck and then Sheldon.

VICE CHAIR MILLIGAN: Boy, this has gotten interesting. I was wondering if anybody was going to have any comments at all.

CHAIR BELLA: You're on the clock. We have 10 minutes left, so make your comments succinctly, please, dear Vice Chair.

[Laughter.]

COMMISSIONER RETCHIN: I yield. I yield my time to Chuck.

CHAIR BELLA: That's okay. Darin wants in too.

VICE CHAIR MILLIGAN: At least Melanie said please.

Rob, I imagine you on every hike lifting every rock, and, Kayla, my condolences.

[Laughter.]

VICE CHAIR MILLIGAN: I want to try to focus a little bit. To me, important background, foundational, I see three, personally three tracks of where we should take this to help drive our work. One is the payment integrity piece, which we've talked about. A lot of provider taxes, a lot of IGT, I think there's a payment integrity piece.

I think there's a quality piece that we should figure out what's the quality contribution we can make, how do we measure it, all of that.

And I think the third track to me is the relationship of this to Olmstead and rebalancing, and I want to touch on each of those really kind of briefly.

On the payment integrity, I kind of am with Bill and others. The UPL is harder here. It's harder in hospitals because -- how much does Medicare really pay for maternity?

I mean, how do we measure comparability for services and populations that are a little different? It gets harder here because custodian nursing home care isn't the same thing as post-acute skilled care and how -- the comparability. So there's the payment integrity piece. I think UPL is part of that picture, IGT, all of that. Payment integrity to me is one.

The second, I want to talk about a little bit about quality and pick up a little about what Stacey said. I think VBC is hard here because I think if it's done well, a lot of times the savings accrue to Medicare. I mean, really well-managed, well-done nursing facilities keep people from going to the hospital with decubiti or falls or pneumonia or whatever, and yet the savings that accrue to the Medicare program, there's a lot of duals. The majority of Medicaid folks in nursing facilities are duals, and the majority of the savings by high-quality care is avoided Medicare spending. So how do we think about VBC, value-based contracting incentives? How do we think about quality?

I do think that the transition in -- let me pivot to the Olmstead, and then I'll just kind of not take too much

time here. On the Olmstead, there's three elements of this to me. One is the more successful states are getting people served in community-based settings, the more you find the acuity level rising in nursing facilities because it's the safest setting for a lot of people that can't safely be served in home and community settings. What that means is the acuity level is rising. The complexity is rising. There's a lot of individuals with mental illness who are living into old age. It's not dementia; it's mental illness. There's a lot of people with behavioral challenges. There's a lot of schizophrenia. There's a lot more of that going on in nursing facilities. How do we measure appropriate payment rates, where looking at it from a Medicare diagnostic criteria isn't -- if states are going to try to keep up and adapt RUGs to whatever Medicare is doing, it's going to get complicated because how you measure adequacy, risk adjustment, case mix with some of the vent dependent, really, really -- people with addiction, all kinds of complexity in nursing facility? And that is the population that's hardest to serve in community setting. So there's an Olmstead piece of rate adequacy in all of this.

There's a piece -- it was mentioned earlier about nursing facilities closing. What's happening in a lot of those places is they're converting the same physical plant to assisted living, and then it gets into the settings rule we heard about earlier because it's still a campus, and they're still -- people are trying to take the brick and mortar and use it, repurpose it, but how does that deal with the settings rule?

I know I'm kind of spraying stuff all over the place, but again, to me, it's the three buckets of payment integrity, quality, and Olmstead. And I think I will leave it there. Thank you.

CHAIR BELLA: Sheldon, are you sure?

Darin?

COMMISSIONER GORDON: Real quick, I agree with Chuck. He hit at some of those points. When you're looking at the nursing facility closure in the same context of what he was describing about facilities changing, I mean, you can't look at nursing facility closure without looking at the other dynamics going on with the shift toward greater HCBS penetration, because like in our state, we had such a high dependence on institutional. And that's changed

dramatically. So in that new world, in the new utilization you're seeing, can you still support the same number of facilities you were supporting when you were heavily reliant on only institutional care for your population? So I'm just thinking we have to broaden that perspective behind just reimbursement. There's other dynamics that are shifting there.

I would say I was a little perplexed, and I didn't understand the data source, why we didn't pull any of the managed care side, because different than on all the other physical health side, the behavioral health side, this one typically is dictated in the managed care agreements how they will pay. And so you can pick up the methodology that's happening there.

We have shifted over time a tendency from cost based, cost-based with add-on payments for quality improvement, very succinct quality improvement activities, to acuity and quality. And that's been happening over the last five years. I'm trying to get to a more value-based driven system.

So I think it may be worth looking at some of the managed care things because I think there may be some

additional lessons to be learned that maybe the broader fee-for-service hasn't ventured into just quite yet.

Thank you.

CHAIR BELLA: The other Darin?

[Laughter.]

CHAIR BELLA: Sorry. Toby?

COMMISSIONER DOUGLAS: Just picking up on what Chuck was saying as well as, I guess, Darin too, when we think of payment policy and its duals, financial alignment, or just D-SNP, Medicaid managed care interaction, is there any lesson learned looking at payment policies that allow for incenting the quality from nursing facility to hospital or home- and community-based setting where the dollars are aligned? Can we see anything there? Are there any payment policies that we would just on a micro level that could, back to our duals work, help on that front?

CHAIR BELLA: There is, as you know, like a demonstration that has been targeted at duals in nursing facilities, that attempted to get at the disconnect between the payment policy. If you pop out and you're out for three days, you come back in at the higher rate. So it was first providing funding to do nursing. That would take

care of pressure ulcers and dehydration and urinary tract infections, but then I think it's actually one of the demos that has expanded and is actually using Medicare payment policy. But it does have -- they had to figure out that interaction with states because states are the ones paying for the custodial, and then the demo was saving money. So I think it's worth looking at, long way of saying.

COMMISSIONER DOUGLAS: See, I set you up.

CHAIR BELLA: I know. I didn't even say "duals" all day to until now.

I know some other folks may want to say something, but let me see if any public folks would like to comment on this.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. Any last comments from commissioners?

VICE CHAIR MILLIGAN: Can I just -- I promise it will be brief.

One of the trends -- and Rob and I talked at lunch about this -- I have seen telehealth going into nursing facilities to try to give nursing facility clinical staff a

way to figure out how to manage somebody without sending them to the hospital, and that is a new and emerging, kind of this cross-payer with Medicare effect because the investment might be in the nursing home, but the savings might be at the avoided transport to the hospital.

So I think where I would locate that is what are the innovations that we want to maybe learn about in terms of trying to deal with the cross-payer demo stuff that Melanie just touched on, but it can take other forms, like nursing home-embedded telehealth origination sites.

CHAIR BELLA: So, Rob, we threw a lot of stuff. I mean, there are some core themes there. I mean, you are definitely hearing interest on looking at it, whether you think about IGT or program integrity, and it sounds like that will come back most likely in this proposed rule that might come out, regardless. I think if for some reason there is not an exterior force that brings it back and if you see interest here that we'd like to keep talking about that.

In addition, the issues raised around quality and Stacey's questions, I'd put that kind all in a best practice bucket along with what Chuck was saying.

So do you have any questions back for us to try to un-muddle some of that, or do you hear the same key themes, hopefully?

MR. NELB: Yeah. I think I hear the same themes. There's a lot there, but we will go back and develop a work plan to sort of think about what data we have and how we can roll that out.

CHAIR BELLA: And I think at some point -- do we have plans to talk to any nursing facility operators or states, or can we think about where that fits in this process, if it fits?

MR. NELB: We don't, but we certainly could. And where you're thinking about looking at best practices or something, a qualitative approach like that may be a good way to get a some of that.

CHAIR BELLA: Great. Any last comments? Anne?

EXECUTIVE DIRECTOR SCHWARTZ: No.

CHAIR BELLA: All right. Thank you, guys.

From the commission, commissioners, anything else for today?

[No response.]

CHAIR BELLA: Otherwise the public meeting begins

tomorrow at 9:30, and it is Duals Day. So show up excited and ready to talk because I guarantee you it will be engaging.

But, with that, we're adjourned for today. Thank you.

* [Whereupon, at 3:59 p.m., the Commission was recessed, to reconvene at 9:30 a.m., Friday, September 27, 2019.]

PUBLIC MEETING

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

Friday, September 27, 2019
9:34 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
CHARLES MILLIGAN, JD, MPH, Vice Chair
TRICIA BROOKS, MBA
MARTHA CARTER, DHSc, MBA, APRN, CNM
FREDERICK 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

[9:34 a.m.]

CHAIR BELLA: Good morning. Welcome to our panel. Kirstin -- and I should tell you guys, we just spent 15 minutes on duals acronyms so everybody knows about SNPs and FIDE-SNPs and HIDE-SNPs and MMP and MIPPA. So fire away, Kirstin. Thank you.

PANEL DISCUSSION: FEDERAL AND STATE ACTIVITIES TO INTEGRATE CARE FOR DUALLY ELIGIBLE BENEFICIARIES

* MS. BLOM: Thank you. And just a quick reminder, Commissioners, we do have, for the two states, there is materials in your packets, a set of slides for Idaho and a few one-page handouts from Washington.

I'm just going to do a quick intro and then I'll turn it over to the panelists. This year we are continuing our work on integrated care, which we know is a topic of longstanding interest to the Commission. Of course, we have been closely following federal guidance and state actions in this area. In the spring of this year, for example, the Medicare-Medicaid Coordination Office, or MMCO, published a letter to state Medicaid directors with several new options for integrating care.

And for their part, states were, of course, working to integrate care for their dually eligible populations, even as policies at the federal level are still taking shape. They are using different approaches to align coverage between the two programs, based on the unique circumstances in their states.

So today we are kicking off our work on this topic with a panel of experts in this area. This panel will bring us both federal and state perspectives on where things stand today. We will hear from the director of MMCO on recent federal guidance and state interest in the new opportunities that have been made available, and we also have officials from Washington and Idaho who will share their experiences integrating care in two unique ways, through managed fee-for-service and through a fully integrated dual-eligible special needs plan, or FIDE-SNP.

First we're going to hear from Mr. Tim Engelhardt. Mr. Engelhardt is the Director of MMCO, which is an agency dedicated to improving services for individuals dually eligible for Medicaid and Medicare. Prior to joining CMS in 2010, Mr. Engelhardt was a consultant with the Lewin Group and he previously served as the Deputy Director for

Long-Term Care Financing at the Maryland Department of Health and Mental Hygiene. He received a bachelor's degree in sociology from the University of Notre Dame and a master of health science from Johns Hopkins.

Our second panelist is Ms. Bea Rector. Ms. Rector is the Director of the Home and Community Services Division within the Aging and Long-Term Support Administration in Washington's Department of Social and Health Services. Ms. Rector has worked in LTSS at the state level for 20 years. She is responsible for planning and administering federal and state services for individuals with functional impairments, and their caregivers. In partnership with the Washington State Health Care Authority, Ms. Rector has worked closely with stakeholders and CMS to negotiate the state's fee-for-service demonstration. She received a master of public administration degree from the University of Washington.

And our third panelist is Mr. Matt Wimmer. Mr. Wimmer is the Administrator for the Idaho Division of Medicaid. He has worked for the Idaho Department of Health and Welfare since 2008. He was selected as a fellow for the 2019 Medicaid Leadership Institute program and currently

serves on the board of the National Association of Medicaid Directors. Previously, he worked with the San Diego chapter of the American Academy of Pediatrics, providing county-wide coordination and support for First 5 San Diego's Healthy Development Services program.

Each of our panelists will give a brief presentation and then we are planning to use the majority of the time allotted for today's session for a conversation between you guys and the panelists. Following this session, my colleague, Kristal, and I will give you sort of a short run-through of our work plan, and then you will have a chance to provide feedback on what you heard from the panel, as well as the work plan that we share with you.

So now to start us off I will turn it over to Mr. Engelhardt.

* MR. ENGELHARDT: Thank you. Thanks for the chance to be here, and I want to first acknowledge the great work of the MACPAC staff. We consult their products with great regularity, and much of it is valuable to us, as I'm sure it is to Congress, so a big thank you to their great work over the years.

Despite your briefing this morning, will you allow me

to give a quick background overview of the basics? Twelve million people are eligible for Medicare and Medicaid at the same time. Of them, 3.5 million are what we call partial benefit dual eligible. That means they are on the Medicaid program and Medicare covers their premiums and, in some cases, their cost sharing for Medicare benefits, but nothing else. The remaining 8.5 million people are what we call full benefit dual eligible, which means they have access to the Medicaid benefit package, primarily long-term services and supports and community-based behavioral health services.

That population of 12 million people has low incomes and high rates of chronic illness. Beyond that, it is a group that is diverse in many ways. Forty percent are under the age of 65 and eligible for Medicare by virtue of disability or end-stage renal disease. A little over 40 percent have at least one mental health diagnosis, and it encompasses groups of people that we typically segment in different ways -- nursing facility residents or home and community-based service users, or people with intellectual and developmental disabilities, or serious mental illness, and on and on. And it is important to keep that diversity

in our heads as we think about interventions and policies and other things.

Collectively, we spend, between the states and CMS, just a little over $300 billion each year to serve that population of 12 million people.

Better services for dually eligible beneficiaries are a big strategic priority at CMS right now, and we organize our work into two main tracks. The first one we refer to as modernizing the Medicare savings programs. The MSPs, it is hard to overstate their importance in helping low-income beneficiaries afford their Medicare coverage. It is expensive to enroll in Medicare. And so being in one of the Medicare savings programs is going to save you about $1,600 a year in premium costs alone, and for a low-income individual that is money that will go towards stabilizing housing, toward putting food in the refrigerator, and meeting other of life's needs.

So for my money, though we rarely talk about it as such, Medicare savings programs are as big and as important of a social determinants of health initiative in our agency as anything else that we may focus on.

Despite their importance, the operations of the

Medicare savings programs are messy and inefficient. To give a few examples, beneficiaries become eligible for subsidies for their Part D coverage at a different place and through different mechanisms than how they become eligible for their Medicare savings program subsidies for Medicare Parts A and B, and that creates a lot of inefficiencies for beneficiaries to navigate the eligibility system.

Once they do, we still exchange data with some states, between CMS and states, as I say, at rates of frequency that can be as little as monthly, which creates delays in effectuating changes in eligibility status, which means bad beneficiary experiences, it means payment by one payer and recoupment and repayment by another payer in ways that are inefficient for all parties.

And then for providers serving dually eligible beneficiaries, the claims payment process, what we typically think of as the crossover process, is not nearly as functional as we wish it were and too often requires duplicate work by providers who are already taking on a challenge in serving a tough-to-serve population. So, in short, we have made it a lot harder to serve this

population than it otherwise needs to be.

We are acting on each of these challenges. We have already completed a significant amount of work to reduce the frequency with which providers inappropriately bill people cost-sharing when they are statutorily protected from such cost-sharing as a qualified Medicare beneficiary, QMB program, I should say.

In December, we sent a letter to the state Medicaid directors highlighting 10 opportunities to better serve dually eligible beneficiaries, all of which can be done without any waivers or complexities but actually just improve our operations of the programs. As part of our interoperability agenda we propose new rules to accelerate state CMS data exchange, and we have been soliciting public input on crossover payment problems.

The MSP work is not particularly glamorous, but it is important, and I think the people that we serve deserve better.

The second track of work we refer to as promoting integrated care, and we use integrated care in different contexts, depending upon the work that we do. In this context, I think of it as programs for dually eligible

beneficiaries that maximize meaningful care coordination, that minimize cost-shifting incentives between the programs, and include total cost of care accountability across both Medicare and Medicaid. And, most importantly, a meaningfully integrated program needs a better and more seamless beneficiary experience, ideally one health system, one network, one 1-800 number, one appeals process across all of their separate benefits.

Research by ASPE and MedPAC and others has consistently found that well-integrated programs have been able to achieve impressive results for dually eligible beneficiaries. Nonetheless, less than 10 percent of duals are in what we would consider a meaningfully integrated system and instead default to a relatively fragmented world of separate Medicare and Medicaid programs.

We are working to improve access to integrated care in a variety of ways. There are some states in which integrated care is created through the marriage of Medicaid MCOs and Medicare Advantage dual eligible special needs plans. Idaho is a great example, and Matt will surely attest to that in a little while, but that is the predominant form of integration in states from Pennsylvania

to Minnesota to Tennessee to Hawaii, and others.

Over the last two years, we have been engaged in Medicare Advantage-related rulemaking intended to strengthen the D-SNP platform for better integration, including implementing provisions from the Bipartisan Budget Act of 2018. Over 30 states also have programs of all-inclusive care for the elderly. I think most of you are familiar with these, but these are fully integrated, fully capitated, provider-based managed care systems for older adults, many of whom are dually eligible for Medicare and Medicaid.

This summer, we finally modernized the regulatory basis for PACE sites for the first time in over 10 years, and while we are all familiar with the reality that PACE remains relatively small, it is growing at a relatively rapid pace. There are now more than 46,000 Medicare beneficiaries who are enrolled in PACE programs across the country.

And last but not least, we are working on innovative new versions of integrated care, primarily, although not exclusively, through something that we refer to as the financial alignment initiative, what everyone else refers

to as the duals demos. We have 12 such demonstrations in 11 different states. They currently serve over 400,000 full-benefit duals. They are run in conjunction with the CMS Innovation Center and subject to a rigorous external evaluation.

We now have evaluation reports from Research Triangle International, covering 10 different demos. We have 15 different reports, because we get them at different points in time. Six of them have regression-based utilization analysis against the matched comparison group. Eight of them have cost analysis, similarly, against a matched comparison group.

And the results, at least to date, are very promising. In five out of the six states where we have data we have statistically significant reductions in in-patient admission. In four out of five where we have the same data for skilled nursing facilities we have statistically significant reductions in SNF admissions. In half of those states we have reductions in long-stay nursing facility admissions. In three out of the eight we have statistically significant Medicare savings, and almost all of the states project Medicaid savings as well.

It is positive results like these, albeit early results, that led us, in April, to make more opportunities available to states to pursue some of these similar demonstration opportunities. We offered basically three opportunities to states. One is new states who aren't already engaged in this work could choose to participate in one of these models. We also invited states to propose completely novel approaches to integrated care to us, and then welcomed states that already had demonstrations to extend or expand them, subject to certain criteria.

We have already effected such changes in California, Massachusetts, Illinois, and Ohio. Those actions will make integrated care products available to over a quarter million duals in 2020 and beyond. We are happy with that progress.

I am quick to note, especially to you, there is much more for us to learn and evaluate, more for us to adapt, based on the findings to date. I, however, feel like we are far down the road now to better outcomes at lower cost, and I am excited by that.

I am enthusiastic about most of the evaluation results but none more so than those from Washington State, where

our evaluators have consistently found reductions in inpatient and SNF and nursing facility placement and in Medicare spending. Because of the unique terms of our work in Washington State, we have shared a significant amount of those Medicare savings back with the state. And fortunately for you, there is someone at this table who can talk about it much more eloquently than I, so I will yield to Bea Rector.

* MS. RECTOR: Good morning. I appreciate the opportunity to come and talk about Washington's approach to improving care for individuals who are dually eligible. In your packet you have got three documents, because we wanted to be able to provide you with a little bit more background and detail than what we are able to do in just a 10-minute presentation. You have a fact sheet about health homes. That provides you an overview of the goals, the eligibility, the provider network structure, services delivered, and the critical role the care coordinator plays with beneficiaries.

You have a beneficiaries outcome document that tells the story of three individuals who have participated in the service, and a lessons learned document that outlines some

key factors of our intervention, features of our health home model, impacts of the program on health outcomes, beneficiary experience, and Medicare savings.

Just by way of background, Washington State has 1.9 covered Medicaid lives, and 1.7 are in managed care for behavioral health and acute care services. Our long-term services and supports system is operated primarily in fee-for-service, with the exception of a PACE program.

Many of our duals do participate in long-term services and supports, and our duals are carved out of managed care, so largely they do receive their services in a fee-for-service environment for their acute care as well.

We often get a question of why the managed fee-for-service model, because it is the only one left right now, I think, in the nation. And there were a couple of reasons for that. First of all, we had piloted fully integrated care in our state with two health plans, and we had some lessons learned from that. We had some successful chronic care management pilots that showed savings for Medicaid-only clients and good health outcome improvements, and we wanted to be able to expand that approach.

Duals, again, are largely served in our fee-for-

service service delivery systems, and we did try to stand up a full integrated managed care model in two of our most populous counties, at the same time we were going to do the managed fee-for-service model. We got pretty far down the road on that and were excited, but the rate structure, the health plans just could not make work with the assumed shared savings. So we had a health plan back out and knew that it wasn't going to work for us to have only one health plan in a fully integrated model.

So what we heard from our beneficiaries is that no one enjoys going to the nursing home, nobody enjoys going to an ER or a hospital. When people have multiple chronic health conditions, which, of course, duals do, getting the care they need can be as challenging as assembling a jigsaw puzzle in the dark. This is especially true when people have needs for mental health, chemical dependency treatment, or require daily tasks assistance with bathing, medication management, and transportation. They often have several doctors and care providers. Each provide a part of the care they need but may not be communicating with one another about the care needs of the individual that they are serving.

We know that when the pieces of an individual's health care puzzle fit together, particularly also with the social services supports that they need, they do better and their care costs less. When talking to beneficiaries about what improvements we could make to the delivery system, many individuals identified the need to have a care coordinator who bridges these systems of care, who could help them focus and understand the health delivery system, and also assist them in getting better at managing their own chronic conditions.

So in developing the health home model in Washington, we took lessons learned from those previous pilots about who could best benefit from intensive care coordination, and we married that with predictive modeling of future costs to really inform both the benefit design and the target population.

So home health services in our state are available to individuals with chronic conditions who are enrolled in Medicaid, including duals. Individuals must also be at significant risk for health problems that can lead to unnecessary utilization of hospital ER, inpatient, nursing facility, and psychiatric hospitals.

We determined that risk by using a predictive risk modeling system called PRISM to identify individuals based on their claims data, both Medicaid and Medicare, and basically somebody at risk is somebody who is predicted to cost 50 percent more than our average disabled individual on Medicaid or the average Social Security income individual.

Targeting of the intervention in terms of care coordination is key. Effective risk-based targeting is essential for a return on investment. Individuals with high risks have costs that are six times higher than individuals with low risk, so they provide a unique opportunity to really be able to make a difference, both in health outcomes but also in reducing avoidable costs. We have found that targeting based on expected future costs or inpatient admission risk is much more likely to produce a higher return on investment than targeting based on ER utilization or care gaps.

One of the critical components of our model is strong community-based care coordination. Community-based care coordination is essential to the success of our model. You have to have skilled care coordinators who have the right

mission to be successful in the work. Our model is focused on care coordination at the community level. We contract with entities to be leads, who see this work as part of their mission, and have an ingrained knowledge of how to deliver services where people live. They are built on existing trusted relationships with beneficiaries.

And Area Agencies on Aging have been a critical partner in this work as they have the infrastructure, the knowledge of the population, and embrace values of both self-direction and self-management. And it's absolutely true that a high percentage of people who are high risk happen to need long-term services and supports, so, of course, Area Agencies in our state play a very large role in our Medicaid delivery system.

Washington's model is not managed care. Instead, the state contracts with lead organizations who play that accountability role. They're responsible for contracting with care coordination entities to create a network in their regional coverage area, and that network is to really act as a bridge of medical, behavioral health, chemical dependency, and long-term services and supports.

Fidelity in terms of care coordination is key.

Ensuring that health homes is not just like any other care coordination is important, and the difference is really built in the strength of the training approach, the longevity of engagement of these care coordinators with the beneficiaries, and the relationship and goal setting that they achieve.

So we train care coordinators to a fidelity model of care coordination, how you screen, standardized screening assessment, standardized health action planning, motivational interviewing. Again, how do you establish and keep a trusted relationship and really engage a beneficiary in their own health outcomes? We have monthly webinars to spread best practice across those care coordinators and problem solve.

The Health Action Plan is a plan that the client writes with assistance from the care coordinator that is person-centered. It identifies what the client wishes to do to improve their wellness and health, so what is important to them as opposed to for them.

The centerpiece of the Health Action Plan is the client's self-identified both short- and long-term-related goals, including action steps the clients and others will

take to help improve their health. And then with the beneficiary's consent, that Health Action Plan is shared with a majority of providers that work with that client, so everybody is kind of rowing in the same direction.

The care coordinator helps bridge systems of care, establish rapport, build confidence, and help the individual, whether that's visiting with them, with their primary care providers or coaching them on how to work with their primary care providers, and the social services providers to, again, build that confidence in self-managing their own health.

We've had a lot of successes with the program, and, you know, just to highlight those, between the years of 2013 -- and we started our alignment demonstration in July of 2013, and we've gotten preliminary results through 2017. So we've achieved a savings of $167 million in Medicare savings over that period of time. Eighty-seven percent of the beneficiaries report very high satisfaction with their care coordinator. Most focus group participants reported improved quality of life and health improvements. And so from a state, you know, there's a four-to-one return on investment. Yes, we are investing additional money in

Medicaid health home services, and we also are investing additional money in community-based long-term services and supports. But it's achieving significant health improvements and significant savings for the individuals that are participating.

This program is not without its challenges, and I would say that one of the significant challenges is in a managed fee-for-service program you are making investments, and you're waiting to see the results and waiting to get those investments back into your system. So it takes a lot of work and a lot of trust from the legislature to make those appropriations, and we've had to do a lot of work over the years, and the Centers for Medicare & Medicaid Services have been very helpful to us in writing letters, et cetera, about the promising results of the demo.

But, of course, we have gotten three checks, and that makes a big difference, and they have been able to use that money to reinvest and increase health home rates. we've increased the qualifications in terms of broadening the qualifications of who the care coordinators could be. Probably our biggest challenge is the fact that you don't have up-front money to invest in the provider network, and

so the outreach and engagement, finding the beneficiaries, creating the Health Action Plan is all done before those care coordinators get one payment. And so they're hiring care coordinators before they're actually able to bill for the service, and that's a significant challenge.

Having said that, we're very proud of the work that our beneficiaries have done to improve their health outcomes. We're very proud of being able to share in Medicare savings and prove that investments in Medicaid really can make a difference in the spend on Medicare and health outcomes. And we are looking forward to extending the demo as well as potentially negotiating how do we use D-SNPs to better align service delivery for our duals.

CHAIR BELLA: Kit, was your question a clarifying question? If not, can we hold it? Okay, perfect. Thank you.

* MR. WIMMER: That's really impressive, Bea. It sounds like you've got some great things going on in Washington.

I'm going to tell just a little bit of our story on our integrated managed care plan for duals, which we call "Idaho Medicaid Plus," and I'm just going to kind of walk you through what it is, what it isn't, and give you a

little bit of the history and kind of where we're headed and some of the challenges that we're facing.

So this includes all the Medicaid benefits that are secondary to Medicare, and we've got about 11,000 of our 27,000 or so duals enrolled at this point, and I'll walk you through kind of how we've done a managed care rollout over the last year or so.

But it also includes Medicaid benefits not provided by Medicare, so state plan personal care services is a good example of that, as well as all of the 1915(C) long-term services and supports, so home-delivered meals and extended personal care services. We have some supportive living for people with intensive care needs and that type of thing.

And then the one thing I didn't put on the slide but which I should have is there is care coordination provided through those plans, and that's fairly intensive. So everyone's contacted when they enroll, and then depending on that initial first contact, then they get a care management plan. At a minimum they're going to be contacted the next year to see if their needs have changed or they can reach back out to the care coordinator and talk to them. Or if there's, you know, something in the claims

that indicate that they need some additional assistance, that care coordinator will reach back out to them and work with them on that. So that's a positive aspect of this and one that all the beneficiaries are really liking.

It doesn't include DD services, developmental disability services. We all manage those directly. And so those are not included. Intermediate care facility services are not included. We do have nonemergency medical transportation that is a separate brokerage, and then we have a separate dental plan that is carved out as well.

Behavioral health services are included as part of this, so it's fairly comprehensive, but there are a few things that don't wrap into it.

And then it's offered in 22 of our 44 Idaho counties. We do have some pretty darn rural places in Idaho, you know, counties with lots and lots of land bigger than Rhode Island and have 2,000 people in them. And it's an optional plan for duals in 13 of those counties, so they can opt into it. But it's the primary source of Medicaid benefits in our nine urban counties across the state.

I'll kind of walk you through the history of how we got here with this plan. In 2006, we had a big effort

around Medicaid reform, and I think the idea at that time was let's structure the Medicaid program so that we can support managed care going forward. That didn't quite pan out the way it was planned, but it sort of set up some interesting things where it put the duals into a single benefit plan and kind of structured it that way in Idaho code, and then set us up so that we could start offering that opt-in plan.

And so since 2007, we've had that opt-in plan, and we started out with Blue Cross of Idaho, our local Blues plan, and United Healthcare. But the numbers of people that were opting in was really, really tiny. We had plan memberships under 1,000 people, and so that wasn't really very viable long term. United Healthcare saw that and tapped out in around 2011. That's kind of a losing proposition if you're a health plan. Blue Cross of Idaho hung in there and kind of, I think, was hoping it would develop into something more and kept working with us on it, and that has, you know, after many years, paid off. They've been a great partner along the way.

So when the duals demonstration came out with the Affordable Care Act, we thought this is our moment. We

were pretty excited, and we ran around and talked to all the other plans that, you know, might possibly be interested in Idaho. We could not attract a second plan to save our lives.

And so, you know, we kind of said, well, there's a missed opportunity, but along with that we kind of did some thinking and added the long-term services and supports to the plan. So that was kind of -- you know, we made some progress anyway. And then with -- and I think that's kind of the story that I want to tell to you all, is that it's been slow and steady progress over a number of years that has enabled us to get to where we are.

So in 2017, you know, we had Molina Healthcare expressing some interest and filing for D-SNPs in a number of counties in Idaho, and so we knew that we had another opportunity. Finally, we've got a second plan with some interest, and we can move into managed care in a bigger way.

And so that same year, we worked on statute to transform our upper payment limit, you know, for nursing facilities into a quality program, still funded via a provider assessment, but it's a quality program rather than

just a strict UPL program. And we did that knowing with the new managed care rules that we would need to be able to do that and kind of with an eye towards moving into a broader managed care landscape. And then we started a lot of planning for this whole Idaho Medicaid Plus rollout.

In 2018, just last year, Molina Healthcare, that was our first year in the market. They started in January. And then we really went into planning for the managed care rollout in full force.

In November, we rolled out in just a single Idaho county, Twin Falls County, not a big county, about 3,000 duals members. And so we kind of did this slow and steady progression. And that went pretty well. You know, there were a few bumps, but the plans were really invested in this succeeding. We were really invested in it succeeding. They did a ton of outreach; we did a ton of outreach. We had meetings with providers. We had, you know, beneficiary town halls where folks would come and bring their paperwork and ask us questions. And those were -- I think those were a really critical factor for our success, just that kind of boots on the ground, get out there, talk to the providers, talk to the beneficiaries, and tell them what's going to

happen and how it's going to happen and answer their questions.

So that all went pretty well in Twin Falls County, and then in 2019, just the start of this year, we rolled out in the eastern side of the state and went to three more counties over on the eastern half of the state. In January, we had some legislative stuff happening there, too. We're a state where our rules, our regulations have to get approved by the legislature, so we had rules going forward at the same time we're expanding. And that was sort of a nail-biter, but it was all okay.

And then we moved to northern Idaho, so three more counties in northern Idaho, in June of this year, and that was -- we got the most kind of pushback from beneficiaries there. Idaho in general has a pretty strong independent streak, and northern Idaho is even more independent. And so some of the beneficiaries were really concerned about, you know, what was happening, but we worked through it, again, with that engagement strategy. And then this August, we kind of got to the big -- you know, where the people live, in Treasure Valley, so Ada and Canyon counties, which is Boise and Nampa and Caldwell, and about

10,000 of those duals. And so that kind of got us to where we are today.

And all that has been pretty successful so far. There's been definitely some bumps on the road. There's been some concerns about, you know, the level of behavioral health access that we've got through some of the plans. We've been able to work through that. There's been provider concerns about, you know, "Am I going to get paid? Is this going to be a cash flow issue for me?" We worked through those. So, by and large, it has been a very successful rollout over the past year.

And so that brings us to where we are today. We're planning to bring on seven more rural counties in 2020, and Molina has filed for those, and so we're also looking at initiating passive enrollment in 2020 for counties where there's only one plan, so into the Medicaid side of the benefit.

And then the other thing I didn't put here but that we are planning as well is to try and bring some value-based payment aspects into these contracts. They don't really have that today, but we're trying to at least make some of the payment contingent on performance on measures and those

types of things. And so that's kind of what we're doing now.

So where we've been, you know, that slow, steady progress, that county-by-county expansion has been really helpful to us. We've done this through an open application process. It hasn't been an RFP. It's been a request for applications. And that's been important to us because, like a lot of states, you know, state purchasing is a challenge, and we've got a state purchasing agency that we've got to work in collaboration with, and that's not always easy.

Doing that through an open application removes a lot of those barriers and makes it kind of just here's the straightforward open deal that any plan can participate in. So that's been helpful.

You know, the emphasis on the engagement I mentioned. The limited number of carveouts has been helpful. But I think we're looking at this as potentially a platform for future growth, and we're very aware that the way that we've done this is really backwards from what a lot of states have done. A lot of states, you know, will start out with kind of their medical program as a comprehensive managed

care program and then kind of move into duals and that kind of thing. You know, I wish I could say we planned it that way, we were very forward-thinking, but this is just sort of how it worked out in Idaho and sort of the path that we've taken to get there.

So for the future, we would love to have this type of integrated approach across the entire state, but there's some counties that are just so rural that it's hard to see how they're ever going to really be able to support this. So that's a challenge.

We want to leverage these plans beyond duals. We've kind of done some very early exploration of, you know, what if you did have this -- leveraged this approach and kind of take a similar pathway to saying, you know, you could -- you have an opt-in plan that's kind of a companion to this, and make that available to the population that's Medicaid-only population, that doesn't have a duals benefit.

We're right in the midst of implementing on the nursing facility quality program, and I think all along the way, you know, this has been kind of baby steps. The nursing facility quality program has some basic incentives for quality and some disincentives if you are under

quality, but I think we could be more aggressive there.

Also, the request for applications offers a pretty good deal to managed care plans, and we did that purposely to try and attract a second plan and do all that. But now that we're built out and, you know, these folks are -- they're about 10 percent of our population, but they're about 20-plus percent of our budget. So as we bring all of this money over into managed care, we've got to be real careful about how we manage it, and I don't know that we can continue offering the same deals that we have in the past to plans in the future in the interest of managing the state budget. So that's kind of a challenge.

We have interest from another big national plan right now who's kind of looking at coming in as a third plan into the Idaho market. I think that would be a really good thing in a lot of ways but also challenging to manage. So, you know, we're kind of looking at that.

We've also had -- we've periodically had a few plans come around and look and say, you know, "Maybe we want to enter as a third plan." But we are a pretty small state; 20,000 duals is not a ton. And so, you know, we'll see what comes of that.

Then the other challenge, I think, is with the coordination around behavioral health benefits. We have an awful lot going on with behavioral health. We're expanding in January, which is super exciting, but that means, you know, we're trying to expand coverage for behavioral health in areas like partial hospitalization; we're looking at an IMD waiver so that we can cover psychiatric hospital services for people not just with substance use disorder treatment needs but also people with serious mental illness. So all of that kind of needs to be coordinated across all these plans. We don't want to have the situation where, you know, you've got one benefit over here and another benefit over there and it's not working effectively.

And then I think the big thing that we're going to have to do is really build up our capacity to effectively work with managed care. We've got some great staff, and honestly, they deserve all the credit for bringing this up and bringing this forward. They're pretty amazing.

But I think going forward, we're going to have to make sure that we've got a program that doesn't just rely on us finding amazing staff, but that makes sure that we can

consistently develop amazing staff to work with these plans and make sure that everything is running effectively.

So we're pretty excited about it -- early results from our plans are showing good things in terms of reductions and hospitalizations, reduction in ER utilization, reductions in nursing facility admissions, all the things that you would expect.

And so we're very hopeful, and we think we've done some great work, and we think we've got a lot of additional work to do going forward.

CHAIR BELLA: Thank you. We really appreciate the three of you being here. This is an issue of great interest to this commission, and I think you'll see us spending some really dedicated time on it. And so hearing from both of you in kind of how we think about getting more of you in other states is going to be really important to us. So we're going to have a lot of questions for you.

We're going to start with Kit.

COMMISSIONER GORTON: So I'll just join Melanie in thanking you for coming and in particular for so eloquently demonstrating how state flexibility leads to innovation and program success. These are two neighboring states, and the

cookie cutter just wouldn't have worked in either of them. So thanks for demonstrating that, and thanks for coming so far.

I sometimes feel very isolated here on the East Coast, so nice to hear from the West.

My question is for Bea. Forty percent of the duals are under 55, and our experience in Massachusetts, when I was running the MMP in Massachusetts, was relying on AAAs, the Area Agencies for Aging, was problematic with that population. The philosophy of a AAA is safe aging in place. The philosophy for younger people with disabilities is promotion of independence and right to risk.

So we found that to be a cultural challenge, and I wonder if you could just talk a little bit about -- you mentioned loosening rules for coordination. Are you including the CILs, the centers for independent living? How are you making sure that your care coordinators are, for lack of a better word, culturally competent to the subpopulations they're serving?

MS. RECTOR: That's a great question. I would say that if you've seen one AAA, you've seen one AAA.

But what I would say is that in Washington State, the

area agencies on aging have had a statutory role in long-term services and supports for the 18-plus population since 1995.

It has been a many-year evolution around culture and really working with an under-60 population, and 40 percent of our Medicaid LTSS population is under the age of 60.

One of the beauties of creating kind of a care coordination network and having a lead entity that's responsible for contracting is you really want to make sure that you've got all those players within your care coordination network, whether they be independent living centers, community mental health centers, area agencies on aging, physicians' offices and practices, individuals that specialize in HIV/AIDS. In our state, that's been a big component in some of our geographic areas.

The more diverse and broad that care coordination entity is, the more likely that when you have somebody who is high cost/high risk that you're approaching, to really engage in health homes, that they will do so because the person approaching them or the entity approaching them is one that they already have trust in, that's already known in the community. And perhaps that individual is even

receiving some kind of service from that entity.

But I also would say that this fidelity model of training is critically important.

So the importance of person-centeredness, self-direction, really taking the lead from the beneficiary about what's important to them and what they want to work on -- and it can be small. It can be "I want to attend my son's high school graduation, and I don't want to be in a wheelchair. I want to walk up the bleachers, so that I can sit with family and friends." And if that's the goal, that's the goal we're going to work on.

COMMISSIONER GORTON: Thank you.

CHAIR BELLA: Sheldon, then Chuck, then Darin.

COMMISSIONER RETCHIN: There's a conspiracy.

[Laughter.]

COMMISSIONER RETCHIN: Thanks. I really appreciate all the presentations, particularly good to see Tim with his finger on the button still, and the enthusiasm that you have and we all share on integrated care in this vulnerable population.

As Tim knows, I actually was one of the plans that started out with FAI in Virginia. When I looked at it

originally, the amount of money that was going to go into it, I originally came to the conclusion, I just wasn't sure that we could afford to save that much money.

[Laughter.]

COMMISSIONER RETCHIN: But, after getting into it, I think the key word is "patience."

But I have a few questions or maybe a comment along the way. First, maybe you addressed it, Tim, and maybe the other panelists would like to address it as well in some of these demos. I won't use the word "demo," but what's the science behind -- or where are we going with the opt-out rates? There are variations in different states that have been really extraordinary and we've reviewed here at MACPAC before.

Second, I guess getting back to my own experience, just the sustainability of the enthusiasm from the payer community, while there may be savings there, are they making money after the working capital goes into it? To that end, I wondered if you had considered more formalizing the risk corridors.

Third, I guess I wonder, as I read over the vignettes and have looked at this myself, where the duals live. Many

of them live in areas where there is really -- and I know this will again be a shock, my interest, but where there are just -- there are doctor deserts. The primary care supply, much less the engagement in a busy practice -- so you can imagine seeing a 22-year-old computer programmer at Microsoft is very different than seeing a dual.

So I think, getting back to the patience aspect of this, this is definitely an ultra-marathon, and it's going to require a lot of patience from the MMCO and as well as at the states.

I know I threw a lot out there, but I wonder if you could comment on those.

MR. ENGELHARDT: Sure. It's good to see you, Dr. Retchin.

The first question was about opt-out. I'll reframe it slightly to note for all the commissioners. When we began our work on the duals demonstrations, we deployed passive enrollment which, if I said this to MedPAC, would have elicited gasps. But because you're MACPAC, this is nothing.

But it means we passively enrolled eligible individuals into both the Medicare part of the coverage and

the Medicaid part of the coverage, and, of course, this is a place where the two programs are just very different in their orientation to managed care and it being mandatory or voluntary or something in between.

It should be clear that passive enrollment has to be considered in its context and what it achieves and what the beneficiary experience is but also what it leads us to. I do believe that utilizing passive enrollment was important to having the requisite level of enthusiasm among payers to take the risk of participating in these things. I think the experience in Idaho is a good illustration of like sometimes it can take a really long time to build the enrollment base in a purely opt-in world.

So we had a variety of experiences. We had some markets in which of the people who are passive enrolled, a very significant number of people opted out before their enrollment took place. And then we had markets where the experience was different.

Right now, we have over 70 percent of the eligible people are enrolled in this fully integrated product in Ohio. We have other markets where it's close to 20 percent. Some of that is market-specific.

Over time, though, after we kind of like worked our way through passive enrollment in some large bolus, we now typically just enroll those people who are becoming newly dually eligible. In many of those cases, it's somebody who was in a managed care product for their Medicaid benefits for some period of time, and then they turn 65. For that population, the experience of passive enrollment is not like a thing that maybe is disrupting a network after 20 years of fee-for-service. It's actually a thing that's preserving like a delivery system they have known and lived in for a significant amount of time.

So where we have kind of shifted to that form of passive enrollment, we have opt-out rates that are much, much lower than they have been historically.

Second, you raised the concept of sustainability of enthusiasm among the payer community. We were fortunate to have people with stamina, like you and like Kit and some others, who worked their way through times in which it wasn't clear whether or not products like this would be financially sustainable on the payer side.

Our experience since that point has been very different. We have had significant stability. We have

markets where there are new plans trying to get into the line of business. I think that is, in part, because of learning and figuring out how to operate successfully on the payer side. It is not insignificant, because we have made significant improvements to Medicare's risk adjustment system over the last several years that had the net result of saving money to the government, but by reallocating a little bit less payment for people who are not dually eligible and a little bit more for people who are dually eligible, and that was a big catalyst too.

And then I think your point about deserts is an important one. I would elaborate further to say I don't think that's a matter of simply supply. I think it's also the reality as you dictated. You could be in the middle of Seattle and have providers who currently, legally can choose not to serve people who are dually eligible, even while they serve other Medicare beneficiaries. And that's a reality we all have to grapple with, especially in a world in which as MACPAC itself has helped us analyze. In certainly fee-for-service, those providers don't get full cost-sharing payment from most of the states. They get only a fraction, if anything at all, and that means we

operate in a world in which a Medicare-participating physician who sees a low-income individual often gets paid 20 percent less than a Medicare-participating physician who sees a high-income individual.

CHAIR BELLA: Do either of you have anything to add?

MR. WIMMER: I'd just add that as far as the primary care, we've kept our primary care at 100 percent Medicare, and I think that's helped a lot. There's no differential there. We have pretty decent access, and that's been helpful.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: Thank you all for coming.

Matt, I'm going to have a couple questions for you, but I did want to just offer my compliments to Bea and to Tim.

One of the things I do want to note for the commission and for others, a lot of the work that the MMCO has been doing is kind of quietly improving data integrity, quietly improving the timeliness of files, and working on appeals and grievances and cleaning up a lot of things. So a lot of the work to make this successful is not kind of a high-profile policy-related work, but it's kind of the guts of

the mechanics of making it work.

I want to acknowledge Tim and your leadership making that happen, because a lot of the success of these programs depends on really the logistical timely accurate data to make it flow. So I wanted to acknowledge you.

And, Bea, it's no surprise that Washington State has continued to lead. Washington State has been a very early leader in rebalancing efforts, long-term service and supports efforts, before dual SNPs existed as an entity, and it's no surprise that you as a state continued your leadership in kind of working to serve seniors and younger individuals with disabilities who kind of have the characteristics of needing home- and community-based supports but also needing medical supports to make it fly.

So I did want to acknowledge that this is an extension of a long vision toward serving people where they want to be served and honoring rebalancing efforts.

Matt, the questions I have -- and really impressive what you've described -- two specific questions. The first one -- and it's kind of as you reach out into more and more rural areas. We had a panel about dual eligibles in 2018, and one of the issues that Arizona raised on that panel was

just some geo-access-related challenges in Medicare Advantage and compliance, and their work in terms of advocacy with CMS around getting CMS to accept telehealth or the fact that Medicaid can offer a transportation benefit, so that if you don't have a provider where you live, you can get to a provider.

I'm curious about your approach to, as you expand out, addressing some of the Medicare-related geo-access issues and whether you've been able to advance advocacy ideas around that kind of thing. So that's my first question.

Let me just mention the second question and then to kind of keep the flow going as a group. I'm curious about your approach to partial duals. One of the trends, I think, that I've observed is that states are kind of leaning into how they approach supplemental benefits on the Medicare side, the D-SNP side. As Medicare offers more supplemental benefits that can look like environmental modifications or attendant care, those sorts of things, states are kind of leaning into that more as a required, almost, supplement benefit that D-SNPs offer, which could help address the fact that they don't qualify necessarily for Medicaid-provided HCBS-type services because they're

not in full Medicaid benefits.

I'm curious, your approach to partial duals in general in your program, and so that's my second question.

And thank you very much for making the trip.

MR. WIMMER: Sure.

And to your first question, I think the answer is we've been kind of, heads down, focused on just expanding to urban counties in Idaho. We haven't really tackled that problem head on. I think we're kind of at the point where we're going to be getting there soon because this next year, we'll have all the rural counties that are going to be viable as part of our approach, and then we'll have a bunch of rural counties that are going to have issues that we're going to need to address.

For your second question, I think to a certain degree, we've been kind of leaning in, as you say, on some of those supplemental benefits. Those were really important to us for a few years when we pulled back on dental benefits, like a lot of states did following recession, and then restored them just fairly recently. During that time, the duals plan, one of their big selling points was you can still get dental benefits as a supplemental benefit through

this, and that was really, really helpful.

There are a couple other smaller things like that where we don't have a whole lot of audiology, hearing aid-type benefits under Medicaid for adults, and so they've been able to use that to fill some gaps there.

Does that answer your question?

VICE CHAIR MILLIGAN: Absolutely. I mean, I think one of the things that we're seeing as a trend in a lot of states -- and I was curious how Idaho approached it -- is thinking about for integration, the benefit package comprehensively encourages like the relationship with Medicaid and Medicare, and it sounds like your collaboration with your local plans has enabled that to happen as the state has had to address budget challenges and other issues. So, yes, thank you.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: I want to echo everyone's thanks for you being here. It's a favorite topic of mine, and also thank you -- I like the creativity states bring and how they're approaching the issue and the need for that creativity, given each state's different circumstances, so thank you.

I have three questions, but this one is kind of a combo for Tim and Bea. Tim, you had made the comment about Washington saving significant money on both the Medicare and the Medicaid side, and then at the same time, I heard Bea talking about the significant investments they've had to make on the Medicaid side, and the documents you even shared talked about the investment on the Medicaid side and something I'm familiar with about what Medicaid will have to do to help generate some of that savings.

Outside of the shared savings arrangement and the agreement you have with Medicare, help me understand the savings that you're seeing on the Medicaid side that was being referenced, and if I misunderstood the comment, then please correct me.

MS. RECTOR: So I think one of the challenges that we've had in the financial alignment demo is that we haven't been able to fully evaluate the Medicaid expenditures and savings with the comparison states. So, you know, a third of the potential shared savings have been held back in order to wait to see really what is the outcome for the federal spending on the Medicaid side and the state side.

What we do know from our own evaluations, our own internal evaluations, is that in order to save money on the medical side, we have spent money on HCBS. And so an example of that is you've got somebody who is new to a disability or new to kind of what's happening as a result of their disability; we will bring in client training under an HCBS service to help with nutritional, you know, education, becoming comfortable with whatever the new level of functioning is. We will even bring in kind of rehabilitative services that may not be covered under the state benefit or under Medicare. So we know that there's some additional expenses.

We do know, because health homes in our state is available to Medicaid-onlys -- they're not part of our alignment demo -- that the MCOs are reporting savings on the Medicaid side as a result of this intensive care coordination model.

COMMISSIONER GORDON: Yeah, that's helpful and reinforces some of the stuff that I would anticipate, and this gets to my second question, which is really more for Tim, but it's playing off of that. You know, a lot of folks have looked at this and are talking about the

investment on the Medicaid side to help bring down some of the expense on the Medicare side. I think, you know, in the state where we did the D-SNP alignment approach, you know, I think it's harder for those states and other states that want to go down that path and say how do you capture some of the savings, because you're not even capturing enough from the Medicare side. You're doing it because it's the right thing to do. But, one -- there's kind of like two parts to this. Tim, give us your thinking about how -- you know, is there any thinking from your office, you know, how to help states think about how to capture savings through that approach if that one's more appropriate for them? I think this is probably what you would see in Washington State, but it is something -- you know, one of the things that I've talked to people about when you do the alignment on the D-SNP side is when we looked at our nursing home residents, nearly all of them came to us by virtue of Medicare. And we felt if we were interceding through an integrated model that, while we would be spending some money long term, we would be able to have some impact on our nursing home utilization and in turn save us money. But just your thoughts around that

topic?

MR. ENGELHARDT: Sure. We called formally our suite of demonstrations the "Financial Alignment Initiative," and it was exactly for reasons that Darin's raising, which is we felt like Washington State needed to feel like they had an ROI on their Medicaid investment based on recouping Medicare savings. And in other capitated managed care constructs, we created a class of plans that we call "MMPs" that were in many ways a lot like Medicaid MCO plus a D-SNP, with the important difference under the hood in how we set capitation rates, essentially saying that both payers would kind of benefit equivalently on a percentage basis from all of our actuarial assumptions about what efficiencies could bring.

In other words, it didn't matter if all of your savings was from keeping people out of the hospital and you invested more in home and community-based services; we would still set the Medicaid capitation rate in a way that was on net lower, even though the Medicaid side of the investment may have gone up. So we tried to like engineer this mechanism by which it's not shared savings in a retrospective way; it's shared savings in kind of a

prospective way. So we tried on the theory that that was important for state investment and enthusiasm and all of these different models.

In the D-SNP world, we don't have all of the same mechanisms with which to try to solve for that, but I actually think Chuck -- I think Chuck just alluded to a possibility, too, which is that because states do have contracting leverage with D-SNPs, they can make requirements of them. And whether those are care coordination based requirements intended to keep people out of nursing facilities down the road or whether they're contracting requirements that require the coverage of a particular type of service through Medicare Advantage supplemental benefit flexibility, those are mechanisms. They're a little bit less elegant, but they're there. It doesn't change the realities that where we have a Medicaid MCO, we still have separate rate-setting policies, we have separate actuarial soundness reviews on the Medicaid side, and we haven't found the perfect way to bring those two things together yet.

COMMISSIONER GORDON: And that's helpful. I'd add a third to that. It touches on what you all were thinking

about --

CHAIR BELLA: Hurry. You have more people in line.

COMMISSIONER GORDON: I'm sorry. I had three questions, that the -- around the issue of being a little bit more aggressive on your managed care Medicaid assumptions to try to balance that out as well.

And the last one for Matt, you said that ICF was carved out, and I just find that interesting given kind of what you see with the dual integration models. So how did that work?

MR. WIMMER: We actually really considered having ICF carved in. But there's a few factors happening in Idaho that led us to say no let's keep that out. One of them is we've got a big effort on the developmental disability side to kind of improve what we're doing with person-centered planning, to kind of restructure all those benefits. We thought it would work better if we just kind of were able to isolate all of the DD services and deal with those in one fashion rather than having to kind of work across the plans. So that's sort of the short answer.

CHAIR BELLA: Peter.

COMMISSIONER SZILAGYI: Yeah, thank you very much.

These programs seem incredibly important. I'm a pediatrician, so I don't care for too many duals, although I care for complex children.

I had a question for Bea about the return on investment and the shared savings. Can you just clarify, how did you calculate that? Was this sort of a before-after? And you have three years of experience. Do you see any trends in the savings, in the return on investment? Because I could potentially see that there are additional home-based costs early on where you may end up saving more in subsequent years for the same cohort of patients. So if you could just clarify for me how the savings were calculated and the trends.

MS. RECTOR: So, originally, as I talked about, we had three chronic care management pilots in our state with Medicaid-only. So this was, you know, in the early 2000s. And we had done some difference of the differences type evaluation to determine savings. And so we did have some projected kind of belief as we had the conversation with CMS about a return on investment off those early chronic care management pilots, which really resulted in less utilization of inpatient, less utilization of nursing

facility, and there was also some ER reductions in those early chronic care management pilots and a statistically significant impact on mortality.

So, you know, as we go into and now have four years of experience in the duals shared savings, what I would say is that four-to-one is based on all the investment that we are making in health homes. So paying for the health home service, which is a Medicaid service, paying for the administrative staff at the state level, both in the Medicaid agency and the social services agency of the folks who monitor contracts, do the training, et cetera, et cetera. So we're able to say what is our total investment in health home services and what have we received by shared savings. That's the four-to-one return on investment, and that's based off our current actuals, with that clawback of the Medicaid potential additional savings that might come.

You know, when we look at shared savings by year, the first year was $11.6 million the state got; the second year, $10.7; third, $14.2; and four is $15.5. So part of what we're doing is continuing to increase engagement, so we only have about a 30-percent engagement rate right now in terms of the individuals who have been enrolled that

have actually engaged and created a Health Action Plan. So we think that, you know, the shared savings potential to grow as we continue to get the capacity of the care coordination organizations to engage more duals, there's a lot more shared savings to be had out there in our program.

COMMISSIONER SZILAGYI: And just a very quick comment. To me, even if the savings -- or the return on investment was much lower, the improvement in the patient experience and quality would make this well worthwhile.

MS. RECTOR: Absolutely. I would agree. Our legislature has talked a lot about that. They want it to at least pay for itself, and they love the fact that there's additional savings that they can make investments with as well.

CHAIR BELLA: I have a question for each of you, and then we'll see if there -- yeah, and then I think we'll probably be at our time.

So, Matt, we are kind of as Commission understanding the different levers that states have and understanding how you align Medicaid contracts and Medicare Advantage D-SNP contracts. If you have a D-SNP that comes to you that isn't interested in doing the Medicaid piece, will you give

them a MIPPA contract?

MR. WIMMER: No [off microphone].

CHAIR BELLA: Okay. And just so everyone -- I mean, that's one of the key levers. So you're pretty far on the continuum of a state that says we're not going to create an opportunity for someone to be in two different plans, for example.

MR. WIMMER: That's right, yeah [off microphone].

CHAIR BELLA: Is there anything else you need to be able [off microphone]. Ah, thank you. Is there anything else you need that isn't allowing you to kind of maximize your ability to have this aligned enrollment?

MR. WIMMER: I think, you know, the obvious wish list item is if people could have, you know, an opt-out on the Medicare side. But I understand the barriers to that.

CHAIR BELLA: Gotcha. Okay, Bea, I just want to reinforce, first of all, Washington State had a tremendous amount of patience waiting for that first check, so thank you for doing that. You are sort of the poster child for how you reconcile a state's reluctance to make an investment that might save Medicare money. And so my two questions for you are:

Number one, are you getting questions from other states that have -- you know, that don't have managed care delivery systems? Because we're trying to figure out how do you get other states to be interested in this shared savings model with Medicare. So are you hearing from other states?

And, two, the same question for you. As you think about doing something with D-SNPs, are there levers that you think you don't have that you would like us to hear, that would be helpful to you if you decide to go in that direction?

MS. RECTOR: So we are getting questions from a couple of states. Indiana and Maine have done some pretty deep dives into our model, and we've spent a lot of time providing some technical assistance and even joining meetings with their leadership groups and their stakeholders via telephone. So that's been really helpful to kind of hear that people are at least thinking about these types of models.

From a D-SNP, we actually haven't taken as much advantage of aligning D-SNP plans as other states, so we're actually behind that curve. We've done a lot of

conversations about, you know, should we say that, you know, if you're not a Medicaid plan you can't offer D-SNPs in our state and require that our Medicaid plans have D-SNP plans, and all of them except for one do at this point in time.

What we're thinking about is -- because people in health homes cannot be in a D-SNP or a Medicare Advantage plan, we need to find ways to allow people in those Medicare models to participate in health homes and get the advantage of it, but we need a way to either pay for the intervention and have the plan pay for the intervention or share in the savings that would otherwise go to the plan. And so that's kind of our next evolution, and there's a conversation about, you know, how could we make that happen? CHAIR BELLA: Thank you.

And then, Tim, for you, this Commission exists to make recommendations to Congress as well as states and the agency, and so if we were to -- are there things that we could recommend that would make your job easier either in the MSP program -- and I appreciate you bringing that up and reminding us; I think there are some things we could say about that -- and/or in your efforts to increase or

modernize, whatever you said, integrated and aligned enrollment? Sort of your wish list, if you will.

MR. ENGELHARDT: Well, you preempted one. The work to bring the Medicare savings program into the current century I think requires lots of different thinkers as well as some operational focus, and so we would benefit greatly to the extent the Commission spent any time and energy on that.

Secondly, maybe mildly off script, but I understand on the agenda at these meetings, we don't talk enough about nursing facility services and kind of the murkiness of Medicaid and Medicare roles in long-term-care financing. We ourselves have been engaged in a project for years in which we have reduced hospitalization rates among nursing facility residents by 10 percent and a 20 percent reduction of potentially avoidable hospitalizations, despite the fact that there are kind of weirdly structured incentives for nursing facility operators and lots of unanswered questions about Medicaid's particular role. And so that's another place I think we would benefit greatly from.

And then, lastly, on the managed care side, I'd really point to work that MedPAC has done recently on the dual-eligible special needs plans, and the reality is that lots

of the Medicare policy decisions on that are state facing and state affecting and state decisions like Matt's on contracting are really important. Yet we operate in a really competitive and dynamic marketplace in which there are lots of puts and takes and newly created types of products that change what states can do and can't do, and to hear from this Commission on that would be really valuable to us as well.

CHAIR BELLA: Just so that we're all aware, you're talking about the D-SNP look-alikes. It would be helpful just to make sure we all know because we're not familiar.

MR. ENGELHARDT: Certainly a phenomenon that we have observed recently is the emergence of plans that serve almost exclusively people who are dually eligible yet are not technically D-SNPs, and that changes the ability to kind of create and cultivate integrated care products, and I think fundamentally changes the state empowerment related to contracting for dual-eligible benefits. So that's something we're keeping our eye on.

CHAIR BELLA: Wonderful. Thank you very much. You gave us a lot to think about and talk about, and we promise you we will -- we will probably be in touch with questions,

but we can definitely promise you we will be doing work in this area. Thank you.

We're going to do a really quick turn-around, thank our panel, allow our panel to leave, and then we'll hear from Kirstin and Kristal, and we'll take some public comment as well.

* [Recess.]

CHAIR BELLA: All right. Kirstin and Kristal, we are all ears.

PRESENTATION OF INTEGRATED CARE WORK PLAN AND FURTHER DISCUSSION

* MS. VARDAMAN: Great. Good morning. Now that you've heard from and engaged with the panel we'd like to turn to discussing the integrated care work plan for this meeting cycle. We would like to start off with a quick recap of some of the Commission's research in this area last year. During the last meeting cycle, staff brought you the results of three contractor research projects on integrated care models.

First, there was the analysis of factors affecting enrollment in the financial alignment initiative, which has lessons for the role of mechanisms and strategies that

could be used going forward. Second, we brought results from work describing the contracts standards for care coordination and integrated care models. And third, we discussed a compilation of evaluations and studies of integrated care models, including an issue brief summarizing themes and identifying gaps in the literature.

The final products for each of these projects has been published on MACPAC's website, and we hope that they are useful resources to the policy community.

The work for this cycle focuses on the variety of options available for further integrating care for dually eligible beneficiaries, which takes into account recent policy developments. For example, last December, you discussed new requirements aimed at integration through D-SNPs, that CMS set forth, and regulations implementing the Bipartisan Budget Act of 2018. In comments on that proposed rule, you discussed the emergence of D-SNP lookalike plans, which are not required to contract with states to ensure a minimum integration standard, and you were concerned that they may undermine efforts to promote increased integration through D-SNPs.

We have also heard some concerns about competition

arising from institutional special needs plans, and, in addition, traditional MA plans have more flexibility to cover non-medical supplemental benefits, which may have implications for lookalikes and competition, more broadly.

And now I will turn it over to Kirstin.

* MS. BLOM: Our work plan for this cycle is centered around these three policy questions: For states already integrating care what strategies could result in more integration? What pathways are available to states that haven't integrated care, taking into account their individual circumstances? And then, finally, what factors present barriers to these integration efforts? In developing these questions we tried to sort of bucket states already integrating care versus not, and then the barriers that all states are facing.

With those questions in mind, this fall our plan is to undertake several analyses to both inform those questions and also your deliberations, including those that are listed here. Contract work with RTI, with a subcontract with CHCS to investigate Medicare Advantage market effects on integrated care, including things like the emergence of D-SNP lookalike plans.

We are planning to do some internal work on a few different areas, including strategies that could result in more integration, such as the opportunities made available under the FAI by CMS earlier this year. Also pathways, like I mentioned, such as the alternative to develop a new model under that CMS guidance. And then barriers that might be causing states to hold back or drawing duals away from integrated options.

We are also looking to hear directly from experts on the ground, like we did today, to learn more about the varied landscape and understand the different perspectives on this topic. So in terms of next steps, we are planning to have a second panel at our next meeting, in October. This time we will be focused on health plans, beneficiary advocates, and providers, to try to get that other side of the coin.

We will also be working internally on the things that I mentioned, with a plan to bring results to you guys in December of the internal work, and then bring results of the contract work probably in the spring of next year.

So with that we will turn the session over to you guys. We are happy to hear feedback on this work plan or

any reactions you have to what the panel raised.

CHAIR BELLA: Chuck.

COMMISSIONER MILLIGAN: I think it's a great work plan. I am interested in the other Commissioners' comments.

One of the things I just wanted to make you aware of, and others aware of, and let me contextualize this for those who don't know. I work at United Health Care. My work these days is very D-SNP and dual eligible focused. GAO is doing a study, coming out of the Bipartisan Budget Act, which is required by the Bipartisan Budget Act, to evaluate the effectiveness of the integration that has been driven out of that and permanent reauthorization of D-SNPs.

They are looking at seven states in particular, just as the sample they have drawn. They are interviewing a whole bunch of interested parties, including the states, providers, beneficiaries, health plans. United participates in Medicaid and D-SNP in all seven of the states that they are studying. We have been interviewed as part of that process. We have provided data as part of that process recently. And it's a really strong focus.

I like the focus of where GAO is going with this,

because it is really focused on what are the member effects, member benefits, provider effects, provider benefits, how much integration is really happening out there, how much alignment is there between Medicaid dual-eligible enrollment and D-SNP enrollment in the same organization? And in their interviews they are also asking questions around if a member is dually enrolled, that is in a single organization and on both sides, how is that operationalized to create a single-member experience and organization around access to care utilization, all of that.

So it's a very strong study. I think it will help align to the work in this work plan, and I would encourage MACPAC to stay in close touch with GAO as the work proceeds on those parallel paths.

CHAIR BELLA: Do you know the timing?

COMMISSIONER MILLIGAN: Melanie asked if I knew the timing. I don't know the timing of where GAO is planning to publish anything. I don't know, honestly, myself, the ground rules between behind-the-scenes confidential sharing of information between MACPAC and GAO, because I know there is a close relationship. But that work is proceeding

apace. I mean, they are working much more quickly than I had anticipated, which I think is a good thing, because it will line up with where MACPAC, MedPAC, and many interested parties are going.

EXECUTIVE DIRECTOR SCHWARTZ: So I know that GAO spoke with Kirstin and Kristal, even before they spoke with you, and then we go into a period with GAO where they kind of go on radio silence, and we won't hear anything until after the report is released, and I hope it will dovetail with ours, but they, by their practice, hold everything pretty confidentially until they arrange a release.

CHAIR BELLA: Sheldon and then Kit.

COMMISSIONER RETCHIN: Well, thanks for sharing this, Kirstin and Kristal. I am looking forward to seeing the plan unfold.

I guess my only -- and I'm sure you've all thought about this. I mean, we just heard Tim, and I am aware of others, just that we are not stumbling and overlapping in terms of the evaluations, because there is a lot going on.

The only other thing I guess -- well, there are two other things I would mention. I sort of heard Tim allude to this, but it is, I guess, the market penetration of MA

plans in different states and the correlation. I looked at this myself previously in terms of the opt-out rates or in terms of passive opt-in, whether there is a climate or an environmental effect for the state enthusiasm because of the penetration MA of plans. It's just a question I have.

And the last, of course, I get back to this primary care question, in terms of the provider aspects. One question I have there is whether there has been -- there are models of payment to primary care physicians that encourage them, in terms of particularly taking risk for an upside. I am aware of a few models that have done that with some success. And I'd like that, so when we do bring providers that we have a diversity of experiences, particularly in terms of volume. I think that's very important. It even occurs to me whether any of the plans -- and I guess this is a question for Chuck -- any of the plans have actually gone to more of a staff model on the primary care side in some markets.

COMMISSIONER MILLIGAN: D-SNP plans can file as HMOs, and many do, and operate as HMOs. And there are provider-sponsored plans. So there are all kinds of permutations of that. We could, maybe, for MACPAC, just do a little bit of

descriptive work around the particular types of membership levels by particular types, whether it is provider sponsored, PPO version, HMO version. I think that would be good descriptive work. And, yes, Sheldon, they do exist.

COMMISSIONER RETCHIN: Okay.

CHAIR BELLA: Kit.

COMMISSIONER GORTON: So I'm a fan of integration. I've worked towards integration all my administrative career. But I think in this work we need to take a balanced approach, and we need to, as we look at the benefits of integration and the positive outcomes of integration, we need not to lose focus on the costs and the risks of integration.

And so I would suggest that we try, in our work, to think about three buckets of potentially negative impacts with respect to integration. The first, at the beneficiary level and the provider level, is integration of necessity requires moving from a many-to-many model to a few-to-few model. That eliminates people's choices and it almost invariably leads to disruption of existing relationships, even in the best of all circumstances. And I think we need to pay attention to what the cost to beneficiaries, the

cost to individual providers, and the impact on the workforce arises out of that kind of pruning.

The second thing is that in moving that model you move the health plans in a direction of fewer and fewer plans are able to meet the standards for this work. And if we look outside of health care and think about what happens when a Boeing, which is a major military contractor, one of the few that are left in aircraft, when they stumble the way they have in the last year. And so I think we need to think about the plan impacts of this. We've seen a lot of good stuff come out of provider-sponsored plans in areas. Those provider-sponsored plans are going to struggle to meet MA geo-access access requirements and those sorts of things. So we may actually eliminate potential providers as we, again, pare from many-to-many to few-to-few.

And then the last piece is the market dynamic. We heard Matt from Idaho talk, and other states have had this experience. Two is barely enough, and if you have two, whether it's providers or plans or whatever, then those two have enormous leverage, because losing one of them essentially torpedoes your program.

And so I think we need to pay attention to the market

dynamics here. I think the example of -- not to pick on United; you could point to a dozen examples, but since it was mentioned today -- of United leaving the Washington market, and the impact that that had on Washington's policy -- am I mixing up states? Idaho. Sorry. The impact that had on where they could go with their policy. And in every county, if they only have two and one goes, then their program is in jeopardy.

And so I just think we need to think about the market dynamics. I think we need to think about the beneficiary impacts and the provider impacts, and the potential for disruption here. All that said, I think it is a direction that we should move in, but I think we need to look at those impacts, and I'm not sure that all of the evaluations, frankly, of the demos, in fact, address those in great detail.

COMMISSIONER MILLIGAN: Yeah, and I wanted to jump in, and my apologies. I do need to leave to catch a flight before the full conversation maybe.

I think one of the things that's going to -- and I'm not picking up on where Kit was, but one of the things I think that would be helpful for the work plan is just the

impact of Medicaid managed care procurement practices on integration. And I actually don't have the concerns about the Idaho because I think an open application process can lend itself to one or more however.

The part I'm concerned about, and I want to refer back to what Tom Betlach said when he appeared before us, the former Arizona Medicaid director, they recently re-procured. They did it regionally. They prohibited any organization from winning every region, because I think they had some concerns around health plans having too much leverage if there was a statewide health plan, and the plans having too much leverage. So they procured regionally. Some plans, and United was one of them, by virtue of that approach, had to leave a region that was integrated, and Arizona had a policy around requiring integration.

And so what that meant was displacing tens of thousands of D-SNP members from their primary care and specialty provider organization because of retaining the Medicaid LTSS benefits. And Tom acknowledged here, in front of all of us, that that was kind of an unintended consequence. They didn't really think through the

downstream effect on the D-SNP providers' relationship by requiring alignment, regionally procuring Medicaid, and regionally procuring Medicaid in such a way that you are prohibited from staying in all of the service areas you previously had.

So I think -- and I only mention all of those details because Tom mentioned them as a regret, honestly, when he appeared before us -- I think we have to think through kind of the implications of Medicaid managed care procurement approaches on integration, because of that kind of dynamic from that direction.

CHAIR BELLA: Bill.

COMMISSIONER SCANLON: Yeah. This relates to both of your comments. It's the plan perspective, I think, that we need to understand both the upsides and the downsides. I mean, when the special needs plans first began I think we were really surprised by the interest in them, and it was related, in part, to the fact that there were some advantages and very few requirements. I mean, an institutional special needs plan, these didn't serve just people in institutions. They served people that might be in institutions, and there was a big emphasis on the

"might." And the same thing with respect to a chronic special need plan. The "chronic" didn't have a very rigorous sort of definition.

So we have a situation now -- I mean, I know things have improved tremendously over time, in terms of realizing you need to have, if you're going to have a balance between requirements and sort of incentives.

But these D-SNP lookalikes, I mean, they raise the issue in my mind is why are they doing this, how did they do this, and what would be the elements that might either encourage them to become a genuine D-SNP or at least require something that provides more meaningful benefit from them. I think that we have to understand the plan prospective on this. I was there early on in MEDPAC, when these SNPs started, and it was really a shock, in some respects, in terms of what was happening so quickly, and with such volume. And we struggled to understand what were the motivations here.

CHAIR BELLA: Yeah, I think you may have seen it, if you haven't had a chance to see it yet, check out MedPAC's June chapter on duals, because it does give more detail on lookalikes, and it had some sort of proxies for how you

tell, and acknowledges that some of that is imperfect and you might have some sort of false positives. But by and large there are a set of characteristics. I see Eric in the audience and he can correct me in public comment if I'm wrong. But some of the things being thrown around, Bill, are like if you have a threshold of over 50 percent or 80 percent, or whatever it is, of duals, should you be required to follow the same requirements, the same model of care requirements, the same MIPPA requirements? So they are starting to throw some of that stuff out there, and I know CMS has talked a little bit about that but feels like it really needs Congress to be able to do something about that.

I will take the opportunity to comment on a couple of things.

So, first, thank you, and thank you for putting together that panel. It was really great to hear those different views. I'm very, very interested in integration. I want us to understand what we mean when we say that word, though. And it's not that there is a black and white definition, but kind of parallel just some of what MedPAC started to tease out. I mean, just because you're in a D-

SNP doesn't mean you're in an integrated product. And so kind of thinking about, when we talk about integration and we talk about aligning enrollment, what are we actually trying to advance? And I think we are trying to advance those things where people get the totality of their needs met.

In a meaningful way, where there is meaningful care coordination, and under the hood, you still don't have a separate assessment for medical and a separate assessment for behavioral health and a separate assessment for long-term care.

We don't have to become a body that tries to define that. There's plenty of other people defining that, but I want us to get tight on what we think that means and what we're trying to promote aligned enrollment into, where we feel like we would have done a service to the people who rely on these programs. So that's my first point.

The second point is I think the analytic work will be really important, and it can be a companion to I think what MedPAC has looked at.

One of the things I just want to flag for you, when I talk to states -- and the states could tell me if this is

true or not -- in particular, a big state that has plans that provide long-term care and very different than the plans that are the D-SNPs, and the states say they can't get a good handle on where their duals are in the Medicare world. So that if they wanted to understand how many of my duals are in Medicaid long-term Plan A, but they're in D-SNP Plan B. They say it's really hard to get that, and therefore, they can't -- they don't really know if they have a problem or not have a problem in terms of whether their enrollment is aligned or not.

I think CMS provides resources to states to help them do that, but it would be worth understanding if states even know how to make sure they can put together a picture of where their duals are on the Medicare side. So that if they're needing that information to make choices about how they use their MIPPA agreements or something, they have the data that they need.

Then my third point is just kind of thinking in line of if we're going to position ourselves to make recommendations. The Bipartisan Budget Act requirements for greater integration standards don't take effect until 2021, but the MIPPA agreements will be due in less than a

year from now and kind of thinking about how, as Congress has tried to raise the bar on integration and make sure long-term care and behavioral health and D-SNP world come together, just keeping our eye on the ball, because that work is going to have to be happening now and understanding are we getting those achieved goals or also understanding -- and I think every time we raise that bar, we create things like lookalikes, like unintended consequences. So just keeping track of those as that latest piece of congressional kind of requirement goes into effect, I think, would be helpful.

Other commissioners?

[No response.]

CHAIR BELLA: Come on. I don't want to be the last one to speak on this topic.

COMMISSIONER DOUGLAS? No. So I guess just your point around integration, I think it is important given so many carved-out services on the Medicaid side. What are we talking about when we're -- because in some states, on the Medicaid side, you're looking at facilitating integration, but mental health is still out. Certain of the home- and community-based services are still in a different system.

So what are we trying to foster, and what's the value of a truly integrated product? As Melanie said, we just need to be careful that integration isn't -- how far do we want to push this when we still have problems on the Medicaid side with integration? CHAIR BELLA: I'm going to turn to the public and see if anyone wants to comment.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: No comments. Too early in the day? Oh, too early in the work. Too early in the work.

Anything from Bea or Matt? Any last words of wisdom from your guys?

[No response.]

CHAIR BELLA: No? Okay. We took it all earlier. Thank you.

Any last thoughts from any of the commissioners?

[No response.]

CHAIR BELLA: Kristal, Kirstin, anything?

MS. BLOM: Thank you for your feedback.

CHAIR BELLA: Okay, great. Thank you. And we are adjourned. Thank you, everyone. We'll see you in October.

* [Whereupon, at 11:16 a.m., the Commission meeting was adjourned.]