PUBLIC MEETING

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

Thursday, April 11, 2019
9:36 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
MELANIE BELLA, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
ALAN WEIL, JD, MPP
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 1: Review of Draft Chapter for June Report and Recommendations on Prescription Drug Policy: Grace Period and Cap on Rebates

Chris Park, Principal Analyst.....4

Public Comment.....27

Session 2: Review of Draft Chapter for June Report and Recommendation on Treatment of Third-Party Payment in Definitions of Medicaid Shortfall for the Purposes of Disproportionate Share Hospital (DSH) Payments

Robert Nelb, Principal Analyst.....53

Public Comment.....72

Session 3: Review of Draft Chapter for June Report and Recommendations on Improving the Effectiveness of Medicaid Program Integrity

Jessica Morris, Principal Analyst.....80

Public Comment.....102

Session 4: Review of Recommendation for June Report Chapter on Therapeutic Foster Care

Martha Heberlein, Principal Analyst.....103

Public Comment.....110

Lunch.....113

AGENDA PAGE

Session 5: Preliminary Findings from Congressionally Mandated Study on Utilization Management of Medication-Assisted Treatment

John Wedeles, Principal Analyst.....115

Public Comment.....145

Session 6: Preliminary Findings from Congressionally Mandated Study on Institutions for Mental Diseases

Erin McMullen, Principal Analyst.....146

Public Comment.....180

Votes on Recommendations Related to Drug Policy, Definition of Medicaid Shortfall for Purposes of DSH, Improving Program Integrity, and Therapeutic

Foster Care.....182

Adjourn Day 1.....212

P R O C E E D I N G S

[9:36 a.m.]

CHAIR THOMPSON: All right. Good morning, everyone. We will go ahead and get started.

We are kicking off today with hearing from Chris Park, talking about prescription drug policy and the possibility of a grace period and changing the cap on rebates.

REVIEW OF DRAFT CHAPTER FOR JUNE REPORT AND RECOMMENDATIONS ON PRESCRIPTION DRUG POLICY: GRACE PERIOD AND CAP ON REBATES

* MR. PARK: Great. Thank you.

At this meeting we will follow up on the Commission's March discussion on Medicaid drug policy with a review of a draft chapter and two potential recommendations for inclusion in the June report. The recommendations affect the Medicaid drug rebate program and would call for congressional action to create a drug coverage grace period and raise the cap on Medicaid rebates.

At this meeting, staff will provide background information on each issue and go over each recommendation

and its rationale. There will be an opportunity for discussion of the chapter as well as specific recommendations including any suggested changes in the wording of the recommendations. We have scheduled a second session in the afternoon to finalize a vote on any recommendations, so we do have some opportunity to incorporate any changes that you have before the vote.

As part of the Medicaid drug rebate program, states must generally cover all of a participating manufacturer's products as soon as they have been approved by the FDA and enter the market, that is, when they are available for sale by a manufacturer in the states. This statutory requirement means that states must quickly determine under what circumstances coverage is supported by the FDA label.

If a state uses a preferred drug list, the state is required to use a pharmacy and therapeutics committee, or P&T committee, to develop the PDL and make recommendations on appropriate utilization protocols, such as prior authorization. This P&T process can take several months, as these meetings are typically held quarterly.

Most states have policies in place to require

prior authorization for drugs that they have not yet reviewed. Depending on how a state establishes this prior authorization criteria, some states may essentially be excluding coverage of a drug for a particular amount of time.

Both Medicare Part D plans and exchange plans are also required to use P&T committees to develop their formularies but they are allowed up to 180 days to make a coverage decision.

Under the rebate program, drug rebates are capped at 100 percent of a drug's average manufacturer price, or AMP. A drug manufacturer is only likely to reach the rebate cap if it increases its price substantially over time, and, therefore, has to pay a large inflationary rebate. This rebate cap limits the inflationary penalty and restricts the amount of rebates that Medicaid can receive. Once a drug hits the cap, a manufacturer can raise its price without being subject to a corresponding increase to its net rebate obligations to Medicaid.

It appears that a large number of drugs covered by Medicaid have reached their rebate cap. Our analysis of fourth-quarter 2015 drug rebates show that about 18.5

percent of brand drugs at the national drug code level, or NDC code, reached a rebate cap in that quarter and Medicaid would have received an additional $690 million in rebates if there were no cap on the rebates.

In March, we discussed options for three potential recommendations. The first potential recommendation was to provide Medicaid a grace period during which they would not have to cover a new drug or new formulation of a drug while they established coverage criteria. We discussed options for a 90-day period or 180-day period. Most Commissioners expressed support for the grace period and were comfortable with the longer period, as it would allow most states to maintain their existing processes and timelines for developing coverage policies, so we drafted a recommendation to be for 180 days.

We discussed another potential recommendation that the grace period be paired with a requirement that the states have a formal coverage policy in place at the end of the grace period. The Commission did not wish to move forward with this recommendation but wanted to include it in the discussion about the grace period.

Third, we discussed whether the rebate cap should

be completely removed or raised to 125 percent of AMP. There was not a clear consensus in the public meeting as to whether the cap should be raised or removed completely. However, more Commissioners seemed to support taking a stepwise approach to provide a chance to observe how a change in the rebate cap might affect manufacturers' pricing decisions while lessening any potential negative consequences. So we have drafted the rebate cap recommendation to reflect raising the cap to 125 percent of AMP.

The first draft recommendation would provide states a grace period. Specifically, Congress should amend Section 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug for 180 days after a new drug or a new formulation of drug has been approved by the Food and Drug Administration and enters the market.

There are several reasons for this recommendation. First, providing states with a grace period has the potential to improve beneficiary safety. Providing states with a timeline to review the literature regarding the safety, efficacy, and other clinical

guidelines would help ensure that medications are not dispensed to enrollees for whom they may be harmful.

Second, states need sufficient time to review scientific literature and allow the P&T committee to develop the PDL and make recommendations on appropriate utilization protocols. A 180-day period would allow states to maintain their existing procedural timelines for the P&T committee. In addition, this would align time frames for Medicaid with those from Medicare Part D and exchange plans.

Finally, some states already take a period of time to effectively cover new drugs, similar to the time they would get under the statutory grace period. So a statutory grace period may serve to codify this practice that has already taken place informally while providing clear guidelines to states on what is permissible.

In implementing the grace period, it would be desirable for CMS to issue some regulatory guidance that provides expectations that the state publishes coverage criteria at the end of the grace period. This would help ensure states use the grace period to make informed coverage decisions based on clinical guidelines and not as

a license simply to delay access to drugs.

A grace period would provide modest savings for the federal government. CBO estimates that federal savings would be less than $25 million over 10 years. States have indicated that a grace period would help alleviate their administrative burden, providing sufficient time to determine appropriate prior authorization and coverage criteria for newly approved drugs.

For beneficiaries, a grace period could reduce potential harm by ensuring that medications are not dispensed to beneficiaries for whom they may be harmful. On the other hand, a grace period could affect beneficiary access to medications and result in delayed access for some drugs. However, current state practices may already result in limited access to these new drugs.

For drug manufacturers, this recommendation could delay access to certain drugs. While this policy arguably codifies what is a de facto process in some states, we expect manufacturers would rather states meet their current coverage requirements.

The second recommendation would raise the cap on Medicaid rebates. Congress should amend Section

1927(c)(2)(D) of the Social Security Act to raise the cap on rebates to 125 percent of a drug's average manufacturer price. Raising the cap to 125 percent of AMP would allow the inflationary penalty to achieve a greater effect and lead to higher rebates, creating savings for Medicaid. These savings would help states address fiscal pressures by allowing them to provide same level of drug coverage at lower cost.

Raising the rebate cap would also ensure that the Medicaid inflationary rebate continues to exert downward pressure on price increases. Raising the cap could change the incentives to manufacturers, as large price increases could result in a larger Medicaid rebate obligation for those manufacturers. Manufacturers would have an incentive to lower list prices on current drugs as well as curtail price increases on future drugs.

Given the potential for market distortions and other pricing changes by manufacturers, a stepwise increase in the cap would allow the chance to observe how a change in the rebate cap might affect manufacturers' pricing decisions while lessening any potential negative consequences.

We chose 125 percent of AMP as a starting point to see how that would compare to completely removing the cap. CBO estimated that raising the cap to 125 percent of AMP would produce about half the savings as removing the cap. Because 125 percent created about half the savings, this amount would still provide pressure on manufacturers to limit price increases but would moderate any potential market distortions.

Raising the rebate cap to 125 percent of AMP would increase the rebates Medicaid receives. The CBO estimates that this recommendation would decrease federal spending about $5 to $10 billion over 10 years. State spending would also decrease as states would receive the non-federal share of these rebates. Based on the average federal share of Medicaid rebates in recent years, this would be approximately $2 to $5 billion in state savings over 10 years.

This recommendation is unlikely to have a measurable effect on Medicaid beneficiaries and manufacturers would be required to pay the larger rebates. Manufacturers oppose this change and say that it would lead to further market distortion, such as cost-shifting to

other payers or higher launch prices.

And so this slide just combines both recommendations for your discussions. And with that I will turn it over to the Commissioners for any comments.

CHAIR THOMPSON: Thank you, Chris. I think this is very responsive to the conversation that we had at the last meeting, and my sense at that meeting was that the Commissioners had a strong consensus in favor of these two recommendations. I think there was some question, particularly about, as you mentioned, the 125 percent number.

So I want to open it up to the Commissioners to comment on the recommendations and their views on those so that we can be sure that when we vote later this afternoon that we have a recommendation that reflects the views of the Commissioners.

I also will just put the public on notice that with all of these discussions where we are going to be formulating recommendations, refining recommendations, and then coming back later in the afternoon to vote, I am going to open up on each subject for public comment so that we can take those into consideration before finalizing any of

our recommendations.

So I will open it up for the Commissioners now, and then public, if any of you want to make any comments about either of these two recommendations, I'll turn to you in a few minutes.

So, Commissioners. Kit.

COMMISSIONER GORTON: So I agree, Penny, that this, Chris, is very responsive to what we talked about last time. My personal preference would be to just eliminate the cap and generate all the savings. However, I followed closely the conversation last time, and, you know, half a loaf is better than none. It would be nice to generate all the savings, but I am perfectly comfortable going with 125, and I don't really have any issue with that.

So that is on Recommendation 2. On Recommendation 1, I just want to say this is something that, as a former state Medicaid chief medical officer, this is something that I have longed to see a policy change on for a very, very, very long period of time, so I am delighted that the Commission is going to recommend this.

I have just one suggestion with respect to the

rationale, Chris, about the subregulatory guidance. I think we had a fairly hardy conversation last time about state practices around their P&T committees, and I think it would be useful in this rationale to suggest that subregulatory guidance reinforce the proper role and function of the P&T committees at state levels. I think many state committees, state P&T committees function as designed, but I think there is variability in practice, and I think to the extent CMS is going to issue subregulatory guidance this is a good opportunity for them to underscore the proper role of the P&T committees.

CHAIR THOMPSON: I agree, and I think we had some public comments in the last Commission meeting along those lines. And again, I also think that to some extent we are trying to provide a grace period here that allows the P&T committees to do their due diligence and their process, and we need to reinforce the idea that to the extent that the P&T committees need changes in any way with regard to how often they meet, how they collect public comments, how they analyze that, et cetera, that we encourage CMS to provide some of that technical assistance and guidance to conform to this recommendation, because again, I think that comes

back to the question of enforcing the end of this period. If we are saying that there is a grace period then we really want to be sure that there is an enforcement mechanism to ensure that a decision is reached in a timely manner, given the amount of time that we are providing the state to consider this.

And, of course, again, nothing, as you say, Chris, in your discussion of this, nothing prevents a state from moving more quickly. Nothing prevents a state from anticipating the new drugs that are coming onto the market or the new formulations that they may have to look at, and all of that, of course, we would encourage as well. So I think that that is another element, to be sure that we are emphasizing in the discussion.

All right. Not seeing a lot of folks trying to jump -- okay, Peter and then Chuck, and then we will go to the public to make sure that we take a pulse there.

COMMISSIONER SZILAGYI: Yeah. I also think this is very responsive to the discussion and I agree with these recommendations.

Just one question, Chris, about the 125 percent and the estimates. Did GAO assume that the launch prices

wouldn't change in their estimates or did they try to model potential actions by the pharmaceutical companies.

MR. PARK: Yeah. CBO, you know, I can't --

COMMISSIONER SZILAGYI: I'm sorry. CBO.

MR. PARK: Yeah. I can't talk to specific assumptions that they made but they would take into account potential manufacturer actions such as increasing launch prices. I don't know like to what extent that affects the estimates but they do take into account, you know, kind of the entire picture about manufacturers either lowering prices or increasing launch prices in the future, when they come up with their estimates.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: Chris, how would you evaluate whether the 125 could then be removed subsequently, down the road? How would you evaluate whether the 125 had negative consequences in terms of launch prices?

So I guess where I am at, Penny, is I am supportive of these recommendations but I think when we write the chapter and we think about the future it would be helpful to consider what that kind of evaluation plan would

be, about whether 125 hit the mark, could be removed, had negative consequences.

So have you -- could you just share thoughts you might have about that?

MR. PARK: Sure. I haven't necessarily thought about that too much, but I think, you know, there could be some observation about how, you know, prices have changed and comparing that to like, you know, historically, how those prices have changed. So like immediately there might be certain drugs to have had their prices increased, you know, drastically every time, and, you know, one thing you could see is if they immediately lowered their list price in response to this change, and to see like to what extent, how much they lowered it, to see if they essentially lowered it back to kind of like the 125 cap or if, you know, they, you know, lower it even more, to that extent.

I think it would be difficult to estimate, you know, how a manufacturer may have changed their launch price, because we wouldn't know kind of where they would have entered the market in the first place. You know, depending on your kind of view on economic theory, some economists would say they would have launched at the

highest price possible as to what the market would bear.

So, you know, there may not be a way to measure that effect but I think, you know, kind of looking at the overall market and how, you know, spending has changed and where, you know, kind of the pricing levers have maybe been affected, I think you could take some look at that to see if removing the cap completely would add additional pressures.

COMMISSIONER MILLIGAN: So just to wrap up, I am supportive of the recommendations, and, Chris, you have done great work on this in reflecting our comments in all of the analysis. I do think that when the chapter is published it would be helpful if we talk about this in terms of it being stepwise, if we articulate our thoughts about how to evaluate whether to take a future step.

CHAIR THOMPSON: Let's see. I have Alan and then Sheldon and then Bill, and then I'm going to stop for a second and just check in with the public and make sure if there are any comments that we should take into consideration.

COMMISSIONER WEIL: Chuck, I really like your question because I am sort of where Kit is on the 125, and

I think we do sort of need a hypothesis. What could go wrong if it weren't capped at 125? Chris, you have done a great job, I think, of laying it out, but trying to go one step further would be helpful.

I just have, I guess, a comment, question, on the 180 days. Somehow, in our prior conversations, I had not noticed that both the exchange plans and Part D plans, there is language about a reasonable effort for 90 days. And, you know, I wouldn't want to have to argue that in front of a judge whether or not someone has made a reasonable effort. But it does seem like if we are going to make a recommendation at 180 -- and part of why we are doing that is we are piggybacking on language for other programs -- it seems like reasonable effort for 90 would be a reasonable thing to also suggest states should try to do.

I'd be interested if other people -- since I think it's the first time I've said it, as I say, I hadn't noticed it was in both of those.

CHAIR THOMPSON: Are there any reactions to that? First of all, Chris, any comments that you would make about that?

MR. PARK: Sure. I think the language asks that

they make a reasonable effort within 90 days to start evaluating the drug. But I think because maybe with the timing of the P&T Committees where, you know, there's a requirement that the P&T Committee on Medicare Part D and the exchange meets at least quarterly. So I think the 180 days gives them time, you know, in case the timing doesn't match up, to allow the P&T Committee to kind of make the official recommendation on the formulary decision. So we could add language to the recommendation that, you know, kind of mirrors those requirements, that the state makes a reasonable effort to begin evaluating a drug within 90 days and then makes a coverage decision in 180 days.

CHAIR THOMPSON: And is that the statutory construction?

MR. PARK: Those requirements, at least for Medicare, are in the Medicare Part D provider manual.

CHAIR THOMPSON: Okay.

MR. PARK: I don't know if there's like official statutory language on Medicare.

CHAIR THOMPSON: Okay.

MR. PARK: So I could look into that.

CHAIR THOMPSON: So can we check that? I guess,

Alan, would you be comfortable with that being kind of in the discussion about the nature of guidance versus in the statutory language, if that's also not the case for the other?

COMMISSIONER WEIL: Yes. Thank you for the clarification. At least from what you've written, it does look like it's in the regs, not in the statute. And if we're making a statutory recommendation, I think that would be fine to leave it out.

Chris, though, I just want to be a little precise. I thought the language was a reasonable effort to conclude the process in 90 days, not to initiate the process in 90 days. Again, we have a little time here, not a lot, but I just want to make sure -- if we're trying to line up, I just want to make sure we're lining up correctly.

CHAIR THOMPSON: Yeah.

MR. PARK: Let's see if I have a copy of the -- okay. This is the provider manual. Okay. So it says, "The P&T Committee will make a reasonable effort to review a new FDA-approved drug product within 90 days of its release onto the market and will make a decision on each

approved drug within 180 days."

CHAIR THOMPSON: So we interpret that to mean a review process --

MR. PARK: Yes.

CHAIR THOMPSON: -- with an eye towards that resulting in at least --

MR. PARK: A decision.

CHAIR THOMPSON: -- a decision.

MR. PARK: At the end of 180 days. And to your point about whether this should be statutory or not, our recommendation is addressing the requirement for Medicaid to cover a particular drug, so I don't think we necessarily need to put it in the recommendation because this just allows them up to 180 days to exclude coverage. And then as you suggested, in the rationale we could discuss within the guidance that, you know, CMS could ask states to make that effort to do it within 90 days.

COMMISSIONER WEIL: If I can just say, given both of your answers that this is in the regs, not in the statute, and that my understanding of what the 90 days meant was somewhat different, I would withdraw my suggestion.

CHAIR THOMPSON: Okay. But I do think it is consistent with what we were talking about, about the idea of suggesting that there be guidance about ensuring that there's a process to get to 180 days, and the kinds of stuff that are necessary and the kinds of practices that may need to be instituted within the states in order to be successful and to, in fact, reach a conclusion at the end of that process that people can rely on.

All right. Let me go to Sheldon, Bill, and then I'm going to go to the public and others that are going to chime in afterwards we'll start to see. Sheldon.

COMMISSIONER RETCHIN: Yeah, I'll just briefly join in on Chuck's point and maybe the discussion that Chris brought up in terms of what this might do to distort the market. I think you were very articulate about that, Chris, and I personally think also, though, looking back afterward, looking at the consequences that may occur, it would be impossible for us to be able to look at -- there would be no anchors for us to look at before and after.

But, moreover, I'm unconvinced this will in any way change particularly the launch prices or the R&D efforts. On the launch price, when you already have drugs

that are launched at $750,000 for a first-year cost, it's hard to imagine that this could distort it much more. And there are other opportunities for scrutiny on launching pricing, anyway.

And then more importantly for me would be maybe looking at the R&D pipeline, but in that case, R&D in the pharmaceutical industry is conducted very differently now than it was 20 years ago. Now they buy platform technologies from a much smaller company, so it's not done intramurally anywhere near as much as it was years ago. And if you're out of the R&D game or you delay the pipeline, you're out of business.

And then, lastly, I'll just say, just to remind everybody, that the 125 percent cap was indeed a compromise. There were Commissioners who were interested in looking at the full cap, taking off the cap, and I think this is a reasonable compromise and should please both sides or probably please no one, which means it was the sweet spot. So, Chris, it was a good job.

CHAIR THOMPSON: Bill,

COMMISSIONER SCANLON: Just to follow up bit on what Chuck and Sheldon have talked about, I feel like that

this is a reasonable compromise as a starting point, and as we talk in the chapter sort of about thinking of the future and seeing what the sort of responses have been, I'd like to keep it open and not use the idea that there's a step-wise approach to sort of improving things, which might imply we're going to go to 125, 150, 175.

I think it's a question of thinking about what would be the optimal structure for changing the rebates that have actually observed some of the behavior. It could be that they're variable caps, because right now 125 -- you know, right now it's 100, and you get beyond 100 and you're free. Then it will be 125. You get beyond 125, and you're going to be free to do what you want with no consequences.

So this question of can we change the incentives more strongly in a positive way, and I think to understand that and to identify the ways, we need to see some of what the response to this might be as well as to sort of analyze more about sort of what the responses might be to alternative scenarios.

CHAIR THOMPSON: Bill, let me ask you, because what I'm hearing from a number of Commissioners is that, "Eh, 125 I can live with." But it sounds like maybe

Commissioners would actually prefer not to have the 125 present in the recommendation given, you know, that I think people are sounding like maybe we would -- we would vote for the recommendation because it's better than today, but if we were really looking at this in terms of what we would actually prefer, we would just like there not to be any limit on -- that there would be no cap.

I want the Commissioners to think about that for a second. I'm going to take some public comments here. But I think I want to come back and just take a pulse. You know, we had this discussion at the last meeting, 125 or not. The staff have produced a recommendation based on their sense of where people would be. But I also don't want to hurry to compromise to a point where people are living with something when actually the vast majority of the Commissioners would prefer something else. So I'm going to come back and check in on that point.

PUBLIC COMMENT

* MR. CLARK: Good morning. My name is Bill Clark. I am a senior fellow with the NORC at the University of Chicago. I had a question and comment regarding Recommendation 1 on the grace period.

As I recall the Commission's discussion, originally the initial presentation referred to four or five states' policies with respect to the grace period that were selected, I think -- I'm not sure exactly how, but it wasn't clear to me whether there was a universe of all state or Medicaid programs where we have actual reported information on the timelines that it does take to approve drugs for the formularies. It seemed like some of the states that were selected were leaders, and maybe some of the other ones were laggards.

So my question is: To what extent is there routinely reported data that the Commission would be able to use in the future to monitor the impacts of the policy recommendation; and if there isn't a routine source of data reporting, whether or not the recommendation should be amended to include such a requirement?

Thanks.

CHAIR THOMPSON: Thank you, Bill. Nice to see you.

Anne, do you want to jump in on that point?

EXECUTIVE DIRECTOR SCHWARTZ: We sent an email to all -- it was either Medicaid medical directors or pharmacy

directors -- it was sort of a variable list from all the states -- and asked them about what their timelines were, and we got responses from, I guess, five?

MR. PARK: Yeah, we got responses from five, and during some of our background research, we had interviewed another four states regarding their policies as we were discussing other issues. So a total of about nine states' information.

Also, while I didn't do a comprehensive search, I did do a quick search on at least when the P&T Committees meet in different states, and it was generally on a quarterly basis.

CHAIR THOMPSON: So Bill's other point was about whether or not -- again, this I think would be a point for maybe narrative discussion. In addition to this point about trying to make sure that we have CMS issuing some help and guidance and support to states in terms of thinking about the steps that are necessary to meet the requirement, that there also be some obvious monitoring of that, which could include some reporting of what states are finding and some adjustment and refining of the standards over time. Okay.

MR. TURNER: Good morning. My name is Wayne Turner. I'm a senior attorney with the National Health Law Program. I want to thank the Commissioners for hearing the concerns that I raised at the last meeting regarding the Pharmacy and Therapeutics Committees in Medicaid and really raising the standards on transparency and accountability for those committees.

I just continue to have serious concerns over this grace period proposal. I think that the potential benefit for states in easing their administrative burden just does not compare with the potential harm to low-income Medicaid enrollees. I see states as using this as an opportunity to delay coverage as a cost-saving measure.

In my own work in HIV, for example, many long-term survivors have exhausted their treatment options through the development of drug resistance, and so they are really reliant on new treatments and new medications coming down the pike. So the prospect of having to wait six months to get that new drug is just -- is really serious. And so I think that that's true for people with many medical conditions that are in desperate need of new treatment options.

Again, it is not clear to me how an exceptions process would work, and, again, if you are in desperate need of treatment, going through an exceptions process, you may not -- you're racing against the clock. You may not have time to do that.

Also, the language of this recommendation, I don't quite understand what "otherwise restrict coverage" means. I mean, we have statutory protections within R-8 on creating emergency supplies and providing pathways to coverage for excludable drugs. So I don't know what "otherwise restrict coverage" means.

Anyway, in terms of the priorities of what needs to be done and what's -- I just don't see a grace period as being top of that list.

Thank you.

CHAIR THOMPSON: Chris, can you comment on the point about "otherwise restrict" --

MR. PARK: Sure. That is how the language is stated within Section 1927(d)(1)(B). It provides situations where states can exclude coverage. But the language they use within that particular piece does say "exclude or otherwise restrict coverage." And so that

might be similar to what we saw with the hepatitis C drugs where states were covering it but with some pretty restrictive requirements. And so it might not meet the definition or the intent of the statute in providing coverage because the requirements are so restrictive.

So I think that is, you know, allowing basically states to have restrictive requirements in there where it might be like on a case-by-case basis where they would approve coverage. But the reason why the recommendation is worded that way is because that is the language that's used in the statute.

CHAIR THOMPSON: Thank you. I want to pick up on a couple of points that Wayne just raised. Again, I think this could be further expression of these points in the justification and in the rationale. So, again, the idea that there be -- to the point of, well, what if states are just using this as a way to delay coverage for the purposes of saving money? I think that to the extent, again, that we emphasize the idea that there ought to be actual activity taking place in this 180-day period and that ought to be focused on issues of clinical matters that need to be assessed so that there can be appropriate indicators put

into place for people who are in need of these new therapies, and then, secondly, this point about whether or not there's a process by which people who are in desperate need can still access therapies during these periods of time, and it would seem that this would obviously not prohibit states from being able to take advantage -- to, in fact, have those kinds of procedures in place, and that may indeed be necessary for states to do. That could be part of what we would look to the federal government to kind of work with states around.

Okay, next?

MS. HICKEY: Hi. Thank you for taking my comment. Carolyn Hickey with Sarepta Therapeutics. I have a comment kind of following up on this. It's kind of just the expectations after the 180 days, because as currently in statute, drugs from a manufacturer that has a signed Medicaid drug rebate agreement when it's used for medically accepted indications, which is FDA-approved indications, it must be covered by state Medicaid programs.

So I just wanted to kind of make sure that is included in the chapter, and so what is the expectation after 180 days? Is it coverage? Which is what it should

be currently based on statute. And I understand the point here around the discussion to kind of codify practices that are already happening, because in some states we are seeing access challenges greater than two years after FDA approval. And these are for therapeutic areas for very rare diseases for pediatric patients, and so, you know, manufacturers have skin on the table here with their Medicaid drug rebate agreement, and so it would just be helpful to provide a little bit more clarity so that when CMS is going to draft subregulatory guidance, if that is your recommendation, that it's just clear what those expectations are for coverage of these drugs.

CHAIR THOMPSON: And just to reinforce, that is, in fact, our intention.

RESUME DISCUSSION

* CHAIR THOMPSON: All right. So let me come back to the Commissioners. I want to just ask if there's any further reaction to the public comments or to any other part of our conversation around the first recommendation. I want to start with that one. So let's just make sure that we kind of focus on and continue and finalize the conversation on each recommendation one by one. So,

Melanie -- oh, I'm sorry. Stacey, you wanted to jump first. Did you want to jump in on the first one or the second one.

VICE CHAIR LAMPKIN: The second one.

CHAIR THOMPSON: Yeah, okay. So, Melanie.

COMMISSIONER BELLA: Yeah, so I do support the grace period, but I think there's real legitimacy to the claim -- to the concern about a process and an exceptions process and people not being able to even avail themselves as an exceptions process. And I worry that if it takes CMS several years to put out subregulatory guidance, then we're just sort of this kind of black hole. So I think we should think about -- I'd like us to be very strong in the chapter about the expectation on CMS and about something about -- we've got to make sure that -- I think the goal here should be that the state -- this actually makes those processes tighter, because I think de facto much of this is happening. So if we can actually use this as a way to make it tighter on the time frame and more transparent, but we do need to make sure that that guidance comes out and that it's pretty explicit and there is some sort of way for people to continue to get access. And I know we can't

dictate all of that, but I worry about we're putting a lot of reliance on subregulatory guidance that may not coincide right when this policy will go into place.

CHAIR THOMPSON: Yeah. I mean, it could be regulatory as well as subregulatory guidance. I mean, we're talking about a statutory change here, and so -- but I do think that part of our rationale here, as we have discussed this several times, is the idea that there be thoughtful, deliberate conversation about this, the use of the P&T Committees, the use of public comment, the idea that, you know, it makes sense that you would need this time. But then when you complete this process, you really do have to come to a decision in conformance with the statute and the expectations of the programs.

And so I completely agree that all of these discussion points need to be emphasized and the justification and the discussion. I don't know what to say about the timing. You know, to some extent we're here recommending statutory change. I do think that we can express the importance that we attach, as you suggest, Melanie, to these steps and to these clarifications so that the underlying structure is there to support the intent of

our recommendation.

Peter?

COMMISSIONER SZILAGYI: This is to just support what Melanie and others were saying.

As Alan was talking, in my mind I was thinking about there are several new cancer therapeutic drugs coming out for children's cancer, neuromuscular drugs coming out, and I was just wondering about this whole exception process, if there really is a breakthrough drug.

So I support this discussion, and it's partly a question. What are states doing now regarding the exception process if there are clear -- what appears to be a breakthrough drug? I actually don't know.

Are these committees meeting more frequently than quarterly, or what is the current process?

CHAIR THOMPSON: Chris, do you have any insight that you want to comment?

MR. PARK: I can't speak to that specifically.

I think there have been cases where there might be a P&T committee meeting like on an emergency basis to address this issue.

Frequently, from the states that we have talked

to, between the time the drug comes on to the market and when the P&T committee meets to kind of make their recommendations on PDL coverage, the states are covering the drug on a prior authorization basis. That level of prior authorization can vary greatly, depending on the drugs, though sometimes it might be on a case-by-case basis.

So there is at least a way for -- kind of like an exceptions process, for a beneficiary to go through that process on a case-by-case basis to try to get access to the drug.

However, those requirements and steps that you need to take as to how to go about that prior authorization process may not be readily available. The patient and the doctor may not fully understand that there is a pathway to at least try to get that drug currently.

CHAIR THOMPSON: So that is not statutory?

The statute presumes that everything is being covered, right? I mean, that's the issue. The statute presumes that at the moment the drug enters the market, it's covered. So the statute doesn't have anything to say about any of these other pieces that now we're discussing.

So it kind of does raise the question as to whether or not when we have this recommendation, which we are now constructing a new kind of regime in which we say, "Well, our assumption isn't that it's covered immediately. Our assumption is that there is a need for a certain amount of time for states to work through the evidence and get their systems and other procedures in process."

So if we are doing that, do we need to have an accompanying recommendation, then, that says what happens during this time when we are facing some of these lifesaving therapies and others that -- so maybe there's something that we should combine with this if we are now changing the assumption, which is not true in point of fact that it is available to everybody at the moment that enters the market. But we're dealing here with what we have as a statutory construction.

Alan.

COMMISSIONER WEIL: Yeah. So I'm sensing a little rumbling discontent, and I want to listen to it. And I don't know how, what -- quite what to do it, but I'd like to try to express at least what I'm feeling and what I think I'm hearing others say.

If I'm remembering right, unlike the DSH where there's a court case and there is a reason, this is our own initiative. There's no burning platform here of the whole regime is about to get thrown out by the court, and that question is -- we're trying to be responsive, I think, to an issue that Kit has expressed effectively about this.

But there is this -- like everything else we do, it's in a context, and part of the context here is the coverage decision isn't the only thing that matters. The prior auth rules matter, and often trump, in some sense, the coverage decision, because they can be used to significantly delay access to a drug, far beyond the day it becomes approved, at least that's how I understand it.

What I'm hearing, I think, from others -- I don't want to speak for others -- is to actively recommend a change in the coverage. I don't think it's just about what happens in the 180 days. I think the question is to actively recommend a change in when the coverage decision is made without grappling with the question of whether and the degree to which prior auth and maybe other -- but I think that's the one that's primarily used -- other mechanisms can impede access even after a coverage

determination has been made. That that feels incomplete.

So I don't know if we can fix that right here, but I am feeling a little sense of we're making a recommendation about a slice of the problem of the issue, I should say, when what actually happens on the ground is determined by things that are related to but are different from where we're making the recommendation.

CHAIR THOMPSON: Let me ask others to jump in on that point. Kit.

COMMISSIONER GORTON: Okay. So talking about anything in the rebate program is talking about a slice of a huge context, right?

There's a little bit of a theory-of-everything problem here, and so the question which people will have to grapple with in their own minds is, Can you get comfortable enough with the slice to move forward on a slice, or do we have to deal with it in the aggregate, which I think is probably politically unpalatable, if not unpalatable for a variety of technical and other reasons?

One is I feel silly saying this to a lawyer, but coverage is coverage. It has a technical definition, and in any coverage decision, that doesn't give people

untrammeled access. The decision to grant coverage does not create untrammeled access to the product service.

So the rules are replete with processes and requirements and recommendations and other things -- exceptions, processes. So all of these things exist.

States and health plans regularly afford people access to experimental care, even though Title 19 says that we don't pay for experimental care. States use state dollars; plans use plan dollars. And where it makes sense to give somebody access to that kind of care, they do.

These processes exist. They play out. Are they even? Does everybody have equal access? Does it help if you have a health law attorney who is a member of your family? Yeah. All of those things can give some people better access than other people.

But, in general -- and I was reminded with the comment about the HIV. Even from the beginning of that, what is covered, what is not, remember the labels are often very imprecise. So there's always a lot of judgment that goes on in these processes.

The single-state Medicaid authority always has the right to pay for something before the P&T committee

meets. The P&T is about regularizing a process and trying to make it even and fair and predictable and transparent to everyone. But there are always going to be periods of time, whether it is a day or a week.

I've heard the argument -- and it's a compelling argument -- that this man will die if he does not get this drug this week. Okay. Well, if we think that's a compelling argument, then we have to, as compassionate human beings, address it on that level, but you can't build a process that in a fair, transparent, regular, and predictable way deals with that kind of exceptional decision-making. You can't make it into policy in three days or five days or seven days, which is why there are policies around emergency supplies, why there are policies around exceptions, why there are fair hearings. There's mountains of due process here.

Just to take it to the theory of everything in total, this isn't just about drugs. Here, we're talking about -- because it's the rebate, but new surgical procedures, new durable medical equipment, all of these things leak into the marketplace. And the people who administer the programs on a day-to-day basis have to

decide what they'll pay for, under what constraints, how it makes sense, what's in the budget this year, whether the evidence is the evidence.

We tend to talk about scientific evidence as either it's for or against. There are grades upon grades upon subgrades of is evidence level A evidence, is it level E evidence. So there are a whole bunch of decisions. That's what P&T committees sort of sift their way through. That's what medical directors of health plans sift their way through. That's what armies of consultants and actuaries sift their way through is figuring out how to deal with this.

And I don't think -- I don't believe -- and others will draw their own conclusions, as they should. And if we need to continue to talk about this, Alan is absolutely right that we should take the time to talk about it. I don't see a reason -- we haven't taken away any of the beneficiary protections that exist currently, and in fact, in our rationale, we've suggested upgrading some of these things.

We've underscored the importance of P&T committees. So I just don't think that we should let the

perfect be the enemy of the good here. I think that we have made some progress, and it's a tough and complicated issue. And coverage and specific utilization of management decisions, those are two different things. That's the fundamental core.

To equate coverage with open access would be to essentially say that under the EPSDT program, children can have anything, but in fact, that's not what the law says. Maybe as a pediatrician, I've been more sensitized to the distinction between coverage and in managing that coverage once it exists.

I don't think that prior authorization -- I was going to talk about this later. I will talk about this later. But I don't think prior authorization and utilization management should be equated with denial of access because prior authorization and utilization management are about appropriate access in amount, duration. So it's getting the right drug to the right person in the right amount at the right time for the right reasons, and the nurses who do this have seven rights. And I can't rattle them all off. But that's what it's about.

CHAIR THOMPSON: And I do think that that was a -

- actually, I think this concept came up first at a state panel, and it was one of Darin's old compadres, I think, from Tennessee who kind of brought this forward first.

It was in the context of exactly what you're describing, which is therapies for which there were indications and contraindications and how do you manage that in a way that is, as you say, fair and open and transparent and reasonable.

All right. I'm going to bring this conversation to a close shortly, but I do know that, Darin, you've been wanting to jump in. Chuck wants to jump in, and, Sheldon, you wanted -- Sheldon is passing.

So I'm going to have Darin and Chuck jump in, and then we'll close this off. And then we'll go on to the second recommendation.

COMMISSIONER GORDON: I go back to some of the things we heard from some of the panelists, not just Tennessee, but some of the other panelists as well. This was about setting the appropriate medical criteria for which the drug was appropriate. That was the context in which this issue was brought up.

That what we heard from one of the panelists is

that it is not uncommon that the evidence that was provided to the FDA for their approval of that therapy is not often or quickly made available to states for them to intelligently develop their criteria, the clinical criteria for which the therapy is proven to be most effective.

So I think that was the context in which people are looking at this because oftentimes -- Kit articulated it well -- you'll put it out there, and you'll put some criteria around it and some prior authorization criteria, but it is not fully informed. That can have consequences as well: I'm giving a therapy in instances where it's not only not proven to be helpful, but where it could potentially be harmful. In order to provide adequate time for an agency to review the evidence and ensure that their criteria is consistent with the evidence for which the therapy is proven to be effective, so I just wanted to make sure we remember that context.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: I continue to support the recommendation. I do think it's helpful in the narrative to re-anchor to Part D in exchange plans because there is criteria here.

I do think it's helpful to go back to what Kit said. This is setting rebate kind of policy, which is to say that a state would not be out of compliance with rebate policy if it evaluates the criteria in terms of medical necessity.

I mean, I think what we heard on that panel is you need to figure out which diagnoses, which medical conditions meet the medical necessity criteria for good clinical evidence that this drug is appropriate for this person.

I want to go back to what Melanie said. I think that we should articulate in the narrative an expectation the states and the federal government work to ensure early access, where appropriate, for individuals and sort of what Kit said.

I think there's a lot more good-faith behavior actually at the plans, at the states, about making access available early for individuals who need lifesaving medications, and having been part of that on the state side, I do want to push back a little bit on the assumption that it's all cost savings-driven. It's all kind of cynical that way.

I guess the other comments I want to make is that I think for every lifesaving drug that we're talking about, the drugs that Peter referred to and that one of the commenters referred to, there are 20 drugs where it's really just a change in formulation for the same thing but at 10 times the price. Having states have an expectation to cover that immediately with no authorization requirements isn't good fiscal policy, and it isn't an improvement in care.

So I'm going to circle back and say I support the recommendation. I think the narrative is where we have to do the heavy lifting.

CHAIR THOMPSON: Okay. Let me bring to a close the discussion of that recommendation. We'll see that recommendation back up this afternoon, and we'll put that up for a vote.

I do want to turn to the second recommendation. What I want to do here is just pulse the Commission.

Stacey, you wanted to jump in here. My thought is that maybe the 125 is not what we want. That if we really would prefer a recommendation that says just eliminate the cap, that that's the recommendation that we

ought to vote on.

I was just getting a sense from some of the commentary. I know that the last meeting, we were a little split on this, but in the commentary today, it seems like -- at least the Commissioners that were speaking up were speaking up as "I can live with 125, but really in my preferred world, it would just be eliminating the cap altogether."

So, Stacey, do you want to jump in?

VICE CHAIR LAMPKIN: Yeah. When I put my hand up to get on the list, it was after about the third person sounded a little bit squishy maybe on the 125, and I wanted to clarify from my perspective.

In the March meeting, I was one of the people who was not so sure about eliminating the cap in the first place, but it wasn't really because of market distortion, necessarily. And so we had some really good conversation in March and then further thinking since then that kind of got me past my initial concerns with eliminating the cap.

So my own comments on this were going to be I could agree with the 125, but I didn't think the compromise -- for me, the compromise isn't necessary to get me there.

As you were saying is the 125 necessary, I was experiencing the same question, just based on the early comments and my own reaction.

CHAIR THOMPSON: So let me just put it out for the Commissioners who want to weigh in. It sounded like from folks that spoke earlier, that at least for Kit -- Kit, you specifically said you'd prefer just eliminating the cap.

I think we had some of this conversation about if the idea -- and I think this goes to rationale. If we're saying 125 because of market distortions, I think there was a lot of conversation about would we really know whether that occurred or didn't occur.

I, myself, feel a little skeptical about being able to draw any causality or relationship between sort of, well, we set it at 125, what we saw in the market was this, that, or the other thing, and that was related to the 125.

So I'm trying to think about how to do this. I mean, I could just do the old raise, a show of hands. So I think maybe in the interest of efficiency, that's what I'll do is ask those Commissioners who would prefer to see the recommendation be eliminating the cap to just raise your

hand.

[Show of hands.]

CHAIR THOMPSON: Yeah. All right. We've got -- one, two, three, four, five, six, seven, eight, nine, ten -- I'm in the middle. Martha, you're in the middle.

Are there any folks that if we had a recommendation to eliminate the cap, who would feel -- who preferred the 125, who would say I'm going to have a hard time living with eliminating the cap?

We heard from a number of people who said, "I prefer to eliminate the cap. I can live with 125." So now I'm asking the reverse: Are there any Commissioners who would say I would really like the 125, and I can't live with eliminating the cap?

[No response.]

CHAIR THOMPSON: All right. So I'm going to suggest then that we revert to eliminating the cap, as this recommendation, and we'll vote on that.

I do think that given the fact that we've been split about this as little bit, we should reflect the fact that we discussed the possibility of just raising the cap to 125, but explain the rationale for why we decided to

have the recommendation be eliminating the cap altogether.

Okay. So those will be the two recommendations that we will take up at the end of today, so we will come back to those for actual votes. I know we are a little bit behind time but that is okay. We are getting where we need to go. We will find a place to catch up.

All right. So let's go ahead and turn to the next conversation, which is about DSH. And as we did, again, with prior conversation, the way that we will handle this is that Rob will walk us through all of his additional analysis from the last meeting, we'll talk about the recommendation, we'll have a little bit of initial Commissioner questions, clarifications, commentary, we'll check in with the public and ask for your comments, and then we will come back to conclude the conversation and decide on final recommendation of language.

All right, Rob. Take it away.

REVIEW OF DRAFT CHAPTER FOR JUNE REPORT AND RECOMMENDATION ON TREATMENT OF THIRD-PARTY PAYMENT IN DEFINITION OF MEDICAID SHORTFALL FOR THE PURPOSES OF DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

* MR. NELB: Thanks, Penny. This morning we are going to review a draft chapter for the June report and a potential recommendation related to the DSH definition of Medicaid shortfall.

I am going to begin with a brief background on the DSH definition of Medicaid shortfall and how it has changed as a result of a recent court ruling that affected how shortfall is calculated for patients with third-party coverage. Then I will recap the Commission's March discussion about potential policy options to reverse the effects of the court ruling. And I will compare those options to various policy goals that Commissioners expressed at the last meeting.

Based on this analysis we have prepared a proposed recommendation for you to consider, and so I will share the text of that recommendation as well as the expected impact on states, providers, and enrollees. At the end of today's session I will be looking for your feedback on that recommendation as well as any comments that you have on the draft chapter. However, as Penny said, the specific vote on the recommendation will be later this afternoon.

So first some background. As you know, DSH payments are statutorily required payments to hospitals that help support their uncompensated care costs. DSH payments to an individual hospital cannot exceed the hospital's uncompensated care costs for both Medicaid and uninsured patients. Uncompensated care for Medicaid patients is referred to as Medicaid shortfall, and is defined as the difference between a hospital’s costs of serving Medicaid-eligible patients and the payments that it receives for those services.

This definition gets a bit complicated for Medicaid patients with third-party coverage because most of the payments for those services are provided by the third-party payers, such as Medicare or private insurance.

Previously, CMS required hospitals to count the payments that they received from third-party payers when calculating Medicaid shortfall. However, in March of last year the D.C. District Court rules that payments from third-party payers cannot be counted because they are not explicitly mentioned in statute.

At last month's meeting, Commissioners agreed that Congress should change the statute in order to help

reverse the effects of the court ruling and to ensure that DSH payments do not pay for costs that are paid for by other payers. However, there was a lack of consensus about whether Congress should make any additional changes to this statute, to the definition of Medicaid shortfall that CMS was previously using.

So this table illustrates what is included and what's not in the three different options that the Commission discussed at the March meeting. The first option is to revert to CMS's prior policy, which it issued through FAQs in 2010. Under this policy, Medicaid shortfall is counted for all patients who are eligible for Medicaid, including patients with third-party coverage, such as Medicare or private insurance.

A second option that the Commission considered is a hybrid approach, that would not count shortfall for Medicaid-eligible patients who have private coverage but would still count Medicaid shortfall for patients who are dually eligible for Medicare and Medicaid.

And finally, the last approach, which we are calling a Medicaid-only option, would only count Medicaid shortfall for patients for whom Medicaid is the primary

payer, and therefore wouldn't count shortfall for Medicare or privately insured patients.

To help evaluate these options I am going to compare each of them to three goals that Commissioners expressed at the last meeting. First, several Commissioners were interested in understanding how the options would affect the DSH funds that are available to safety-net hospitals, particularly those that serve a high share of Medicaid and low-income patients.

Second, Commissioners wanted to ensure that the policy didn't create disincentives for hospitals to serve Medicaid-eligible patients with third-party coverage.

And finally, Commissioners wanted to promote administrative simplicity in order to help reduce burden for states and hospitals and also to help ensure that DSH payments can be properly audited to make sure that they are accurately made.

So looking at that first goal, in terms of distribution of DSH payments, the first option of just reverting to CMS's 2010 policy would return the distribution of DSH payments back to the status quo that existed before the court ruling. We have documented this

in several of our previous reports on DSH. In our most recent report we looked at DSH audits for 2014, the most recent year available. At that time, about 70 percent of DSH payments were made to deemed DSH hospitals. These are hospitals that are required to receive DSH payments because they serve a high share of Medicaid and low-income patients.

However, as you know, state DSH-targeting policies vary widely so some states direct all their payments to the deemed DSH hospitals and some very few payments there and spread DSH payments across all hospitals in their state.

As we have looked at the various DSH targeting policies we found that sort of the reasons why they vary have to do more with state policies than they have to do with the definition of uncompensated care or the way that CMS has defined Medicaid shortfall.

One exception to this are hospitals with neonatal intensive care units that treat a lot of low-birth-weight babies. Because low-birth-weight babies are generally automatically eligible for Medicaid based on their health status, even if they have private insurance, what happens

under CMS's 2010 policy is that the surpluses that hospitals receive for those patients end up reducing or eliminating the amount of DSH payments that the hospitals can receive. So if we went with the hybrid option, the second option, where we are no longer counting shortfall for privately insured patients, this could potentially increase DSH funding that hospitals with NICUs could receive.

The third option, the Medicaid-only option, would have that same effect, in terms of hospitals with NICUs, and then it would go a step further and also no longer count shortfalls for patients dually eligible for Medicare and Medicaid. And as we have looked into this policy a little more, it seems that doing so could actually increase DSH payments for some safety net hospitals in those states that distribute DSH payments based on hospital uncompensated care costs.

And this is a bit complicated, but largely because safety-net hospitals tend to have less Medicare shortfall than other hospitals because of all of the extra payments that Medicare already makes to those hospitals. So there are Medicare DSH payments, which even though they

have the same acronym are a bit different, but Medicare DSH payments, uncompensated care payments, bad debt payments, other things that, overall, when we look at the numbers, the deemed DSH hospitals have a higher share of their costs covered by Medicare than other hospitals. And so in those states that distribute DSH funds proportionally, based on uncompensated care, you know, those deemed DSH hospitals sort of lose out a little bit in that equation, and so going to that Medicaid-only option could potentially increase the DSH payments that those hospitals would receive.

Looking at the next goal of hospital incentives, we had a lot of discussion about this at the last meeting. It is important to note, from the outset, that we really just don't have any evidence that CMS's 2010 policy affected hospital behavior one way or the other. There are a number of factors that may affect how a hospital serves patients and we can't really say that the way Medicaid shortfall is defined, you know, had a big effect.

However, we do know that under CMS's 2010 policy, hospitals generally are eligible to receive less DSH payments for each privately insured patient that they see,

and they are eligible to receive a little bit more DSH payments for every Medicare patient that they receive. And so, in theory, that could potentially affect hospital incentives to serve those patients.

So looking at the options, if we go to that second option, the hybrid option, where we are no longer counting shortfall for privately insured patients, this could potentially eliminate a disincentive for hospitals to help enroll privately insured patients into Medicaid.

The Medicaid-only option would have that same effect regarding privately insured patients, but then would also have this additional effect related to patients dually eligible for Medicare and Medicaid.

And here, the effect is a bit mixed. So in theory, this could create a potential disincentive for patients to serve patients dually eligible for Medicare and Medicaid, but because of all those other additional Medicare payments that I mentioned -- Medicare DSH and other incentives to safety-net hospitals that are already baked into the Medicare program -- it likely rebalances those incentives. And so, again, overall, those hospitals are actually still receiving more for each Medicare patient

than other types of hospitals.

Okay. Last but not least, let's consider the goal of administrative simplicity. Under CMS's 2010 policy, you know, in order to count shortfall received for all patients with third-party coverage the DSH auditors need to actually collect information about all the third-party payments that hospitals receive. Because these data aren't often available from other sources, the auditors have to collect the information from hospitals directly, and it is a bit difficult to verify the accuracy of the data.

So looking at the first option, it would just be reverting to the status quo. The second option would no longer require auditors to collect information about private insurance payments, which are some of the more difficult data to collect. And the Medicaid-only option, the third option, would be the simplest and wouldn't require any information to be collected about third-party payments, because we are not counting shortfall for those patients.

So, on balance, weighing these different options against the goals you articulated, we are proposing a

recommendation that is based on that third option, the Medicaid-only option, because it seems to advance most of the Commission's policy goals.

The text of the proposed recommendation is here. I will read it quickly. "To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid for by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer."

In terms of the expected impact of this policy, CBO estimates it will have an insignificant effect on federal spending. There is no change to state DSH allotments. However, as we have discussed before, this could potentially affect spending in states with unspent DSH funds. Under the court ruling, we have seen that some of those states, because the court ruling increases the amount of uncompensated care, some of those states are claiming a lot more DSH funds. And so going back to this policy would sort of reverse that effect.

For providers, the policy is expected to kind of

reverse some of the redistribution that we expect because of the court ruling, and ultimately it is likely to increase DSH payments for hospitals that serve a higher share of Medicaid and uninsured patients.

The effect on enrollees is expected to be minimal and will ultimately depend on how states and hospitals respond.

That concludes my presentation for today. As I mentioned at the beginning, I welcome any comments on the draft chapter as well as your feedback on the proposed recommendation. Thanks.

CHAIR THOMPSON: Thanks, Rob. Well, as always, you have done a great job of taking a very wide-ranging conversation from the last meeting and boiling it down to something digestible and understandable, so congratulations on that front.

I did want to ask you, we did get -- after our conversation at the last meeting we did get a couple of public comments, including from the AHA and from a hospital system. So can you just talk about those -- I want to be sure that we, you know, take into account that perspective, so can you summarize those comments and provide any

commentary on that?

MR. NELB: Sure. So we received two public comments, the letters that are in your materials, one from the American Hospital Association, which, of course, represents all hospitals, and they make two points, first urging us to delay making a recommendation in light of the ongoing litigation, and second, to suggest that we get better data on the effects of such policy on hospitals and beneficiaries' access to care.

I'll just note a couple of things here. First, let's see. So as I mentioned, the proposed recommendation is looking at a statutory change. So --

CHAIR THOMPSON: And we are taking this up as a policy matter, not as a matter of sort of what a court might look at, in terms of the legality of a definition or an authority. We are looking at it from the standpoint of what's good policy.

MR. NELB: Exactly, yeah. And so, you know, our recommendation is not directed to the court.

And then, second, in terms of the data piece, I think, as noted, I mean, the Commission has made previous recommendations to try to get better data on all sorts of

hospital payment stuff, and it continues to be an area of interest.

As I noted, even if we had more data it is unclear really how we would evaluate how changes as small as the definition of Medicaid shortfall really affects something like hospital behavior. And so that it something to keep in mind.

The second comment letter that we got was from Doctors Hospital at Renaissance, which is a hospital in Texas. They were a party to one of the lawsuits related to this issue. This hospital serves a high share of Medicaid and low-income patients and they have a NICU and children's hospital that's sort of within the hospital itself.

The letter makes a couple of different points. First, you know, concern about the potential effect of the recommendation in terms of the amount of funds that a safety-net hospital might be able to receive. Here I want to clarify that, you know, so under the court ruling, as we have gone through some of those scenarios, these hospitals are eligible to receive a lot more payments than before, whereas under this recommendation it sort of brings back to the level of funds that they would be able to receive

before.

However, as I noted, if we go with this third recommendation that we have proposed, it will allow these hospitals with NICUs to receive more payments than they were able to receive under CMS's 2010 policy. So sort of the effect for a hospital like this is probably better than what it was under the 2010 policy but maybe not as much money as they are getting under the court ruling.

There are some other comments in here around, you know, about cases where maybe a patient doesn't pay their deductible or premiums and how that may affect, you know, whether the hospital actually gets paid by the third-party payer, so that is something we could clarify a little more in the rationale.

And then there are just comments, which, similar to the AHA letter, have to deal more with the lawsuit and about how CMS defined this issue in regulation, but don't really address the statutory changes, which is the context of the recommendation we are looking at.

CHAIR THOMPSON: Thank you, Rob.

Okay. Let me open it up for Commissioners. Melanie.

COMMISSIONER BELLA: Thank you, Rob. Every time I think I have my head around this I am all confused. So can we talk through, just a minute, about -- so my overriding concern is that when you are talking about duals that there can be sort of double payment, double dipping, when you start to think about Medicare bad debt, Medicare DSH, and whether we do or do not count Medicare payments for duals in shortfall.

Could we walk through that and make sure that the policy we are doing is not inadvertently -- I think today there are ways to sort of game, and I want to make sure that what we are doing isn't -- is trying to stem that rather than kind of increase that.

MR. NELB: Sure. So I do think the proposed recommendation does try to sort of separate out what's paying for what. So under current law how it is, so Medicare is the primary payer for hospital services, and then Medicaid helps cover the cost sharing and deductibles for patients who are dually eligible.

The overall Medicare payment to the hospital is based on the regular Medicare payment formula, and part of that formula includes different adjustments for safety net

hospitals, such as Medicare DSH payments and other funds for teaching hospitals, all sorts of things that go into what that Medicare piece is.

In terms of the cost sharing and deductible amount that Medicaid normally pays for, if Medicaid doesn't pay that amount because the state has a "lower of" policy, for example, that amount is considered bad debt for the hospital. And under current Medicare payment policies, that hospital gets reimbursed by Medicare about 65 percent the bad debt cost.

For DSH purposes, under the 2010 policy, states were supposed to be counting all those sorts of Medicare payments that the hospitals were receiving and comparing it against the hospital's cost of serving those patients. And if there was any residual shortfall, then Medicaid DSH could pay for that.

But as you note, you know, with all these different payment streams going on, it's hard for the auditors and just for others to really make sure that Medicaid DSH isn't paying for something that Medicare is really intended to pay for.

COMMISSIONER BELLA: And I should clarify my

comments. I'm not even suggesting that people are intentionally doing this. I think the way the reporting happens and what does and does not get counted and when it gets reconciled could lead -- what I'm trying to figure out is: Is it possible that something counts towards shortfall that also counts toward bad debts? And in that respect, are we making this better or worse with how we would treat Medicare payments for purposes of Medicaid shortfall?

MR. NELB: Sure. So, yeah, the timing and the process of Medicare bad debt payments are a bit hard to track, and my understanding is that they're not as well linked to a particular claim, which is how when an auditor goes through, they're trying to pull all the claims that have to deal with dual-eligible patients and not deal with the payments that the hospital receives for other sort of Medicare-only patients. And so there does seem to be some sort of challenge there.

The DSH audits are typically conducted about two years after the payments are made, which theoretically should allow some time for the different payments to all come through. But as you note, it's just very difficult to track these, and so I think that's one of the appeals of

the third option, the Medicaid-only option, considering it's no longer having to try to reconcile all those different payments and just focus on the shortfall that exists for Medicaid-only patients, which is a lot easier for the Medicaid agency to track and for others.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: So my question is just kind of a follow-up to Melanie's and is kind of a more direct question. My assumption is that the percentage of total Medicaid shortfall for a particular hospital that serves duals, the amount that's attributable to shortfall for dual-eligible patients is a relatively small percentage, because Medicaid only pays for the deductible. Most hospitals receive Medicaid payment for that, but it may be somewhat short.

So by taking dual eligibles out of the equation for this, it's not going to have a great impact on the total amount of Medicaid shortfall a hospital would qualify for.

MR. NELB: Yeah, that's my instinct as well. It's important to note that duals do tend to use hospital services more than other patients; when they use the

services, they tend to be more expensive. So hospitals do have a lot of costs for duals --

COMMISSIONER BURWELL: Yeah, but Medicare pays for it.

MR. NELB: Medicare is the primary payer for it and has a lot of other things in place to help cover hospital costs for those patients.

CHAIR THOMPSON: Let me pause on the Commissioner conversation and see if we have members of the public that would like to comment on our conversation or options before we continue on.

PUBLIC COMMENT

* MS. LOVEJOY: Hi. I'm Shannon Lovejoy with the Children's Hospital Association. Thank you for the opportunity to provide comment.

You know, from our last meeting, our request to the Commission has not changed. We still ask that you delay issuing a recommendation on this issue. There is ongoing litigation. This is not settled policy yet. We know that states are reacting very differently to all the different changes that have occurred with the CMS policy as well as the court case, and some states are on their second

redistribution of funds. But we do feel that this really needs to play out a little bit more on the court system before we can really assess the impact of this policy.

We also wanted to point out we think there might be a little bit of misconception, something we haven't mentioned before, of who the hospitals are that are getting the funding. The funding is being redistributed between deemed DSH hospitals. It's not just a variety of hospitals. Children's hospitals are deemed DSH hospitals, and so this is causing issues with how funds are being distributed in the state between the hospitals that Congress set out to say that these are who these payments should be targeted to.

And then just, you know, to further reiterate obviously, the CMS policy is especially problematic on the private-pay side for sure. You know, this is penalizing hospitals that are trying to do the right thing and enroll kids into Medicaid so they can get a full range of support. So we are very concerned about the potential recommendation to implement a CMS policy. But thank you very much for taking a look at this issue a little bit deeper. We do think that the Commission has continued to learn more about

this issue and, again, hope that you will consider delaying your recommendation at this time.

Thank you.

CHAIR THOMPSON: Thank you.

MS. GONTSCHAROW: Hi. Zina Gontscharow with America's Essential Hospitals. Thank you for the opportunity to comment today and for the Commission's thoughtful work on this important issue.

I will say that due to the varying impact of this policy, America's Essential Hospitals is neutral right now on the treatment of the third-party payments for purposes of calculating a hospital-specific DSH limit. However, if the Commission is recommending that Congress make changes to the DSH statute to address this issue, we urge that the Commission recommend that Congress also modernize the statute while they're at it. Specifically, we are talking about modernizing it through the calculation of the cap to reflect the true costs that are incurred by DSH hospitals today.

To date, CMS' policies regarding the calculation of the hospital-specific DSH limit exclude important real costs to the hospitals providing services to uninsured and

Medicaid patients. For example, many DSH hospitals directly employ or contract with physicians to staff their hospitals and must subsidize this often sizable cost of indigent care provided by these physicians.

And, similarly, hospitals also incur a wide range of additional costs that are not technically inpatient or outpatient hospital costs, but are routine parts of providing high-quality, whole-person-focused care. Allowing for inclusion of these non-hospital costs incurred by hospitals is a logical next step in updating the hospital-specific DSH limit, regardless of the treatment of the third-party payment.

Without these payments, particularly for hospitals that serve a disproportionate share of low-income patients, hospital services would not be available to this patient population.

Again, we thank you for the opportunity to comment and look forward to working with you on this issue in the future.

CHAIR THOMPSON: Thank you.

MR. CLARK: Good morning again. Bill Clark, NORC. I'm just curious about the impact of the policy on

essentially locking in a cost shift to Medicare because under Part A the states are obligated to pay the cost-sharing deductibles, and by basically saying, oh, Medicare has a policy to cover bad debts, therefore they can cover that at 65 percent, isn't that actually substituting for the state's obligation under Part A?

Thanks.

CHAIR THOMPSON: Do you want to respond to that, Anne or Rob? I mean, we're not doing anything that changes any other aspects of the states' obligations with respect to duals.

MR. NELB: Yeah. States are required to pay -- they have an option under statute to pay either the full Medicare cost sharing or the lower of the Medicare amount or what Medicaid would have paid. So there's still some obligation for the state.

MS. OFFNER: Thank you. I'm Molly Collins Offner with the American Hospital Association. I appreciate you summarizing our comments that we submitted earlier in offering commentary.

I just wanted to emphasize we continue to urge the Commissioners to delay the recommendation with regard

to emphasizing the role of the courts here, but also the need for better data was certainly discussed at some length in the March meeting and a little bit this morning. So we continue to urge a delay here.

Thank you.

RESUME DISCUSSION

* CHAIR THOMPSON: Okay, Commissioners. I want to come back to this and try to settle on -- first of all, you've heard some public comments urging us not to take this up at the moment because of the pending court case. As I've said before, it's my view that we're trying to address this as a policy matter and not as a legal matter in terms of what we think the right DSH policy is, and that's the place where I feel comfortable, not in sort of saying based on current statutory language or new uses of authority or certain processes that, you know, CMS could or could not do certain things.

I actually think to the point that some of the commenters have made to us, that if the Congress took up our recommendation and addressed this as a statutory matter, it could settle the waters and create some certainty that I think would be beneficial to the community

at large. But I want to check on that and specifically ask any Commissioners who are feeling uncomfortable on that basis to express themselves. If everyone feels comfortable on the basis that we're proceeding, I'd then like to focus our attention on whether or not the particular option that we've devised here, that Rob has devised is one that we feel puts us in a good position with respect to achieving the objectives that we've discussed.

Actually, on that basis, I really like the administrative simplicity of this and the straightforwardness of this. And I also think as a policy matter, when we're talking about shortfall, having Medicaid DSH focused on the thing that Medicaid is primarily responsible for seems correct to me. So it also to me aligns with kind of a policy viewpoint that's consistent.

So I would be for myself supportive of us moving ahead and supportive of us voting on this recommendation.

Do Commissioners have additional points they would like to make, different points that they would like to make with respect to any of that?

[No response.]

CHAIR THOMPSON: So if everyone is feeling

largely satisfied with moving ahead on this recommendation and with this approach, then I think that we'll just ask, Rob, for you to come back with this, this afternoon for our vote.

Okay, Sheldon, did you want to jump in?

COMMISSIONER RETCHIN: Well, I'm very supportive and agree with you, Penny, that simplicity I think carries the day. And I'm also in agreement that it's very different and I'm not persuaded that waiting on the judicial system to correct what is bad policy versus what is good policy. So I think that it is our obligation to comment on the policy. And I go back to Figure 2.1 where we're looking at actual payments received. I don't understand a plaintiff's argument, getting into the judicial issue, of how you can count dollars received as a shortfall. That just doesn't compute.

The only thing I did want to mention, I have made this point many times that the public comment just now I guess from America's Essential Hospitals, that the employment of physicians is a really true cost and it is something that I would urge the Commission to return to consider at some point with appropriate data.

CHAIR THOMPSON: Good. Okay. We have two more subjects to get through in terms of looking at recommendations that we're voting on for this afternoon. We will not get through that without at least one break. So I'm going to go ahead and ask us to take a quick break. Let's give ourselves -- we're, you know, not too bad on time, so I think we can take a full break of 15 minutes. And then we'll come back and pick up the other two subjects before we break for lunch. Thank you.

* [Recess.]

VICE CHAIR LAMPKIN: All right. Let's reconvene.

Post break, we are going to pick up a topic that is one that has been long a concern of the Commission, and Jessica is coming back to take this home on this latest round of program integrity conversation.

REVIEW OF DRAFT CHAPTER FOR JUNE REPORT AND RECOMMENDATIONS ON IMPROVING THE EFFECTIVENESS OF MEDICAID PROGRAM INTEGRITY

* MS. MORRIS: Good morning, Commissioners.

In this presentation, I'll be summarizing the draft chapter which we sent to you on improving the effectiveness of Medicaid program integrity as well as the

rationale and language for two potential recommendations. This chapter largely reflects the information provided in the Commission decision memos at the January and the March meetings.

At those meetings, I presented findings from a 2018 study we conducted that sought to collect information from states on the return on investment of various PI strategies.

The findings were inconclusive for a number of reasons. Many states did not or could not calculate ROI for many activities, but when states calculated ROI, they did not use consistent methods that would allow for cross-state comparisons.

Many states often did not have an incentive to calculate ROI for mandatory activities or could not calculate ROI for activities embedded in broader programmatic functions, such as those related to provider enrollment, for example.

Moreover, states had varying levels of success with different strategies and were often unclear about what design and implementation features were of high value. They were often unaware of other states' experiences and

how they address challenges.

Key themes in the chapter that we highlight based on interviews we conducted as part of the study include that we found that while states seek information and guidance from the federal government to identify high-value PI activities, CMS has not taken steps to facilitate collection of information or systematic sharing of lessons learned that would help states determine which policy design and implementation approaches are most worthy of state investment.

In addition, many states have been unable to comply with the statutory requirement that each state contract with a recovery audit contractor to conduct post-payment reviews of Medicaid claims to identify overpayments. The mandate has not proven effective for all states.

In response to these findings and a perceived lack of response by the Secretary to MACPAC's past recommendations, the Commission is considering the following two potential recommendations for the June report to Congress.

Therefore, the first recommendation is similar to

the one proposed last month but with some revised text that aims to respond to the Commissioners' comments. For example, the word "demonstration" was removed, and we've added language that reflects an examination of both current and new program integrity activities.

Additionally, this recommendation is directed to the Secretary in response to the discussion last month.

The rationale for this recommendation indicates that the federal government should take a lead role in developing and disseminating information on the effectiveness of Medicaid program integrity approaches.

Specifically, as part of his statutory authority to protect the integrity of the Medicaid program, the secretary should examine current activities and establish new pilot projects to identify the policy design and implementation features that best help states reduce fraud, waste, and abuse, and provide specific information to states on program integrity activities that have high rates of return on their investments.

While CMS currently works with states on a one-on-one basis, it does not benefit other states.

Conducting a rigorous assessment of PI efforts

across multiple states would help states identify which optional PI strategies have high value and how to design and implement both optional and mandatory activities for maximum effect.

Such an examination could help determine the factors that account for variations across state strategies and to share this information in a way that helps states invest in policies and strategies that work and eliminate potentially ineffective, redundant, and outdated programs.

With this recommendation, the Secretary would have to devote existing resources to collect information from states and determine which features of policy design and implementation contribute to the effectiveness of certain program integrity approaches and disseminate the results to states.

For states, this change is intended to provide them with additional information on the effectiveness of various PI efforts, which presumably would help them invest in strategies with better outcomes.

Some level of state effort would be needed for the Secretary to collect data from states, assess current strategies, and test new ones, and it will depend on how

the pilots and assessment are conducted by the Secretary.

Although we don't expect a measurable effect on beneficiaries, presumably they gain value from states that are doing the most effective job in addressing fraud, waste, and abuse, and when payments are properly made for high-quality services.

For providers, the additional information on effective PI policies could reduce administrative burden and improve provider trust that the program is focused on making appropriate payments for covered services.

The implications on MCOs will depend upon the strategies CMS studies and the current practices of managed care organizations relative to those strategies.

The next recommendation we are proposing has to do with the mandated RAC program and is the same language we discussed at the last meeting.

The RAC program was made mandatory for all states based on the favorable experience of a few states. The assumption that if it worked for a handful of states, it would work for all states, has not been borne out. The mandate has not been proven effective for all states.

Several states have been unable to procure a RAC

as needed to comply with the federal mandate or have required a waiver of certain aspects of the requirement. Under current law, states unable to procure a RAC must seek CMS's permission to waive the statutory requirements.

In the past few years, 25 states have sought waivers for procurement care issues and the low volume of fee-for-service claims. The time limit of waivers are granted for a two-year period in which time the states must require to resubmit a waiver request with an updated justification.

For many states, the RAC program has become an administrative burden due to the time and resources it takes to solicit a vendor, manage procurements -- many of which have failed -- and prepare waiver applications and renewals.

Under this recommendation, CMS would no longer need to review waivers of this requirement. The CBO estimates that making the RAC program an optional state activity would increase federal spending by a modest amount, less than $50 million over one year and less than $1 billion over five years, which is the lowest range for a policy change that would affect federal spending.

This recommendation would give states the option to determine if they want to implement a RAC program under the terms they choose to outline in a state plan amendment. They would no longer be required to procure a RAC vendor or pursue a waiver if they are unable or unwilling to implement a RAC program. As a result, some states would be relieved of the administrative burden associated with the waiver application process for a mandated PI activity.

While it is unlikely that this change would have any measurable effect on beneficiaries, reduced state administrative burden may free up resources that could be directed to Medicaid beneficiaries.

For providers, removing the RAC mandate may result in the elimination of the RAC program in some states. This may, in turn, reduce the burden on providers with fewer claims, requests, and audits. There would be no change for providers in states continuing to use a RAC, presumably. And we don't expect a measurable effect on MCOs under this recommendation.

This concludes my presentation for today. I look forward to any feedback you have on the chapter on the two proposed recommendations. The plan going forward is to

have a vote on these two recommendations this afternoon and incorporate into the June report.

VICE CHAIR LAMPKIN: Thanks, Jessica. This is great.

As I said before, this is not new territory for the Commission. It's a little bit more informed territory for the Commission with the study that Jessica referred to and that we're building off here.

As we left things in March, we had some wording changes for that first recommendation, but everybody seemed to be pretty much in the space where we were comfortable making recommendations in these areas, I think. So I think the focus of our conversation here is around the wording of the recommendations, the rationale, and then chapter feedback.

I will kick us off but also definitely want to hear from others here.

I think the chapter is great. I would suggest a couple, maybe, of additions. I'd like to see us maybe emphasize a little bit more strongly that this is not the first time that we've commented in this territory. We do allude to it in the draft.

And I don't know exactly what that looks like, Jessica, but just a reminder that this is something that the Commission has felt is important that HHS has an important role to play in assisting states in this kind of way.

MS. MORRIS: Sure.

VICE CHAIR LAMPKIN: And then, also, as I review the chapter, there are two or three places where we make reference to encounter data or managed care, almost as a side thing. I wonder if it makes sense to bring home a little bit more maybe in the part of the chapter where we're talking about the federal government role. That part of what may come out of this may be improved understanding of which of these mechanisms should sweep across both fee-for-service and managed care or be primarily fee-for-service with delegation to managed care, something like that, see if there's a role of managed care as part of what could come out of this.

Then on the rationale, I wanted to suggest that we emphasize the resources that go into this process. Today, we bring that up several times, as we receive the different mechanisms, that something is very resource-

intensive or the states don't have the staff and they have to contract it out and so forth.

While we may not be able to put a dollar amount on the expenditures the states make to pursue program integrity, it is resource incentive, and for that reason as well as the others listed, it's important to make sure we're driving towards cost-effective solutions and ones with a return.

MS. MORRIS: Thank you, Stacey.

VICE CHAIR LAMPKIN: Okay. Penny?

CHAIR THOMPSON: Yeah. I just wanted to make a few, and I agree with Stacey about the fact that I think this is very consistent with where we've been taking these conversations. I am primarily going to comment on this first recommendation and this language.

I agree about directing this to the Secretary. I think it could be useful in the discussion to discuss how the Secretary could use resources in the Department other than CMS to help carry this out, including the OIG and some of the Assistant Secretaries for planning the evaluation and finance, and so it may be worth bringing that into the picture so that we encourage the right kind of

collaboration in the Department about how you go about doing this.

I think it's really important when we talk about success, and so I like that we're using the word "success" instead of, for example, "return on investment," because I think success is more than just strict return on investment.

I'm a little concerned that when we talk about beneficiaries, for example, here, we're talking about them as not really having an effect other than they benefit from a program that has greater integrity.

Some of the efforts that we discuss about program integrity place burdens on beneficiaries, just as they do sometimes place burdens on providers. So I think that we ought to highlight the idea that those burdens ought not to be excessive to the point of impeding access and impeding other benefits without demonstrating that they're necessary and that they are creating these other returns and without evaluating whether there are less administratively complex and burdensome ways to get to the same point.

So I think that's something that I would like to see us strengthen the discussion about. It's not just

about did you do something, did you get recoveries, which I think is what this kind of state of play is today. It's how people look at this: I spent some money, and I recovered some dollars. We're not getting good visibility into understandings of prevention and avoidances. We're not getting good information on administrative costs and impacts on providers and beneficiaries. We're not getting good information on alternative methods and how to take advantage of new technologies.

When I say new technologies, I'm not just talking about what a lot of people talk about, big data or something like that. I'm talking about how do you get and receive information from providers and how do you make it easy to respond to questions or provide documents if you're a beneficiary and so forth.

So I do think I would like to see us really strengthen the idea that we don't want to just encourage a big effort about going in and collecting some data on recoveries. That is not what we're talking about here.

The other element that I would like to see us build up in the rationale and maybe in the chapter is we spend time talking about methods, which are kind of a

hybrid mix of contracts, approaches, and techniques. We really do need to bring in the other layer here, which is about the program areas' focus and risk.

So I would like to see us talk about it's not just about the approach that you use; it's also about whether you aimed that approach towards a program area that was vulnerable or had risk. Some of the techniques would be good and useful and successful, according to our criteria, when we talk about certain program areas, but not when we talk about other program areas. And I think maybe that pulls in the managed care concept. So I would just like to see us sort of introduce that point.

Then, finally, I just wanted to make -- as I've talked about before because of my consulting practice and client relationships, I'm going to abstain and just stay away from the second recommendation.

But I did want to just ask. We say something about it was made mandatory for all states based on the favorable experience of a few states. Is that true?

I thought the legislative history was that -- I mean, yes, some states had used contingency-based contracts, but I thought it was also about the fact that it

was a requirement being placed on Medicare as well as Medicaid.

MS. MORRIS: Yeah. I think those few states were predominantly a Medicare practice, that they started testing it out there, and it was successful. And then it was brought in for Medicaid.

CHAIR THOMPSON: It was my memory, but check me on this. It was my memory that it was like a lot of that conversation initially was about Medicare and focused on testing Medicare and what was the experience of Medicare, and Medicaid kind of got brought alongside of that, rather than what I think it reads now, as though some state Medicaid agencies did some things, had some success, and then it got expanded.

MS. MORRIS: Sure. We can clarify that.

CHAIR THOMPSON: But whatever the factual matter is.

MS. MORRIS: No, I think you're correct, and I think we just need to make sure we tighten that up so that it was clear --

CHAIR THOMPSON: Okay.

MS. MORRIS: -- that those pilots were in the

Medicare program.

CHAIR THOMPSON: Okay. So I think that's another -- you know, it helps make the case that maybe this isn't the right fit because states have some different considerations.

VICE CHAIR LAMPKIN: Darin.

COMMISSIONER GORDON: I agree with a lot of what Penny said with regards to chasing the ROI because there is some impacts that are hard to capture in this process, and we've seen that. So they have to look at it more broadly than that, the sentinel effect that does occur when you implement some of these programs and policies.

On Recommendation No. 2, I was just curious, and your response may be similar to Chris' response earlier about CBO's estimate, even though you highlight that it was one of the lowest -- it's the lowest range they do for policies.

MS. MORRIS: The lowest.

COMMISSIONER GORDON: I'm just curious if they've given any context for even saying that there would be an expense. I mean, a recommendation is if states -- well, today there's waivers. Today there's states that can't get

anybody to do it, and if we're saying now it's optional, presumably those who feel they're getting something for it will continue to do that. The states who aren't doing it and are getting these waivers will presumably not do it.

MS. MORRIS: Right.

COMMISSIONER GORDON: Did they give any context why they thought there would be an expense at all?

EXECUTIVE DIRECTOR SCHWARTZ: I'll take that.

I mean, I think they take a strict look at when a requirement exists on the margin, even if there are states that are having trouble now and aren't doing it, if there is a requirement, more states are going to do it. And, presumably, there's some activity in recoveries associated with that.

They don't give us any more insight into their analysis other than that, but I think you can't just look and say that the states that are doing it now would continue to be the ones who would be doing it in the future if it's made optional.

COMMISSIONER GORDON: Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: And we also don't know in that bucket, $50 million in a year. It's like

between zero and $50 million.

COMMISSIONER GORDON: Yes. That's the range.

EXECUTIVE DIRECTOR SCHWARTZ: So I don't know. It could be 2; it could be 47. When there's legislative language for Congress, they will give it a more precise score.

COMMISSIONER GORDON: Okay, yeah. I wasn't reading that into it, that presumably the states that are doing it will continue to do it and those who don't would be the ones that would opt not to. But I was just trying to get a sense of if that gave any added context to that, and I do appreciate that it is a range. I was just trying to think through what might likely be the reaction by a state. And putting back on my state regulator hat, I was thinking that, you know, if I felt either through direct success of collections or the sentinel effect that it had, that there was value to it, then I would continue it. And if not, then that's when I was discontinue it. So I was just trying to think through if they had given some broader context to that, how they think states might react to it. But that's helpful, Anne. Appreciate it.

EXECUTIVE DIRECTOR SCHWARTZ: I mean, I think

when you remove a requirement, you create the opportunity for states to stop doing it.

COMMISSIONER GORDON: Yes, that is a very accurate statement.

[Laughter.]

COMMISSIONER GORDON: If it's not a requirement, then a state may not do it. Yes, that is accurate.

VICE CHAIR LAMPKIN: Okay. Chuck and then Alan.

COMMISSIONER MILLIGAN: There are times when states don't do requirements, too.

[Laughter.]

COMMISSIONER MILLIGAN: My comment is going to be a little bit out of scope, I think, and, Penny, it goes back to the beneficiary impact comment. And I was just sort of thinking about really the beneficiary impacts in the audits that I was kind of part of when I was in a Medicaid director role. It often involved home and community-based services, and it often involved where a federal OIG took issue with what CMS approved and a state implemented. And it resulted occasionally in big disallowances, which resulted occasionally in cutting programs back.

This focus has been on the state program integrity activities. I think that's appropriate. So I'm not really commenting so much on that.

I do think that it would be useful to have a review conducted about where the federal HHS OIG and CMS need to get better aligned because states are implementing what CMS has approved often, and then OIG will come in after the fact and say CMS exceeded its authority in approving that or it's not in compliance with federal statute.

I do think that if we take the lens out a little bit -- and, again, I haven't made this comment in previous meetings. I hadn't really thought about it in previous meetings. But to me, if it was possible to omit the word "state," just conduct a rigorous examination of current program integrity activities, to also look underneath that particular issue, I think it would be an improvement because there is an intra-HHS issue here with how we evaluate program integrity. But if that's out of scope, I don't want to kind of derail or distract from the utility of this particular recommendation.

MS. MORRIS: I just would highlight that we

didn't look at federal program integrity activities, though I definitely agree that there are federal activities at the OIG level that work with the states. So I would defer to the Commission on that.

COMMISSIONER MILLIGAN: And, you know, at this stage of the game, it's probably not the right time to try to add scope here. But I think it would be something maybe worth coming back to because, again, to me the most problematic beneficiary impact audits were initiated by federal OIG, taking issue of what CMS had approved.

VICE CHAIR LAMPKIN: So, Chuck, you're comfortable with us actually picking that up as a later topic that we can flesh out a little bit more?

COMMISSIONER MILLIGAN: Yes, I am.

VICE CHAIR LAMPKIN: All right. Alan.

COMMISSIONER WEIL: I'm very comfortable with the content here. I have a comment sort of on tone, and it ties in, Penny, to your appreciation of moving from ROI to success. I think the chapter still reads very much -- at least there are places where it reads to me as a little bit negative towards states' inability to calculate ROI as if they should be able to do so. And I think that was sort of

our hypothesis. It's not their hypothesis. And so the language that makes it seem that they're falling down on the job or they're unable to set priorities because they can't calculate ROI feels to me like a misplaced sentiment. I mean, I can be more specific, but there's sort of one paragraph that really jumps out, and then it filters through later on when you go through item by item, and it sort of says can't do this, can't do that. And I'm sort of like, well, but they don't want to, and there are reasons they don't want to, and we even understand the reasons they may not want to, or it might not be the right metric. So I just think it steers the discussion a little bit back in a way that our recommendation is moved on from.

VICE CHAIR LAMPKIN: Any other general comments or comments on the wording of Recommendation 1?

[No response.]

VICE CHAIR LAMPKIN: Everybody's comfortable with the direction to the Secretary instead of Congress? That was something that we talked about last time.

[No response.]

VICE CHAIR LAMPKIN: Okay. Any other comments on the rationale related to 1?

[No response.]

VICE CHAIR LAMPKIN: All right. Now, Recommendation 2, the wording didn't change from March. Anybody have any new concerns about the wording here?

[No response.]

VICE CHAIR LAMPKIN: Any comments about the rationale or the way this recommendation is discussed in the draft chapter?

[No response.]

VICE CHAIR LAMPKIN: It looks like this may be the session where we -- oh, yes, of course. We may still make up time, but we do need to hear from the public. Any public comments on this topic or these recommendations?

PUBLIC COMMENT

* [No response.]

VICE CHAIR LAMPKIN: All right. We'll vote this afternoon.

CHAIR THOMPSON: Great. Thanks, Jessica. Thanks, Stacey, for leading us through that.

All right. We're going to finish off the morning reviewing recommendations for this afternoon with discussion by Martha about our June report chapter on

therapeutic foster care.

REVIEW OF RECOMMENDATION FOR JUNE REPORT CHAPTER ON THERAPEUTIC FOSTER CARE

* MS. HEBERLEIN: So thank you. As Penny said, at this meeting we're going to conclude the Commission's work in response to the congressional request to examine the merits of a uniform definition of "therapeutic foster care" in Medicaid.

So as a reminder, Kate presented the draft chapter that will serve as the Commission's response at the March meeting, and so this presentation builds on that session with a vote on a recommendation directing the Secretary of the U.S. Department of Health and Human Services to more clearly inform states of their options related to Medicaid coverage of therapeutic foster care services.

So I will begin by briefly summarizing the Commission's past discussions. I will then present the draft recommendation, the rationale, and the elements of guidance before concluding with potential implications.

So at prior meetings, Commissioners discussed the importance of the services provided under therapeutic

foster care and how they benefit a vulnerable population. The Commissioners also noted that the services provided under therapeutic foster care should meet the diverse needs of children and that a continuum of services provided by multiple agencies may be necessary and appropriate, depending upon the needs of the child.

The recommendation that you will vote on today is based on the view the Commission expressed at the March meeting that additional guidance could help states provide therapeutic foster care services within the existing Medicaid statute without restricting future practice changes or limiting state flexibility.

So the draft recommendation reads as follows: The Secretary of Health and Human Services should engage the Centers for Medicare & Medicaid Services and the Administration for Children and Families to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

The rationale for this recommendation is that further direction from the Secretary could help provide important clarification to states on how they can use the benefit design flexibility already afforded them in Medicaid to cover therapeutic foster care services. Guidance could also provide states examples of what can be considered a Medicaid-financed service and what is the responsibility of another agency, such as child welfare.

This additional information could assist states in better understanding what services can be covered and how, while still leaving flexibility for states to operationalize the benefit and for the practice of therapeutic foster care to evolve over time.

The subregulatory guidance should be developed jointly by the Centers for Medicare & Medicaid Services, which administers the Medicaid program, and the Administration for Children and Families, or ACF, which administers federal child welfare programs.

Children in need of or receiving therapeutic foster care services are typically served by multiple agencies, including Medicaid and child welfare, as well as juvenile justice, behavioral health, and education. While

not all these children are in child welfare custody, state child welfare agencies are typically responsible for certifying therapeutic foster homes, and federal child welfare funds may pay for living expenses such as room and board, administrative costs, and the recruitment and training of foster parents.

In making this recommendation, the Commission points to other instances in which multiple HHS agencies have collaborated to provide subregulatory guidance. For example, CMS and the Substance Abuse and Mental Health Services Administration previously released joint informational bulletins that described Medicaid coverage of behavioral health services for children with significant mental health conditions or substance use disorders, including the services that can be offered under existing authorities and state examples how those authorities were being used.

So the following elements of the guidance are included in the rationale that will accompany the recommendation. We're obviously open to suggestions on what elements should be included but wanted to note that, unlike the recommendation, you will not be voting on the

exact wording of these.

So based on Commissioner discussion, such guidance should clarify which therapeutic foster care services can be covered under Medicaid and which services can be provided using federal child welfare funds under Title IV-E, and describe how these funding streams can be blended together to serve children.

The guidance also should include examples of current state approaches to providing therapeutic foster care using Medicaid funds. The guidance should highlight the use of evidence-based practices and trauma-informed services, as well as other promising practices in therapeutic foster care and parent recruitment, training, and retention.

Finally, the guidance should provide ways to effectively coordinate with other agencies serving the same high-need children and youth, including child welfare, juvenile justice, education, and behavioral health agencies.

So as for the implications of the recommendation, as it is clarifying existing policy, it would not have a direct effect on federal Medicaid spending. The additional

guidance may assist states in designing a benefit package to address the needs of children with complex behavioral health or medical needs in the least restrictive setting possible.

It also could clarify which services can be billed to Medicaid and which are the responsibility of other agencies and how best to coordinate these services.

For beneficiaries, the guidance may help them and their families understand what Medicaid services may be available to meet their needs. And as for plans and providers, this recommendation may assist them in understanding appropriate coverage and billing practices for therapeutic foster care and the responsibilities of the various agencies.

So, with that, I will leave you with the draft recommendation, and I look forward to your discussion.

CHAIR THOMPSON: Thank you, Martha. I think that what you've presented here is very consistent with what we discussed in the last meeting, and I was also reading carefully the public comments that we got from the Family Focused Treatment Association, which I was very appreciative of.

I'm going to ask Peter to kick us off on the conversation.

COMMISSIONER SZILAGYI: Sure. Excellent job, Martha, and Kate at the last meeting.

Actually, I have very little to say. I think, by the way, the chapter is really excellent, has evolved, I think, with the comments of Commissioners and experts and was very good. And I think this draft recommendation threads the needle really well between not coming up with a definition of "therapeutic foster care" -- and as we had talked about at length, there's very good reason to not have a clear definition of "therapeutic foster care." It's really hard to define the population, and it's really hard to define exactly what kinds of treatments they should get, and it might limit states. So what's really needed for this population is not so much a definition but examples -- well, clear guidelines for what could be covered under Medicaid and good examples -- this is a group of providers across states and organizations across states that are really looking for best practices. And so I think giving examples of what states are doing is a really good idea and trying to move states toward the most modern and evidence-

based, trauma-informed care is the right way to do it.

So I think the draft recommendation and sort of the guidance is really the right approach.

CHAIR THOMPSON: Any other comments by the Commissioners on the wording of this recommendation?

[No response.]

CHAIR THOMPSON: I'm going to pause for a second while you contemplate that and see if there's any members of the public that would like to provide us comments before we close this conversation?

PUBLIC COMMENT

* DR. BOYD: Thank you, Madam Chairman and Commissioners. My name is Laura Boyd. I'm the public policy director for the Family Focused Treatment Association, and I simply want to thank you for your work, your thorough work in this, and the recommendation. We look forward to serving these very difficult kids. They are coming more and more, as you know, into our service needs. And, again, we just simply want to thank you.

CHAIR THOMPSON: And thank you for your comments and your ongoing work with these populations. Thank you.

Kit and then Chuck.

CONTINUATION OF DISCUSSION

* COMMISSIONER GORTON: So I just want to react to something that Peter said because he said it very crisply, and I don't recall that the chapter does it as crisply. The charge from Congress is do we need a definition. Our conclusion, as Peter said, was we think a definition is not helpful and might actually be harmful.

I don't know that we came right out and said that in the chapter. Maybe I missed it. But maybe we should, you know, somewhere early on lead with that response, that we don't see the point at this -- we not only don't see the point of developing a uniform definition right now, but we do, in fact, see downsides to doing that, for example, blah, blah, blah. I think that might be worth being explicit about.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: I just wanted to thank you, Dr. Boyd, for your letter that you sent. You know, and for everybody who reads the transcript or attends these meetings, we do get the letters that get submitted, and we do read them. So I thought the letter that you sent in was very helpful to this process. So I want to acknowledge the

commenters who take the time to write us.

CHAIR THOMPSON: Okay. Any further commentary?

[No response.]

CHAIR THOMPSON: Kit, you're not suggesting that we have a recommendation not to have a recommendation, right? You're just saying that we --

[Laughter.]

CHAIR THOMPSON: We would say this is our recommendation and that we actually considered but rejected the idea of a definition for some of the those reasons; instead we think things should, et cetera. It's a rationale.

COMMISSIONER GORTON: Rationale.

CHAIR THOMPSON: Just to clarify that point.

All right. So I think we'll settle on seeing this language when we get back in the afternoon. Thank you, Martha.

One last moment for any comments from the Commissioners or the public before we adjourn for the morning?

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: We are scheduled to be back in public session at 1:30, and I think based on how we did on the schedule, we actually were behind, and then we got ahead. So I think we'll stick with 1:30 for reopening the public session, and we'll see everyone then. Thank you.

* [Whereupon, at 12:02 p.m., the Commission was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

[1:32 p.m.]

CHAIR THOMPSON: Okay. We will go ahead and pick up for our afternoon session, and first up in our agenda is John Wedeles who is going to talk to us about the study on utilization management of MAT, which was a study provided for in the SUPPORT Act.

I want to alert the members of the public that the study is due October 24th, so because of the nature of our cycle and timeline this will be the primary point of public discussion. John will be providing the preliminary findings that we have here but work will continue on into the summer, but given the due date it will be unlikely that the Commission will be able to engage in any kind of public discussion in advance of needing to print and publish the report to the Congress.

So we do have some time set aside in the agenda today to go over the results thus far, but I want to encourage the Commissioners and members of the public to say as much as they would like about both what John presents this afternoon and also any other parameters or issues that should be considered in the context of our

response to the Congress.

So with that let me kick it off to John.

PRELIMINARY FINDINGS FROM CONGRESSIONALLY MANDATED STUDY ON UTILIZATION MANAGEMENT OF MEDICATION-ASSISTED TREATMENT

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

The purpose of this presentation is to provide an update on preliminary findings from our analysis of medication-assisted treatment, or MAT, utilization management policies in state Medicaid programs. Our presentation builds upon the discussion of MAT at our January meeting, where we heard from an expert panel of providers and payers on how certain utilization management policies are affecting access to treatment. I will also discuss next steps regarding additional research and submission of the final report to Congress by October 24th of this year.

As background, the SUPPORT for Patients and Communities Act, also known as the SUPPORT Act, requires MACPAC to conduct a study of state Medicaid utilization control policies for MAT and consider the potential effect

of these policies on access to MAT.

As a refresher, MAT is an evidence-based form of treatment for both opioid use disorder and alcohol use disorder, and includes both medication and supplemental psychosocial counseling. However, as noted in our accompanying memo in your materials, and by the expert panel convened at our January Commission meeting, barriers to access for MAT exist for a variety of reasons, including stigma around SUD and medications, concern related to misuse, federal rules restricting prescribing to certain provider types, and utilization management policies.

Consistent with statutory requirements, our study consists of three components. First, identify quantity limits and refill limits on MAT medications, primarily using the findings from a 2018 SAMHSA study on Medicaid coverage of MAT; second, a deeper review of additional utilization control policies in eight select states; and third, determine whether managed care utilization management policies and procedures are consistent with federal regulations that allow MCOs to place appropriate limits on services for the purpose of utilization control.

Our preliminary findings indicate that MAT

utilization management approaches vary by state and by type of medication. Some states apply additional restrictions beyond best practices, such as requiring prior authorization for certain preferred MAT medications. This may be confusing to beneficiaries and providers, lead to excessive administrative burden, and create barriers to treatment.

On the other hand, fewer states are imposing lifetime limits compared to prior years. In addition, most of the eight states we reviewed allow patients to receive MAT medication without requiring supplemental behavioral health counseling.

The utilization management approaches we will be discussing further today include prescription co-payments; prescription drug monitoring programs, or PDMPs; preferred drug lists, or PDLs; prior authorization; retrospective drug utilization review; and limits for counseling services. It is important to note here that certain approaches affect access to care differently, particularly initial access to treatment.

In terms of prescription co-payments, for most states MAT drugs do not appear to be subject to different

co-payment amounts. However, in Maine, patients have a separate co-payment structure for methadone, in which co-payments are slightly lower compared to other types of drugs. We also found that certain beneficiaries in Illinois and Washington State are not subject to co-payment for any covered prescription drugs.

With regard to prescription drug monitoring programs, or PDMPs, nearly all of the eight state Medicaid programs we reviewed have access to their PDMP, but several states reported challenges in using these programs to effectively monitor prescribing patterns. For example, in Illinois, Tennessee, and West Virginia, providers can only view one patient at a time.

I will also note that the SUPPORT Act included two provisions to address access to and use of PDMPs for monitoring drug prescribing and use patterns. Specifically, the law clarifies that in states where Medicaid agencies are permitted to access PDMP data, the agency may share and facilitate access to data for Medicaid-enrolled providers and Medicaid MCOs. In addition, effective October 2021, providers will generally be required to check a qualified PDMP before prescribing

Schedule II controlled substances to a Medicaid beneficiary.

In terms of preferred drug lists, 49 states -- excluding Kansas -- and the District of Columbia cover at least one form of MAT medication with preferred status. All of the states we reviewed have at least two MAT medications with preferred status. Of note, Illinois covers all MAT drugs with no prior authorization, including those used to treat both opioid use disorder and alcohol use disorder, which should promote access to these drugs.

In contrast, Arkansas, Tennessee, and Utah have policies in place that require prior authorization for certain MAT medications, despite being preferred drugs.

As just discussed, a state's preferred drug list often dictates which drugs require prior authorization. Generally, prescribers need only seek prior authorization for non-preferred drugs. However, in some instances, a drug may still require prior authorization even if it has a preferred status. There are several types of requirements that may accompany prior authorization, such as documentation or results of drug screening tests, attestation to PDMP use, or tapering plans.

At the January meeting, Commissioners expressed an interest in including retrospective drug utilization review in our analysis. Retrospective drug utilization review is used in all eight states we reviewed, although for most states it is unclear how these reviews are applied specifically to MAT drugs. We did find documentation that Washington State uses retrospective monitoring to examine whether expanding access to a particular form of MAT -- in this case, intramuscular naltrexone, had an effect on uptake.

Most states we reviewed do not require referrals, co-payments, or prior authorization for MAT counseling sessions, which should promote access to these services. As noted, Illinois has no limit to outpatient visits under fee-for-service, but prior authorization is required for more than 20 visits in managed care. In Arkansas, prior authorization is required for more than 12 visits and referral from a primary care provider is required after 3 counseling visits. In Maine, behavioral therapy is limited to three hours per week for 30 weeks in a 40-week period.

We reviewed Medicaid managed care contracts to determine whether utilization control policies for MAT are

consistent with federal regulations that allow MCOs to place appropriate limits on a service for the purpose of utilization control, provided that the services can reasonably achieve their purpose and are sufficient in amount, duration, and scope. Washington State was the only state we reviewed with managed care contract language that included utilization review for SUD treatment, although it does not specifically mention MAT. As noted in the accompanying memo, it is likely difficult to monitor whether MCOs are adhering to this contract language.

In terms of next steps, staff are continuing to verify state-specific policies on utilization management of MAT. The final report will include background information on MAT, that was shared with you in January, and additional details on national and state policies. Again, given our public meeting schedule and the statutorily defined submission date, this will be the only public meeting that we will use to review the report.

This concludes our presentation and preliminary findings on MAT utilization management policies. We welcome feedback from Commissioners on these findings and the proposed direction for the final report.

CHAIR THOMPSON: Thank you, John. Martha, I am going to ask you to kick off our conversation on this.

COMMISSIONER CARTER: Thank you, John, for this really good overview. I am going to try to synthesize my thoughts here.

I think that what we've got is really good. I would like to see additional information on how these policies actually affect patient access to timely care and how these policies actually affect administration of -- are we using M-A-T or MAT? What is the preferred --

EXECUTIVE DIRECTOR SCHWARTZ: When you write it down it doesn't matter.

COMMISSIONER CARTER: Well, I will say M-A-T -- how these policies actually affect the ability of practices on the ground to administer MAT programs.

Just a little bit of background. We know that opioid addiction is a chronic disease that is characterized by multiple relapses. We also know that buprenorphine, Suboxone, is generally not the primary drug that people are using. They are using Suboxone on the street to avoid being dope sick.

So all the policies that are around control of

Suboxone access -- I mean, there are some good reasons to, say, have a pharmacy lock-in, but those are more germane, I think, to the fact that the Medicaid program doesn't want to support the black market, and, you know, pay for drugs on the street, rather than as a public safety issue. It's possible but very difficult to OD on Suboxone. In our experience, in the program where I was CEO, we have not had any patient who came in with a primary, where their drug of choice was Suboxone. I mean, they came in -- they were using Suboxone because they got it on the street because they were trying to treat themselves. So it is a different way of looking at Suboxone usage that I think is really germane to some of these policies.

So I think there's some potential access problems with pharmacy lock-in. You know, again, I understand why some of that is there, but these drugs are different than pure opioids in terms of their overdose possibility, and, you know, they do have street value, so that's the reason to control them.

But, you know, for example, you could -- instead of a lock-in you could require PDMP access, that the provider checks a PDMP before prescribing, and take that

burden off the patient. I want to note that I've read a couple of things that there are some Part 2 problems with this whole issue, and I think that's important for us, in the big picture, to remember.

You know, we had it happen in our program that the pharmacy ran out of the drug, that in a new program the pharmacies in that community weren't geared up to supply buprenorphine, or Suboxone. And so putting that burden on the patient is, I think, not the best way to go, especially for a drug that doesn't have, you know, a public health danger.

I want to talk a little bit about counseling requirements and prior auths. I just think that there needs to be somehow more protection for the patient when breakdowns occur, because there is always something that goes wrong. So, you know, the pharmacy isn't open, the counselor isn't available, and so there needs to be, again, more protection for the patient.

And that gets into difficulties of the practices in running these programs, because they are the ones that are mainly stuck with the compliance tracking for especially like counseling requirements or any sort of

prior auths for that kind of thing, that that puts a burden, a staffing burden, a cost to that program and may limit practices' interest in expanding or opening new programs or opening new groups, because of the additional administrative burden.

I think there were some really good comments in the letter that we got from -- I'm going to butcher it so I don't know how to say this -- Alkermes -- somebody hear from them? -- that I really can't speak to a buy-in bill for -- I think I've seen that in Vivitrol program where the patient actually -- somebody has to pay for the medication before it can be administered to the patient.

So I think there's a lot of opportunity in what we're working on to examine in more detail how these policies affect patient access and reduce access because of the administrative burden on MAT programs.

CHAIR THOMPSON: That's some great commentary, and, you know, some of that, in a less sophisticated way, I had some of the same comments, almost similar to the kind of conversation that we had this morning around, you know, program integrity and other things, which is, you know, if we are discussing something like a prior authorization

program, those can look very, very different, in operation and on the ground, based upon the policy objective, what they're trying to achieve, and the match of the process to that policy objective, and how they are operationalizing that, in actuality.

And so I think those are important details to understand how these things actually play out for both beneficiaries and providers. So I think that a lot of the comments that, Martha, you have made here will really help direct some of the future work in a way that will really be extremely helpful, as you mentioned the public comments that we receive.

Can I ask a quick question about PDMPs? I continue to be confused about this and I don't know if I just keep forgetting the facts or if I'm never clear on them.

I do know and understand how it is that a state cannot have access -- a state Medicaid program cannot have access to a PDMP. How does that happen? Oh, Darin, or Chuck, okay.

COMMISSIONER GORDON: So when we first went down that path to get a database there was a lot of concern over

who all would have access to that information and what their uses may be, from the legislature, and some from the medical community as well. But, you know, some of the legislators said, you know, what if someone politically was going to misuse that information to target folks? So they wanted to continue to restrict the access and made it super tight.

For the longest time we, as a Medicaid agency, could not be included in that after it was out in the system, and we were able to get more and more use cases to how just the existence of it but not having access to us as a major payer was creating some challenges. There was some slight opening-up of that, but it is very piecemeal.

So I think eventually there is growing comfort but the whole concern was this is information that is very private and some individuals may misuse that information and, therefore, we are going to restrict it as tightly as humanly possible, but over time we were able to convince them to start opening up. But it is still not from a practical application perspective.

I mean, so I will tell you, the very next step was they allowed our pharmacy director to have access to

it, to look individuals up. We had 1.5 million individuals on our program --

CHAIR THOMPSON: Yeah. That's not an answer.

COMMISSIONER GORDON: -- and what we did to try to make sure -- you know, to do the best we could in that situation, when the prior authorizations would come in for a controlled substance, not looking at it in this context but a controlled substance in general, they would ask the prescriber if they checked the database, as was required, and they said yes. Well, eventually we were able to have those staff actually be able to look up, and so they continued the process we had previously. Have you looked in the system, and they said yes, and then they said do you see anything, and they said no. And they were able to pull up and they said, well, did you see that this individual had gotten it here and here and here?

So it really did prove our point that it was -- just being in existence wasn't helpful. It actually has to translate to where the agency can incorporate it into its process to ensure that it's actually being used effectively.

CHAIR THOMPSON: Chuck, did you have another?

COMMISSIONER MILLIGAN: Just the same comment. I would make it a little bit differently. In some states, it's focused on the practitioner and not on a program, and so, in some states, the expectation is that the prescriber is going to be doing the look-up and that it's not at a program level. It's a practitioner-based, patient-based model.

In New Mexico, our health plan similarly didn't have access, and it was just our chief medical officer expected to do it one at a time because she was a licensed physician.

In some states, they don't treat it as a programmatic issue. They treat it as an individual practitioner licensure-type issue.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: Penny, as sort of a corollary, what I don't understand is why every pharmacy isn't required to enter medications in the PDMP. That is absolutely not the case.

So even if you look up a patient in the PDMP, they might have gotten a prescription filled that was never recorded.

Again, some of this goes back to Part 2, concerns about, I think, some pharmacies are concerned about entering that medication or think that they shouldn't because they have to have patient permission.

So it's kind of a mess, and just looking at the PDMP isn't sufficient.

CHAIR THOMPSON: And I think the other thing that we can draw out about that, all of these are different ways of trying to get at monitoring an appropriate treatment. So, to some extent, if you make the PDMPs less of an available mechanism, then maybe you have to compensate for that by other administrative processes, and what does that mean? And I think that's where we can really begin to help people understand some of the tradeoffs, some of the actual operational practices and choice points and what some of the tradeoffs are of all of that.

Chuck and then Kit and then Brian.

COMMISSIONER MILLIGAN: Yeah. I mean, Penny, when you describe it that way, to me there is a very analogous policy around Part 2 and confidentiality, which is we are going to err on the side of confidentiality. We're not going to err on the side of kind of programmatic

line of sight, like limited use.

So I do think the more we kind of get into a lot of -- there's a lot of commonalities in patient base and a lot of commonalities in kind of dealing with substance use, and I think it pulls through the Part 2 issue as well.

CHAIR THOMPSON: The last time we discussed Part 2, there were certainly a number of Commissioners who thought it was time to kind of go back and rethink some of those things.

I think I had Kit and then Brian.

COMMISSIONER GORTON: So I want to look at this from a slightly different perspective.

I do think there's one piece that we haven't talked about that we should include in the analysis, and I thought Martha was going to go there, but she didn't quite get there. And that is the federal rules around who can prescribe this stuff and the limits on the number of patients they can prescribe it to because that's -- you might not call that a utilization management technique, but in fact, the federal government's role in restricting the ability of prescribers to prescribe this stuff is a substantial barrier that we heard from the panel and that

we've heard from other communication. So I think that should be in here to point out that not all of this happens at the states or at the plans.

I said a little bit this morning about utilization management and prior authorization, and I just want to revisit that now.

Yes, substance use disorder is a chronic relapsing condition, and yes, some of the treatments for it are subject to utilization management controls, including prior authorization. The same is true for diabetes. The same is true for heart disease. The same is true for asthma. The same is true for cancer. The same is true for virtually all chronically relapsing conditions.

Why do we use these controls? For a variety of reasons: in part for patient safety reasons; in part to prevent diversion and law-breaking behaviors that Martha was talking about; in part to control program costs; in part as a check and balance on the prescriber community, some of whom are wonderfully good at prescribing stuff and some of whom could use a little bit of work, so there's quality control. So there's a whole variety of reasons why people employ these utilization management controls in

these programs.

Nobody does it because it's fun and entertaining. I'm here to tell you these are not fun tools to operate with because nobody likes them. Everybody hates them, even the people who have to use them. We use them for a purpose. Can they be used badly? Can they be used heavy handedly? Yes, they can. But you can run people over with your car. We don't suggest that maybe cars are a bad thing.

I think the Commission, sometimes inadvertently, the tone becomes very anti-utilization management. I think this charge from Congress had some elements in its tone about whether utilization management is a good thing or a bad thing, and I would simply underscore that it's a tool. And we used it in a lot of different stuff, and we need to be very, very careful that we don't in some way impair the use of this very important tool because the Medicaid program becomes a very different animal if there is no utilization management.

And I don't think -- I know there are people who believe that the elimination of utilization management in Medicaid and in fact in all third-party coverage would be a

great thing because then doctors would just be left alone, and patients would get what they need.

We can't afford that system. The quality of that system is not anything that we would aspire to, and I don't think -- as awful a disease as substance use disorder is, I don't think there is any reason to exclude substance use disorder from the other list of chronic relapsing conditions, many of which are also life threatening and have severe impacts on people's quality of life.

I have not heard of what I feel is a legitimate rationale for treating substance use disorder differently, and I think it's important in our report to say, "Yes, these things exist for substance use disorder, but they exist for everything else." If people want to have a broader conversation about whether or not in this country we should stop using these tools, then, okay, let's have that conversation.

But the tools are available for a purpose. They are permitted by law. They are permitted by both statute and regulation, and I don't think we as a Commission should be throwing shade on that.

CHAIR THOMPSON: Are you rebutting?

COMMISSIONER CARTER: Yes.

CHAIR THOMPSON: Okay. So Martha is coming in to have her say about this, and then we'll take that up.

COMMISSIONER CARTER: So I want to clarify, but I wasn't saying that we don't need to have utilization management. I want to make sure that there are clear protections for the patient when breakdowns happen because they always happen, and I don't think that's communicated. If they are policies, they are not communicated clearly to patients or to the prescribers or to the practices about what to do.

I think this has come up actually in other things. How do you get an exception? If you're locked into a pharmacy, what do you do if the pharmacy closes down overnight? It happens.

So just make sure that there is a strong recommendation that the patients are protected in the context of utilization management.

COMMISSIONER GORTON: So I'm 100 percent in favor of beneficiary protections, and the things need to be run well. I am no fan of poorly run programs of any sort, and that includes utilization management programs. And none of

the programs -- commercial, Medicare, Medicaid -- communicate as effectively with their beneficiaries as they probably should, in part because the programs are so complex and arcane.

I mean, we have people like Kisha and Peter sitting at the table sometimes saying, "I just don't understand this," and these are people with immense experience in the world of health care delivery.

So I think that it's hard to understand, and we can always do more. I would be 100 percent supportive of, as we talked about this morning with respect to the P&T committees, emphasizing exactly what you've said, Martha, in terms of saying if you're going to do this, these are the requisites to doing it well. And that includes what are the exception processes, what do people do in an emergency, those --

CHAIR THOMPSON: And I think that's very consistent with where we began the conversation with Martha's commentary about do we understand the policy objective, do we understand the connection between that and whatever process is structured, what does that look like and what could go wrong and how do we prevent that from

happening and what does that mean in terms of our attempt to try to address this crisis in our country.

I think, Kit, you provide a sound warning to us to not be reflexive in the way that we talk about this, but the details do matter. And that's, I think, a lot of the conversation that we're having here to make sure that to the extent that we can draw out some of those characteristics and dimensions, where we could bucket or describe or characterize or categorize the different ways that people are approaching this within some of those larger subject areas, like prior authorization or limits and so forth.

Anne, would you jump in?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just want to provide what I understand is the context for why we have to do this study, and it's my understanding -- and I wasn't there in those closed rooms, so I don't have a complete understanding.

In doing the SUPPORT Act, there was an effort to try and build bipartisan consensus on the different provisions of it so they could get it done, and one of the issues that came up was the barrier that utilization

management creates for treatment. I think they couldn't get to yes on that, and so they gave us a study.

I think the value that we can provide to that discussion is some of this talking about what is MAT, what are the different drugs, and there are different formulations. You get them in different ways, and they relate to those goals around patient safety or diversion in different ways.

A value of this report is to be able to show some of the nuance there about how the policies for the specific drugs relate to the goals of the program generally and utilization management. -- I think some places, you'll see where I think the fit is pretty good and some places where the fit is not good, which may just mean that they're outdated or there might be because one objective has outweighed another objective.

So I think that's a service that this report can provide that in terms of the information that you have gotten from us hasn't been fully fleshed out yet, but that's what I think is --

CHAIR THOMPSON: Yeah. There's differentiators, right?

EXECUTIVE DIRECTOR SCHWARTZ: -- really helping explain how all that works together so that in the next round, they can have a more nuanced approach to it rather than just all MAT is creating a barrier to access, so we should get rid of all of that, and that will be part of an effective strategy for getting people into treatment.

CHAIR THOMPSON: Good. Thank you for that.

Brian and then Kisha.

COMMISSIONER BURWELL: So, since this is a report to Congress, I see it as an opportunity for us. I think even more so than our regular publications. This will probably get more visibility, and it's a stand-alone report. So I don't want to miss an opportunity to do some education around medication-assisted treatment, and I'm advocating for maybe a little broadening of the aperture a little bit about kind of the subject matter, like having a little more background information about the role of medication-assisted treatment and the treatment of this illness, what percent of people with OUD are on MAT, which is a relatively small percentage.

I don't want to create a huge amount of more work, but I would like a little more policy bigger-picture

orientation and the role of utilization management in the context of that.

CHAIR THOMPSON: I think that's a good point.

COMMISSIONER BURWELL: For example, Martha's -- I mean, I didn't know that Suboxone was also a street drug and kind of how it ends up there and the implications of that. I just think there's a lot of education that has to take place around this, and this is an opportunity to do that.

CHAIR THOMPSON: I think that's a good point.

I also think there's some prior work of the Commission that could get sort of reframed into some background material, so that it is someplace that people can go, kind of complete the story here instead of us just referencing a bunch of other documents that we've collected or things that we've done.

So I think that we should take advantage of the opportunity in the right way without just repeating ourselves and just throwing in all of the prior chapters that we've done on this subject. But I do think that there are some things that we can do to provide some of that better context.

Certainly, when we talk about policy objectives and operational realities, that should afford us this opportunity to bring in some of these points about why this is relevant, why people have those policy objectives or have those worries about certain of these versus others.

COMMISSIONER BURWELL: Is there an opportunity to make a recommendation in this report or not?

CHAIR THOMPSON: We can make a recommendation --

COMMISSIONER BURWELL: I mean, I know it will be difficult --

VICE CHAIR LAMPKIN: Isn't the timing really --

COMMISSIONER BURWELL: -- over the course of the summer --

VICE CHAIR LAMPKIN: Yeah.

COMMISSIONER BURWELL: -- voting on it and blah-blah-blah, but it is an opportunity.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I don't think that we have a way to do a recommendation in this report with the time table we have, with the practice that we have had for transparency. But that doesn't mean that the Commission could not do follow-on work to this.

So I think what would be useful today, some of

these sort of points about tone and some of the messages and themes are things that are easy to deal with -- well, not easy to deal with, but are manageable, given the writing of this report. And then if we want to pick up additional work in the next cycle -- I mean, just because they asked us to do it in this report doesn't mean we could never talk about it again.

CHAIR THOMPSON: Kisha.

COMMISSIONER DAVIS: Thanks.

I just wanted to bring us back a little bit to the counseling services and really highlighting how important it is for folks to have access to counseling, ongoing counseling, decreasing barriers.

I have a pregnant patient in particular who is not able to find a counselor, limited access to mental health professionals, very few who take Medicaid in her area -- that's very difficult -- and it being tied to, well, you shouldn't get your medicine if you can't see a counselor. She is also somebody who you would absolutely not want to stop her Suboxone while she is pregnant and could really benefit from a counselor.

So as much as we can strengthen that people

definitely need counseling and we want them to have it and we want to decrease barriers for them to be able to get it, that that can be de-coupled from them getting their medication.

I also have patients who have been on Suboxone for a long time, years, and do they still need to continue to meet that requirement as they have gone on and are living productive lives and again may have trouble accessing a counselor?

CHAIR THOMPSON: Good points.

Okay. Any other comments from the Commission?

Peter.

COMMISSIONER SZILAGYI: Yeah. Just a very quick question. Actually, Anne, your comments helped me. I was trying to figure out whether a study of eight states, although I recognize that you pick these states based on certain characteristics, and whether we were asked to sort of describe what's happening in the United States or a deeper dive on a selection of states and whether we're meeting -- the extent to where we're able to describe what is happening out there.

So could you talk a little bit more, John, about

the eight states and how we selected them? My guess is -- I'm sure this was done in a very thoughtful way, but I guess the general question is, how generalizable are these eight states?

DR. WEDELES: Sure. So the eight states were selected to represent a range of characteristics of their program, so whether or not they have an 1115 SUD waiver, for example, sort of the penetration of managed care, whether the behavioral health benefits are carved in or carved out, geographic diversity as well. So I think, as I understand it, these eight were selected to be sort of representative.

CHAIR THOMPSON: So are they representative or illustrative?

DR. WEDELES: Well, I think they are illustrative, yeah. I think that's --

CHAIR THOMPSON: Okay. Yeah, okay.

COMMISSIONER SZILAGYI: And I think that's probably fine, but we may want to just make that point --

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

COMMISSIONER SZILAGYI: -- that we're not trying to generalize.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. And the other thing is that John references the study that SAMHSA did on the quantity and refill limits, but there's all kinds of things in that SAMHSA study, 50-state data, that we can use. I mean, there's no point in our reinventing the wheel, and the figures that you have in here are from the SAMHSA study, so there is more that we can say.

I personally found reading this a challenge because it's like, even if you're talking about eight states, it's a lot of variations on the theme. And I think there is also a diminishing return from studying every single thing about 50 states. So in the time that we had, this seemed like a reasonable approach.

CHAIR THOMPSON: Just because of the nature of the two sessions that we have before we take votes this afternoon, I'm going to pause and see if there's any public comments on this work that the Commission and the Commission staff should consider, so that we can take that into account.

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Okay, and as always, of course,

invite the public to write any comments to the Commission which could be taken into consideration at that point, too.

All right. So, John, thank you very much for providing this little bit of a preview for us. I hope that the Commission's comments are helpful for you in continuing and completing this work. And I know we have described how we'll move the chapter along during the summer and finalizing it in the fall, and so we'll expect to stay on that timeline going forward. Thank you.

VICE CHAIR LAMPKIN: All right. For our next session, Erin's going to take us into a second SUPPORT Act MACPAC study.

PRELIMINARY FINDINGS FROM CONGRESSIONALLY MANDATED STUDY ON INSTITUTIONS FOR MENTAL DISEASES

* MS. McMULLEN: Thank you. So good afternoon. Today I am going to present some preliminary findings from another congressionally mandated study on institutions for mental diseases.

So before I present those findings, I'm going to briefly discuss the role of the IMD exclusion, the details of our congressional mandate to conduct this study, and how

we have structured this project to be responsive to Congress' request.

As a reminder, this report is also being done outside of our normal report cycle with the final report due to Congress on January 1, 2020.

Commissioners are going to have additional time to discuss this topic at our September 2019 meeting when a draft report is presented. We anticipate that the draft report is going to include multiple chapters, including the preliminary findings that I'm going to discuss with you today.

The report will also include a look at how states have funded IMDs historically and how the IMD exclusion has been eroded over time to allow states to pay for certain services in IMDs. All that information is included in Appendix 1 of your meeting memo.

Okay. So before I dive into the congressional study, I just wanted to take a minute to talk about the IMD exclusion at a higher level. So it's really only a term that has any relevance -- it only has relevance within the Medicaid program.

State licensure agencies don't structure their

regulatory framework around the IMD exclusion; rather, they license facilities based on the services they deliver, such as inpatient psychiatric care or residential substance use treatment.

Therefore, an IMD isn't really one type of facility; rather, a broader term that could encompass several different types of facilities over 16 beds that deliver behavioral health care.

While the IMD exclusion used to be a broad prohibition on using Medicaid funds for inpatient behavioral health treatment, there have been a lot of changes in federal statute and policy over the past 50 years that have really allowed states to have greater opportunities to make payments to these facilities under the Medicaid program. As shown on the map, almost every state is making payments to IMDs using some sort of federal Medicaid authority. While there are lots of different exceptions to the IMD exclusion, there really hasn't been a lot of attention paid to the types of facilities that this care is being provided in and how these facilities are regulated.

Okay. So the next two slides talk about the

legislative requirements for this study. As I said earlier, it's due January 1, 2020, and it requires us to address the topics listed out on this slide. I do want to note that we only have to collect this information for a sample of states.

First, the Commission must report on how IMDs are licensed and what standards these facilities must meet in order to participate in Medicaid. My presentation today largely is going to focus on that area.

We must also report on how each state determines if requirements and standards have been met by these facilities, and we must also provide descriptive information on the types of services IMDS provide and what Medicaid funding authorities states are using to make payments to these facilities.

Congress further directed MACPAC to seek input from several stakeholders, including CMS and state officials, while we carry out this study. If determined appropriate by the Commission, the report may also include recommendations to CMS and Congress. Specifically, the Commission may want to consider recommendations on how state Medicaid programs may improve care and standards for

these facilities and how CMS can improve data collection from IMDs to address gaps in information.

All right. So in order to satisfy these requirements, we've structured the study with three separate components.

First, we're seeking to document state requirements such as licensure as well as the standards applied to IMDs seeking Medicaid payment and how each state determines if those requirements are satisfied.

The second component focuses on identifying and describing IMD facilities. With the assistance of SAMHSA, we're using the results of two facility surveys to identify IMDs in each of the seven states that are going to be included in this study. That information and the results of that analysis will be shared with you in September.

Finally, MACPAC will be issuing a request for public comment in late spring 2019. The request will be distributed broadly. We'll also post it on our website, and we'll invite any interested stakeholders to submit comments relevant to this topic and the topics covered in this study. Feedback received via public comment will also be included in the materials shared with you in September.

So the next several slides focus on preliminary findings of the work that we already have underway related to the regulation and oversight of IMDs both at the federal and the state level. Most of the findings stem from the work that we have done with our contractor, Watson Health, and some of the other preliminary work that we've been doing for this project.

So understanding the role Medicare plays in health care oversight and how it relates to IMD facilities is important. It informs a lot of the different preliminary findings that I'm going to be sharing with you later in the slides.

Specifically, Medicare certification dictates which providers the federal government will regulate and heavily influences the oversight role played by state licensure agencies and accrediting organizations.

In order to participate in Medicare, facilities must first obtain certification, which is generally sought through a state survey agency or a CMS-approved accrediting body.

State survey agencies determine compliance with federally established quality of care standards and life

and safety standards for a variety of health care facilities. In some instances, certification can be obtained through those accreditation agencies, like the Joint Commission, in lieu of seeking certification through the state survey agency.

During the certification process, an investigation and survey of the facility is used to determine whether a facility complies with federal quality and safety requirements. These requirements are known as "conditions of participation," and they exist for approximately 20 different types of health care suppliers and providers.

Conditions of participation aim to ensure minimum health and safety standards are met without dictating the use of certain treatment modalities or practices.

So as I mentioned earlier, the term "IMD" includes a lot of different types of facilities. With the exception of a freestanding psychiatric hospitals, the Medicare certification process doesn't apply to a lot of different types of facilities that may be considered IMDs, so this could include a non-hospital-based residential mental health and substance use disorder treatment

programs.

As a result, the quality and safety standards afforded by the Medicare certification process as well as the framework which establishes the role of state survey agency and accreditation organizations doesn't apply to these providers; rather, the regulatory framework, or lack thereof, is left up to states.

So both the state licensure and national accreditation process support the framework established by Medicare, though many IMD providers are treated differently by those processes. On the next two slides, I'm going to talk about preliminary findings for state oversight and accrediting organizations.

As I go through the findings, it's important to keep in mind that state licensure and accreditation processes aren't structured around the IMD exclusion; rather, behavioral health facilities are regulated based on the type of service they provide, such as psychiatric treatment. Ultimately, facilities are treated the same way under the licensure process, whether they have 10 beds or 16 beds. For each state included in this project, we had to examine several different licensure types, namely, those

related to the provision of inpatient and residential behavioral health treatment.

So, in general, obtaining a state license is a prerequisite for a facility to participate in Medicare and Medicaid, but we found that there is variation across states regarding which facilities need to obtain licensure. Most states require residential and inpatient mental health and substance use disorder treatment facilities to obtain licensure, but other states may only require those same types of facilities to obtain licensure if they're going to seek public funding. So, as a result, there could be, you know, a segment of behavioral health providers that are unregulated.

In most states, health care facility licensure is conducted by the state survey agency that makes Medicare certifications to CMS. However, for many behavioral health facilities, entities other than the state survey agency may be solely responsible for licensure, including the state substance use authority or the state mental health authority. Sometimes those agencies share responsibility with the state agency. It hasn't been uncommon in the project we're doing to see multiple state entities being

involved in the licensure process.

We've also found that licensure standards vary greatly within and across states. For example, states may have several different residential and inpatient licensure types. That could be long-term residential care or detoxification programs, with different processes and requirements for each type of facility.

Staffing requirements are another area where we found a lot of variation. The degree to which states impose staffing ratios or requirements to have a certain type of health care professional such as a physician or psychologist on staff as a condition of licensure varies pretty widely. As a result, in some states there could be few licensed clinical staff that are required to be in some of these facilities.

Outside of the initial and renewal licensure process, additional enforcement of state licensure standards is typically complaint driven. Our preliminary findings indicate that many states do not use complaint data to do continuous quality improvement; rather, if there is an issue about a certain facility, regulatory agencies typically listen to complaints that they receive when

following up on additional concerns.

Moving on to accreditation, generally accreditation is a voluntary review process that health care organizations seek to demonstrate the ability to meet criteria and standards established by an external organization. A provider may seek accreditation for Medicare certification purposes or for other purposes such as credentialing.

Several private organizations, including the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities, known as CARF, accredit both inpatient and residential behavioral health programs. Inpatient psychiatric hospitals obtain accreditation from a CMS-approved organization at high rates. In part, that's probably because they can participate in Medicare. But residential mental health and substance use disorder facilities seek accreditation at lower rates than psychiatric hospitals. In part, that may be because they cannot participate in Medicare. And federal Medicaid guidance related to IMDs treats mental health facilities differently than substance use disorder facilities when it comes to accreditation status.

Section 1115 guidance requires residential and inpatient facilities that provide psychiatric care to obtain accreditation by CARF or the Joint Commission prior to receiving FFP. That same requirement simply doesn't exist for substance use disorder treatment providers that are getting paid under Section 1115 demonstrations.

The final set of preliminary findings discusses state Medicaid agencies and provider enrollment. Provider enrollment is really meant to complement the state licensure process, and the state Medicaid agency must have a method for verifying providers are, in fact, licensed and that they're in good standing. The provider enrollment process provides an opportunity to identify questionable providers before they're allowed to deliver services to Medicaid beneficiaries.

So to receive Medicaid payment, a provider must first enroll with the state Medicaid agency, and the screening process differs based on whether the provider's potential for fraud, waste, or abuse is considered limited, moderate, or high risk. For example, community mental health centers are considered moderate risk while DME providers are considered high risk.

For providers recognized by Medicare, such as inpatient psychiatric hospitals, this risk determination and screening process is more dictated by the federal government, but for non-Medicare providers, including many residential behavioral health facilities that are considered IMDs, the state Medicaid agency has flexibility in how they assign risk and screen providers as a part of provider enrollment.

Our preliminary findings show that the flexibility in provider enrollment has resulted in variation across states in how they assess risk for facilities that are considered IMDs. In September, we'll report back with additional detail on how this risk classification affects the oversight of behavioral health facilities.

Some Medicaid agencies adopt additional standards that providers must meet in order to receive Medicaid payment. Generally, these standards are meant to complement licensure requirements. For example, we found that some states require providers to use certain patient placement criteria such as ASAM.

We have also found that many MCOs may institute

requirements that go beyond what the Medicaid agency and the licensure agency require of these facilities. For example, some MCOs may require facilities to obtain accreditation before they'll contract with them.

We'll also be discussing these types of standards that Medicaid programs and their contractors use for IMD facilities, including state-specific policies, in greater detail when we meet in September.

Through our work with Watson Health, we're also capturing how Medicaid agencies enforce standards for residential and inpatient behavioral health providers. Generally, we found that Medicaid agencies often have to work with many other state partners when there is concern about specific providers that aren't meeting Medicaid standards.

In terms of next steps, MACPAC is finalizing its work with Watson Health which will identify state-specific policies to regulate IMDs and key finding and themes from a series of interviews that we're conducting. During the summer of 2019, we'll also seek comment from interested parties on the regulation and oversight of these facilities that are receiving Medicaid payment.

Just a reminder, this study is due to Congress on January 1, 2020, falling outside of our normal reporting cycle. As such, that draft report will be shared with you at the September meeting, and it will include the results of our work with Watson Health as well as the feedback that we receive during our public comment.

That concludes my presentation for today, and I welcome your input on the preliminary findings that I've shared. Thanks.

VICE CHAIR LAMPKIN: Thanks, Erin

I would like to say this has been -- this study has been tremendously educational to me. I've heard the term "IMD" for 15 years and knew basically what it stood for, but other than that, it has been a very mysterious topic. So this is really helpful.

I do have a question for you. I want to make sure I'm not misunderstanding or overreacting to one of the things that you showed us, because I also learned a lot about different levels of regulation and how the licensure fits and how the Medicaid enrollment fits with those pieces, and that was really interesting.

But I go back to Slide 11, you had a sub-bullet

on there: "Some behavioral health providers may be wholly unregulated." I read that and I think that means that nobody is looking after them and there are no safety standards and no entity that funnels complaints and visits them periodically. Am I understanding that right? Is that what we're saying here?

MS. McMULLEN: Yeah, I mean, I think this is a problem in a small subset of states where there have been issues about certain providers falling outside of the bounds of state regulation.

VICE CHAIR LAMPKIN: So this is not a widespread problem or issue that you identified in the drill-down but a more isolated, incident that fell between the cracks kind of thing?

MS. McMULLEN: So, I mean, our study is only looking at seven states, so I can say that looking at some of our past work on 1115 waivers for substance use disorder has also kind of gleaned some insight into what state Medicaid agencies -- what types of standards they're having to adopt because the licensure standards aren't where they need to be, so maybe Medicaid is supplementing those standards in a lot of states.

Unfortunately, you know, there really is no good source of information to figure out which facilities are unregulated. I think that would be incredibly difficult to try to figure out just because if you don't -- you kind of don't know what you don't know. If the facility is not regulated, it's hard to say how many of them are out there.

COMMISSIONER BURWELL: Isn't it true that there are -- I mean, what's going on is there's a lack of beds for people who need treatment. Families are desperate. They cannot get their family member into an approved residential bed that is covered by insurance, either their own insurance or Medicaid. But there are providers out there that provide this service on a private-pay basis, and people are paying big money just to put their family member somewhere, and these places are unregulated and, you know, taking advantage of people.

VICE CHAIR LAMPKIN: And because it's private pay that kind of -- that's how it -- part of the way it --

COMMISSIONER BURWELL: Yeah.

VICE CHAIR LAMPKIN: But it has to have more than 16 beds. So it's a place that's been stood up to solve this problem but it's big enough that it has 16 beds to be

falling into the IMD category that we're --

MS. McMULLEN: So they could have 16 beds. They might not. I mean, the way the licensure process is set up in states isn't really based around like whether you're an IMD or not, so it makes it a little difficult.

I think what Brian is getting at and what you're getting at a little bit is around the issue of public funding. There is -- in the work that we did this time last year on access to substance use disorder treatment I think we prepared a map for you that showed the percentage of providers in a state that participated in Medicaid. In some states it was pretty low, I think, in like the 20 percent-ish range.

So in the states were licensures only required, if you're going to be seeking public funding, including Medicaid, I think that percentage of how many facilities are accepting Medicaid might be like a helpful gauge to look at. But it is a pretty complicated kind of issue to figure out who is choosing to seek licensure and who isn't. I think that's something hard for us to kind of get at.

VICE CHAIR LAMPKIN: Okay. Thanks. That's really helpful, especially to link it back to that prior

work. That makes a lot of sense. And I'll stop hogging the conversation now, although I think there's so much to talk about here, in this material. Does anybody else want to chime in? Brian.

COMMISSIONER BURWELL: I mean, to me I get frustrated on a focus on IMD because I think the most important point that you make, or that we make, is that it is not a thing. It is a payment mechanism. So when you get a request like how are states regulating IMD – IMD? You know, they don't exist as a separate entity.

So to me all this discussion is kind of off-target a little bit, and, you know, the real target is residential care for people with OUD, 24-hour residential care and how that fits into the continuum and then how those things are paid for and regulated. And so we're just not focusing on the policy question the way it should be focused on. You know, I just think the conversation gets muddled. I think, you know, everybody gets confused about what an IMD is and how it fits in.

I do know that CMMI is working on new models of care for demonstrations this summer, and I know that they are doing one around models of care for opioid use

disorder, and I assume that there will be some provision for residential care within those models. So I think this will be a conversation, and then states will respond, and so forth. So I think there's a relevance to this study coming up around those new CMMI demonstrations that we should track.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. Again, going back to the SUPPORT Act and sort of the conversation that was going on when that was being passed, of course, you know, one of the policy points in that discussion was getting rid of the IMD exclusion altogether, and where they landed was creating a state plan option for a limited number of years. And my understanding is that part of that is obviously an issue around scoring, but part of it was also well, we don't really know what we're buying, which sort of belies the fact that you are already buying it under waivers and under in-lieu-of services.

So that's a bit why this comes now. You know, it's hard to study a thing that's not really a thing, and yet at the same time policy is being created around nothing.

I can't wait to read that in the transcript.

[Laughter.]

VICE CHAIR LAMPKIN: Okay. Penny and then Alan, Martha, and Sheldon.

CHAIR THOMPSON: I am just going to ask a couple of quick questions. I think this is very useful. I would kind of invoke Kit here in saying some of our words about, you know -- I mean, this is the reflection of the system that's existed for a long period of time, about how CoPs and Medicare and Medicaid work together. And so, you know, it has implications when we apply it to this particular kind of set of services and providers, but this is not a unique proposition in that respect as well. You know, it's an existing regulatory regime that has its own logic and its own rationale, and so I just want to be careful that we're not like overstating what it is or isn't, as it applies to this particular situation.

The other thing that I would just draw out here is funding. So I think another important element of this is not just what the statutory and regulatory constructions are but how funding happens for state survey agencies and when they get it and when they don't, because that could be relevant at a later point in time.

Can I ask just a question about -- the statement that under the 1115 guidance the accreditation requirement existed for IMDs that receive FFP for SUD, or didn't for SUD versus inpatient. Can you just --

MS. McMULLEN: Sure. Sure.

CHAIR THOMPSON: -- what was the logic behind that or the --

MS. McMULLEN: I don't know if I can speak to why it's required for one and not the other. So in November 2018 -- so there's two sets of guidance, one that came out last year, in November of 2018, that was specific to psychiatric care, and in a lot of ways, you know, it echoes similar themes that we heard in the Section 1115 guidance for substance use disorder facilities, the role of that continuum of care, now there needs to be stepdown services available for people that are leaving inpatient psychiatric facilities. But one of the provider requirements does relate to accreditation. Facilities have to be accredited under these waivers.

On the substance use side, there is also a provider requirement. However, they're not related to accreditation. Rather, the substance use treatment

facilities -- rather, really, the state has to use ASAM, or a similar national standard, when they are paying these facilities.

So there's provider requirements on both sides. On the psychiatric side it's tied to that accreditation.

CHAIR THOMPSON: And then the final thing that I just wanted to mention is there's a couple of places where you mentioned complaint-driven investigations, which does happen, and that, of course, does happen -- we don't say it specifically but it does happen with CoPs too. There are complaint-driven investigations.

But I guess sort of starting at a more rudimentary level, let's supposed that you're inside a provider, and it's not regulated or it's not licensed or it doesn't have some of these other steps to ensure patient safety and clinical efficacy, where do you go? So if you were entirely relying on an environment in which you were not doing up-front licensure, accreditation, et cetera, surveying, then it seems like you're in a world where you're dealing with back-end complaints and issues as they arise.

So I think it would be important to also try to

fill in whether that's another gap or whether there is, in fact, a way for people -- a place for people to go and a process for people to use and a set of resources that are available to respond if there are those kinds of issues of patient safety or staffing or any of the other kinds of things that you would normally see dealt with on the prospective basis, through the accreditation or licensure.

CHAIR THOMPSON: Okay. Alan, and then Martha and Sheldon.

COMMISSIONER WEIL: I think Anne may have said, with more precision, what I was going to say, in response, Brian, to you. I mean, I think it is important that we do something other than tell Congress that they asked the wrong question, even if they did ask the wrong question. And it is this notion that since there has been an exclusion there is a gap of knowledge and they are asking if we lift that exclusion, or to the extent we lift the exclusion, what are we going to get? And I think we can help answer that, including part of the answer being it's not so clear what you'll get.

But then it leads to the next question, which I think is where we're driving, which is what additional

state or federal standards would you want to have in place as you do -- as you open the door to this funding mechanism? Given what we see now, what might you want to be careful of? And I do think that's -- I hope that's what Anne was getting at.

And I think we need to use the question that they've asked to direct to where the issues are. I also -- and I realize it's not exactly here, and we will have a crack at this in fall, but, you know, a topic we've brought up repeatedly is as important as institutional services are, given the tremendous unmet need in this domain writ large, from a dollar perspective, opening up new spending opportunities at the most expensive end of the continuum can -- could not be the most efficient response, given all the unmet need, that much of it could be met at the lower-cost end of the continuum. And I think somehow making sure that that broader message of where this fits in the continuum of care is communicated even in a narrower study about what are IMDs.

MS. McMULLEN: Just to comment on that. It's not included in today's presentation because we really tried to focus on what our mandate was, but part of our work with

Watson Health, we are looking at the more intensive levels of outpatient care, both on the mental health and substance use disorder side, since the Commission has been really focused on looking at this type of care in a continuum, as opposed to the standalone service. So we will have that for you in September. We are just not ready to talk about it yet today.

COMMISSIONER CARTER: I have a knowledge of one situation, so take this as an n of 1, but I think it could help illustrate some of the challenges here. A private -- so not state-funded -- hospital in my state, I believe was getting Medicaid reimbursement under one of these demonstrations, that ended -- you had a nice chart here. So there were some demonstrations where they were allowing Medicaid reimbursement for some period of time and then the demonstrations ended.

And so this very high-quality, private hospital that was doing inpatient substance use disorder treatment suddenly stopped getting Medicaid reimbursement. And because they have more than 16 beds they are considered an IMD and not eligible under the current situation for reimbursement.

And I think there are some additional barriers because of the limits of days that can be reimbursed. I think there's maybe some new -- so it's like 15 days in a month. So if the person needs more than 15 days you have to sort of get them in in the middle of the month, and then get them in to the middle of the next month. And so that's just illustrative of I think why this is coming up now. There was a demonstration. There was a mechanism to fund some of this and it stopped, and these services are needed. I mean, yes, we need lots of community-based services but you also need access to inpatient care.

VICE CHAIR LAMPKIN: I have Sheldon and Kit, but, Toby, were you signaling that -- I mean, Darin, were you signaling that you wanted to --

COMMISSIONER GORDON: Wow.

VICE CHAIR LAMPKIN: Sorry -- signaling that you wanted to chime in on --

COMMISSIONER GORDON: Yeah. I was just going to say I think it's also -- I mean, there have been waivers back in the day where states were getting reimbursement for IMD services for a long period of time too. I think the issue was that there are so many different things, as even

this analysis identifies, that states were doing, that were getting reimbursed for that, but it's all over the board and they were using different approaches, whether it's in-lieu-of or other waiver approaches. So I think it was just trying to get their arms around all of that and what is the right answer.

But, I mean, you're right with the statement you made. There were some waivers and then that stopped. But we were 1994 until early 2000s, had a waiver and some other states did as well, where you could get reimbursement for it. It was just all over the board.

VICE CHAIR LAMPKIN: So you guys don't make it any easier by dressing alike and sitting on the same side of the table, I just want to say.

All right. Sheldon and then Kit.

COMMISSIONER RETCHIN: So I really appreciated the work that you did, Erin, and I very much appreciated the sort of historical context, that almost went back to medieval times.

So I have probably a pretty stupid question, that somebody else can answer, or maybe Erin could too, is what's the role -- and states still have a Department of

Orthopedic Health, and have a Department of Diabetes Health. Every state has a Department of Mental Health, and I assume these all grew because of the enormous influence of public opinion on policy that required states to de-institutionalize. What's the context of those departments? I realize it's a funding issue with accreditation and licensure and regulatory oversight, but just from my naïve perspective, what do the DMH's do?

MS. McMULLEN: Yeah. So a lot of them, based on the work that we're doing in the seven states and then kind of just based on what we've heard from other national organizations, a lot of the state mental health authorities or state substance use authorities do have a role to play in the licensure process.

You know, we are seeing, in some states, though, that maybe the mental health authority also has to work with the state survey agency. Maybe they have kind of complementary roles. Maybe one is more focused on kind of the certification of the program, like if they're providing like long-term residential substance use treatment, and maybe the survey agency focuses more around kind of life and safety standards.

I think there are a lot of different ways this can look at the state level. And from what we've found there's a lot of variation. It's really hard to generalize because they all kind of seem to have a unique function, based on how their state has developed.

COMMISSIONER RETCHIN: If I can just add on that, in the two states I've been in, I have seen fragmentation and lack of coordination in terms of policy on those two fronts. Just something to throw in this. I think that -- and I'm struck by the comment that you made, and I would understand about the unsupervised or unregulated oversight, and especially in staffing, which, to me, is just troubling.

VICE CHAIR LAMPKIN: Kit and Toby.

COMMISSIONER GORTON: So I want to go back to Slide 9, if you can get there. It's like two before this one, or one before this one. Yes.

So just to briefly jump on my hobby horse again, "lacking" is a very value judgmental word. It may be absent but it's up to Congress or somebody else to decide whether it's lacking or not. I think we should be less judgmental and more descriptive.

But in the context of this, I think what you're saying is that because Medicare doesn't pay for these services, federal oversight -- it's out of scope for federal oversight, and so the federal government has not put energy into an oversight framework.

I agree that that raises concerns, and I would like us, if possible, particularly with respect to your second bullet, to maybe go down a little bit deeper, right? So on the Medicare side they've done a very nice job in terms of the conditions of participation, laying out the various domains that, you know, need to be looked at. And it's been a long time since I did an inspection of care survey at an institution, but my recollection was that the patient rights provisions were always strongest in the federal regulations. And at least in the state where I did this, the state sort of filled in gaps sometimes, but relied heavily on the federal rules.

And so I sort of wonder if there are no federal rules are the states filling in all the gaps? And it seems to me that it might be of value to, in describing the regulatory context, to say here are the six or eight generally accepted domains, right, so like safety, patient

rights, quality, you know, number of electrical outlets per square foot, you know, all those various things, and then say -- and maybe it's the spreadsheet from hell, but maybe say, you know, here's what gets covered for this half that have been subject to the federal framework and here's what the states, the seven that we looked at, have filled in, and identify are there gaps.

And I'm particularly concerned about patient rights gaps, because in my experience in heavily regulated ICFs, which we, as a state, were operating, patient rights were one of the biggest realms of difficulty. And so if they're not being regulated, I share Stacey's concern about organizations, facilities, institutions, whatever, that appear to be not regulated at all. But if you are being regulated you also need to have the right stuff regulated.

And so I would like, if we can, in the context of this, to maybe, you know, double-click down one level and not just say, well, you know, this is subject to -- but get down to the domain level, if only in a table in an appendix or something, so that we can highlight that, where the gaps are, what the gaps impact. Does that make sense?

MS. McMULLEN: Mm-hmm.

CHAIR THOMPSON: I just wanted to jump in to say I love that point, and it helped me because I was having trouble with talking about certification versus accreditation versus licensure versus provider enrollment, which I think of as kind of if I took Kit's spreadsheet idea right, that would get -- the line would go like this, right, in terms of more stuff, a little bit less stuff, significantly less stuff, really less stuff. And I think that would be very helpful because when we talk about the level of oversight, it does matter.

I know that we keep saying, for example, provider enrollment is about patient safety, but the 855 is all about financial entanglements and relationships and convictions. So I do think this distinction between what these things are looking at and covering does really matter, so thank you.

COMMISSIONER DOUGLAS: Great job.

I know the appendix isn't part of the report, but I thought it was a really good connection back to just the oversight that would be good to weed in or call out. As we look and learn more about the changing role of IMDs and continue to test out new approaches, it raises a question

of how does oversight responsibility and what are we looking and assessing for the right types of oversight within the IMDs would also evolve, so just connecting back that evolution.

Somehow if it can be included, I thought it was a great appendix and a lot of very rich information too that could be tied back with it.

MS. McMULLEN: Thank you.

Yeah. I think we envisioned the appendix being included as a chapter in kind of a full report that you'll review in September.

VICE CHAIR LAMPKIN: Okay. Other comments on the preliminary findings and next steps on those?

[No response.]

VICE CHAIR LAMPKIN: Okay. It sounds like we've given you a lot to chew on, Erin, in terms of context setting as well as kind of a detailed structure of looking at where the gaps are.

So we'll go ahead and ask the public for any feedback and comments on this topic.

CHAIR THOMPSON: Bill, can't get enough of us, can you, Bill?

PUBLIC COMMENT

* MR. CLARK: Is this the public portion?

Oh, Bill Clark, NORC.

I just wanted to say I haven't heard the discussion, but the CMS managed care rule, it did enable networks to contract with IMDs for services as part of MCO networks, and I think that is the origin of the 15-day limit.

The earlier demonstration was the Affordable Care Act 2707, which I understand was actually response to when CMS cut off the earlier state 1115 waivers that had enabled IMD payments.

One question I have with respect to the facilities that Medicaid can and has responsibility for within IMDs are those that have less than the 16-plus beds. I was curious. TO the extent that the Commission might be able to include some discussion in the report about where those facilities are, are they all throughout all the states? Are there a thousand of these in some states, which would mean a substantial number of people could be enrolled in them or treated by them?

Those facilities are completely under the

regulatory responsibility of the states, and so I would think if you're looking for state standards around IMDs that a place to start would be what are the regulations in place of those, of course, in the states where there are facilities of less than 16 beds.

Thanks.

VICE CHAIR LAMPKIN: Thank you.

Other comments from the public?

[No response.]

VICE CHAIR LAMPKIN: All right. I think we have a break up next.

CHAIR THOMPSON: Yes. So we're going to take a 15-minute break here. When we come back, we will pick back up on the recommendations that we discussed this morning, and we'll go through a series of votes on all of the recommendations that we've discussed, and that's how we'll end our day.

So we'll be back at 3:15 sharp to pick those back up.

* [Recess.]

CHAIR THOMPSON: All right, folks. If we can ask everybody to go ahead and take their seats, we'll finish up

today's agenda with a series of votes, as we've discussed.

VOTES ON RECOMMENDATIONS RELATED TO DRUG POLICY, DEFINITION OF MEDICAID SHORTFALL FOR PURPOSES OF DSH, IMPROVING PROGRAM INTEGRITY, AND THERAPEUTIC FOSTER CARE

* CHAIR THOMPSON: Okay. We're going to sort of go about this in the following way, which is in the same order in which we addressed these subjects this morning, we will review the recommendations. In the cases that they needed revision, we'll ask the staff to discuss the nature of the revision. We will then open up any final opportunity for comments or questions, and then we will move immediately to a vote.

For all of the subjects and the potential recommendations that we have discussed today, MACPAC's conflict of interest rules do apply. Our policies are on the MACPAC website. And you can look at our policy in more detail there, but just to clarify, under our policy we talk about interest being particularly, directly, predictably, and significantly affected by the outcome of the vote. We do have a Conflict of Interest Committee that reviews the interests of the Commissioners. The Conflict of Interest

Committee met on March 5th and reviewed all of the reports of interest and financial engagements by the Commissioners. The Conflict of Interest Committee found no conflicts for which it would recommend recusal by the individual Commissioners. Of course, Commissioners themselves may decide to abstain from any vote for any reason.

Okay. So why don't we go ahead and start, and we're going to kick it off with Chris and the recommendations relating to drug policy.

MR. PARK: Thank you. Based on this morning's discussions, we did not make any changes to Recommendation 1, which deals with the drug coverage grace period. We will add some additional language and discussion around this particular recommendation and in the rationale, but the language of the recommendation did not change.

So recommendation 1 reads: Congress should amend Section 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug for 180 days after a new drug or a new formulation of drug has been approved by the Food and Drug Administration and entered the market.

Based on the discussion from this morning,

Recommendation 2 did change. The Commissioners discussed whether we should raise the cap to 125 percent of average manufacturer price or remove the cap completely and ultimately decided that we should frame the recommendation as removing the cap completely.

So the recommendation now reads: Congress should amend Section 1927(c)(2)(D) of the Social Security Act to remove the cap on Medicaid drug rebates.

CHAIR THOMPSON: And just for clarity, to pick up on the conversation that we were having earlier about the language of this, we could have said "should remove Section 1927(c)(2)(D)," but there are cross-references that we didn't want to disturb, so that's why we're presenting it as an amendment.

EXECUTIVE DIRECTOR SCHWARTZ: True nerds.

CHAIR THOMPSON: True nerds. There are cross-references, et cetera.

Okay. So on either one of these recommendations, any final questions Commissioners have before we move to the vote? Sheldon.

COMMISSIONER RETCHIN: Chris, one more time on the -- so the savings, as I recall, would double from the 5

to 10 to 10 to 20?

MR. PARK: That's correct. Removing the cap completely, the CBO estimate is $15 to $20 billion over 10 years in federal savings.

CHAIR THOMPSON: Okay. We're going to vote one by one. This is not a packaged set of recommendations, so we'll vote first on Recommendation 1 and second on Recommendation 2. Anne?

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So, yes, this is the recommendation on restricting coverage for 120 days, the grace period -- 180 days, yes, I'm sorry, 180 days. And I'm going to call the roll, and you can vote yes, no, or abstain. Melanie Bella?

COMMISSIONER BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise I'm going to mark as not present. Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

VICE CHAIR LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil?

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Penny Thompson?

CHAIR THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. That's 16 yeses and 1 not present.

Okay. And this is the recommendation on eliminating the cap on rebates. Melanie Bella?

COMMISSIONER BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise I'm going to mark as not present. Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

VICE CHAIR LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil?

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Penny Thompson?

CHAIR THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Again, that's 16 yeses and 1 not present.

CHAIR THOMPSON: Thank you, Chris.

All right. Now we'll move on to DSH.

MR. NELB: Great. So based on the Commission's discussion this morning, there was no change to the proposed recommendation for changing the DSH definition of

"Medicaid shortfall." Based on all the different options we considered, this recommendation represents that third option, the Medicaid-only option where we're only paying for a shortfall in cases where Medicaid is the primary payer.

The recommendation reads as follows: To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid for by other payers, Congress should change the definition of "Medicaid shortfall" in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.

CHAIR THOMPSON: All right. Thank you, Rob.

Any final questions or comments from the Commissioners before we move to a vote? Chuck.

COMMISSIONER MILLIGAN: One of the comments that was made this morning was along the lines of urging us not to do this because it might discourage hospitals from helping to enroll children in Medicaid, and I would hope and assume that that does not happen. So I just want to comment that in my experience working with Children's and other hospitals, they do put the kids' needs first. Kids

qualify for EPSDT. It's not simply a DSH kind of issue. And I have full confidence that the children's hospitals will continue to do the right thing and enroll children who are eligible for Medicaid in Medicaid in spite of what we might do in this vote.

CHAIR THOMPSON: Thank you, Chuck.

Melanie and then Leanna.

COMMISSIONER BELLA: It's actually not a question about Medicare in our lap, so mine is just a comment just because this is -- and I get the point about this is one slice out of a lot. If there's some way to evaluate the impact of this down the road or to consider how we would look at did this -- what kind of impact did this have by doing this, I just would like to put a plug in for that. So we don't even know if this will happen, but if it does happen, like some way just to check and see -- or at least have it come up as part of a discussion in future years to see if there's been any unintended impact or to see if there's been particularly with our relationship on the Medicare side. That's my only comment, not even a request. Just a comment.

CHAIR THOMPSON: Leanna.

COMMISSIONER GEORGE: I hope I'm not opening up a can of worms here, but I was wondering, because I've been pondering this most of the afternoon, in cases where you have private insurance that because of high deductibles you cannot meet, the private insurance is refusing to pay anything toward it, then theoretically Medicaid becomes the primary payer even though technically it's still Blue Cross/Blue Shield, United Healthcare, whoever it is with the high-deductible plan.

Is there any way we can look at those situations where in the event, let's say, a hospital has more uncompensated care of this type of patient versus the third-party surplus for those long-term -- you know, the neonatal infant care situations, NICUs, is there any way we can possibly get that in there so that those hospitals, particularly like your rural hospitals that don't have large NICU units may be more impacted by that?

CHAIR THOMPSON: You know, Leanna, that's a really good point, and it's one, Chuck, you have brought up before, too, as a concern, and I think some other Commissioners, about what happens in these kinds of circumstances, especially focused on the high-deductible

plans.

Now, Rob, in our definition that person would be a private-pay patient, correct? Or would Medicaid be primary for those individuals since they would lack coverage for the specific services for which they're getting service? Which I guess could also apply to any kind of HSA kind of plan as well, right?

MR. NELB: Yeah, so this is something I think we can clarify. In the rationale, we have the sort of design considerations part where we talk about what we mean by sort of Medicaid being the primary payer. In the current iteration, we highlight some cases like Indian Health Service and Ryan White program, which are payers of last resort after Medicaid. But we can talk about circumstances where, you know, Medicaid is really paying the bill.

Under CMS' 2010 policy, the deductible, if someone didn't pay, you know, that did count as uncompensated care, but the way that that policy was structured, they didn't have to decide whether Medicaid was the primary payer or not. But we can certainly flag that circumstance to make sure the intent is one being where if Medicaid is -- to count shortfall in cases where Medicaid

is the one that's actually paying for the service, but to not count it in cases where other payers are actually paying.

CHAIR THOMPSON: So is that something we're going to have to tweak a little bit more? I just want to be sure that when we're thinking about this -- I don't know under third-party liability rules if you have a high-deductible plan along with Medicaid and now you go in and you're in your deductible period, does Medicaid come in under that circumstance and take over rather than your out-of-pocket? Yes, right? Okay.

So maybe it's just a matter of also sort of clarifying that point as we have that discussion so that we understand that in our conception that would be a circumstance under which Medicaid would be primary for paying for that service in light of the coverage exclusions and conditions that would apply in the private insurance side. Is that -- am I saying that correctly?

COMMISSIONER GORTON: Well, it's not a coverage exclusion, right? It's a payment limitation based on --

CHAIR THOMPSON: Yeah, okay. Thank you.

COMMISSIONER GORTON: So we just need to be

precise about the words. And I think being more descriptive -- right? -- because we're not doing legislative language here, but I think being more descriptive will let the -- ultimately, if they move forward with the recommendation, will let the lawyers take it into account and phrase it the proper way, because I think Medicaid is still not technically under the TPL rules primary.

CHAIR THOMPSON: Right.

COMMISSIONER GORTON: The primary --

CHAIR THOMPSON: But it's responsible.

COMMISSIONER GORTON: But it's responsible.

CHAIR THOMPSON: Yeah.

COMMISSIONER GORTON: Yes.

CHAIR THOMPSON: Okay.

MR. NELB: Yeah, we can try to clarify that and maybe also distinguish -- I mean, there are cases where it's the deductible or co-pay, kind of similar to how it works in Medicare, that, you know, there's that certain piece that the beneficiary has to pay, but then there are other circumstances in private insurance where there's a coverage limitation and --

CHAIR THOMPSON: Yes.

MR. NELB: And so there might be a little different circumstances, but we can flag that.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: Yeah, and clarifying I think makes -- I'm just curious to the extent that a state would have the ability to identify that situation separately. And maybe that's --

CHAIR THOMPSON: Well, I think our idea here is not to disturb the current kind of landscape of third-party liability. Right? So it's not say that at some future point the Commission might not want to take up some of these special circumstances that exist if we have, you know, new variations of private coverage that could be available and how should Medicaid relate to those other kinds of coverages. But in the context of this particular recommendation, we're not trying to change anything about who's primary, who's not, who's liable, who's not in the context of how this operates as an ongoing matter, because those issues do prop up today --

COMMISSIONER GORDON: Yeah, not as an ongoing --

CHAIR THOMPSON: -- and get handled through TPL

processes.

COMMISSIONER GORDON: Yes, my point is not as an ongoing matter, as an identification for purposes of DSH. I mean, I guess for purposes of DSH only. That's where I'm saying I don't know the states' ability to segregate the TPL recipient for that individual that has TPL that was in their deductible for the moment, for that particular payment versus one that wasn't. And so I'm just saying I think you can hit the point, the descriptor. I just think from a practical perspective I know we didn't have that information to be able to discern between the two for purposes of a DSH allocation.

CHAIR THOMPSON: But states do differentiate on those payments for the purposes of actually making the payments. So, in other words, states are, in fact, stepping in to pay for those kinds of circumstances today under TPL arrangements and the processes --

COMMISSIONER GORDON: Yes, after a claim is rejected or saying --

CHAIR THOMPSON: That's right.

COMMISSIONER GORDON: -- I'm just --

CHAIR THOMPSON: Through a series of processes,

that's right.

COMMISSIONER GORDON: There's just not a flag for those.

CHAIR THOMPSON: And how that makes it into a DSH report, right?

COMMISSIONER GORDON: Yes.

CHAIR THOMPSON: Stacey, were you trying --

VICE CHAIR LAMPKIN: Yeah, I just wanted to echo that. I mean, none of this is saying that the provider doesn't get paid for that chunk of money that the deductible is -- but if you think about how it works, if the deductible is $3,000 and the inpatient stay is $12,000, right? So the private payer is still paying the bulk of the admission.

COMMISSIONER GORDON: Yeah, my point --

VICE CHAIR LAMPKIN: And so for the purposes of our recommendation here, I don't even think that we necessarily need to think that Medicaid is primary for the purposes of the recommendation that we're making. That instance would be -- the costs and the payments for that instance would be excluded based on this recommendation.

CHAIR THOMPSON: Right, but take the instance

Leanna was trying to get to in another point, which is so take it -- so say it's a $6,000 deductible. The stay is $3,000. You haven't hit your deductible. The private insurance hasn't taken over --

COMMISSIONER GORDON: So de facto that Medicaid is primary in that situation.

CHAIR THOMPSON: What's happening in that circumstance? Is the responsibility Medicaid's or is the responsibility the individual's?

COMMISSIONER GORDON: Medicaid.

CHAIR THOMPSON: For the $3,000.

COMMISSIONER GORDON: It's Medicaid's.

COMMISSIONER WEIL: It's Medicaid's responsibility, but Medicaid is still not primary. The claim has to go first to the private, or Medicaid won't process the claim.

CHAIR THOMPSON: Right.

COMMISSIONER WEIL: Or won't pay the claim. So Medicaid is secondary, and it's not -- it's out. We would not count that, which I think is what we want.

COMMISSIONER GEORGE: I would not want to see a hospital not getting compensated for services provided

simply because my son has private insurance as well as Medicaid. If he just had Medicaid, they'd be entitled to a higher reimbursement basically because they get a little bit of DSH money, from the sounds of it; where if he has his private insurance, they just get whatever the base rate for Medicaid would have been. That's my understanding.

COMMISSIONER CARTER: But I think the hospital would still get paid. It's just that --

CHAIR THOMPSON: Right.

COMMISSIONER CARTER: -- they wouldn't get counted in this DSH allotment calculation. Right?

COMMISSIONER GORDON: Yes, and that's what she's saying, is that in the --

COMMISSIONER CARTER: There might be a disincentive --

COMMISSIONER GORDON: There's a slight disincentive in that situation where they're not being able to recognize that.

COMMISSIONER CARTER: I see what you mean.

MR. NELB: I could think of how to better articulate this. For the vast majority of private insurance, the payment is much -- 150

percent or so of cost, so if that was counted, then on net in that circumstance -- and that the private insurance did actually pay a portion of it, you know, maybe after -- even like after the deductible, the payment probably could still be above the cost, and so in that case, the hospital would potentially receive less DSH payments for serving a patient in that circumstance, that is, both in private and Medicaid. And so this policy actually tries to reduce the disincentive to serve patients who are both in Medicaid and private insurance.

CHAIR THOMPSON: Okay. So I think we have batted that around to sort of sufficiently -- thank you, Leanna, for bringing that up.

But I think that ultimately that this is an issue about some of the high-deductible plans and what happens to people in those circumstances that may be worth of some additional examination in the future.

I think in this case, what we're talking about is -- so in the circumstance that we're describing here, Medicaid would still pay the provider, but the question of whether it would be counted as shortfall or not, it would be out.

Chuck, are you wanting to say more on this point?

COMMISSIONER MILLIGAN: Yeah. I'm sorry.

Well, a good point, Leanna, so thank you for that.

Private insurance is going to change. I mean, it is trying to kind of shoot at that moving target. There are lifetime caps, lifetime limits. There's going to be a lot of shooting at moving targets.

I do think it's worthy of keeping an eye on the ball. So you're stuck with us, Rob, and vice versa.

But I do think the recommendation still makes sense.

CHAIR THOMPSON: Okay, good.

All right. So let's go ahead and move on to voting. Anne.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Again, yes, no, or abstain.

Melanie Bella?

COMMISSIONER BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: I'm marking Fred Cerise as not present.

Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: I abstain.

EXECUTIVE DIRECTOR SCHWARTZ: You may.

Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

VICE CHAIR LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil?

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Penny Thompson?

CHAIR THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So we have 15 yeses, one abstention, and one not present.

CHAIR THOMPSON: Okay. Thank you, Rob.

Oh, wait a second. We did have one for Rob. Okay.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

CHAIR THOMPSON: Just one for Rob. That's hard to believe.

EXECUTIVE DIRECTOR SCHWARTZ: He had three last time.

CHAIR THOMPSON: Yes.

Okay. Now we're going to go on to program integrity, and we have two here.

Okay, Jessica.

MS. MORRIS: Thank you.

We have two recommendations aimed at improving the effectiveness of Medicaid program integrity.

The first proposed recommendation reads: "The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states."

CHAIR THOMPSON: Do you want to go ahead and do the second one as well?

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

MS. MORRIS: The second recommendation also aimed at improving program integrity reads: "To provide states with flexibility and choosing program integrity strategies determined to be effective and demonstrate high value. Congress should amend 1902(a)(42)(B)(I) of the Social Security Act to make the requirement that states establish

a recovery audit contractor program optional."

CHAIR THOMPSON: All right. And these are unchanged --

MS. MORRIS: These are unchanged.

CHAIR THOMPSON: -- from the conversation this morning.

Any final comments or questions from the Commissioners before we move to a vote?

[No response.]

CHAIR THOMPSON: Okay. And, again, like the recommendations from Chris, these two are not a package, so we are voting on them individually.

So let's go to Recommendation 1 and have that up for a vote.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

COMMISSIONER BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: I'm marking Fred Cerise as not present.

Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

VICE CHAIR LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil?

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Penny Thompson?

CHAIR THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. That is 16 yes and one not present.

CHAIR THOMPSON: Okay. Let's go to Recommendation 2.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

COMMISSIONER BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: I'm marking Fred Cerise as not present.

Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

VICE CHAIR LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil?

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Penny Thompson?

CHAIR THOMPSON: Abstain.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So that's 15 yes, one abstention, and one not present.

CHAIR THOMPSON: Okay. And lastly, we will end our voting session on therapeutic foster care.

Okay. Martha?

MS. HEBERLEIN: Thank you.

So the recommendation is unchanged from this morning, and it reads as follows: "The Secretary of Health and Human Services should engage the Centers for Medicare and Medicaid Services and the Administration for Children and Families to develop joint sub-regulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting."

CHAIR THOMPSON: And, again, as per our conversation this morning, this recommendation is unchanged from the proposal that you made to us earlier, Martha.

Any final comments or questions from the Commissioners?

[No response.]

CHAIR THOMPSON: Okay. Let's move to a vote.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

COMMISSIONER BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: I'm marking Fred Cerise as not present.

Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

VICE CHAIR LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil?

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Penny Thompson?

CHAIR THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. That's 16 yes and one not present. Ta-da.

CHAIR THOMPSON: All right. Thank you all.

I want to just, before we adjourn, make sure that there aren't any outstanding issues from the Commissioners.

[No response.]

CHAIR THOMPSON: Okay. We will adjourn and pick up tomorrow morning at 9:30 and look forward to seeing everybody then.

Thank you.

* [Whereupon, at 3:42 p.m., the Commission

recessed, to reconvene, Friday, April 12, 2019, at 9:30 a.m.]

PUBLIC MEETING

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

Friday, April 12, 2019
9:33 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
MELANIE BELLA, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
ALAN WEIL, JD, MPP
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 7: Review of Draft June Report Chapter on Medicaid in Puerto Rico

Kacey Buderi, Senior Analyst.....215

Public Comment.....237

Session 8: Review of Proposed Rule to Promote Interoperability in Federal Health Care Programs

Moira Forbes, Policy Director.....240

Public Comment.....271

Session 9: Evaluating Integrated Care: Review of Results from Literature

Kirstin Blom, Principal Analyst.....272

Nisha Kurani, Analyst.....274

Public Comment.....299

Adjourn Day 2.....299

P R O C E E D I N G S

[9:33 a.m.]

CHAIR THOMPSON: Okay. We'll go ahead and get started with our agenda this morning. Kacey is going to kick us off with a review of our draft June report chapter on Medicaid in Puerto Rico, and Kacey, take us out.

REVIEW OF DRAFT JUNE REPORT CHAPTER ON MEDICAID IN PUERTO RICO

* MS. BUDERI: Great. So today I'll be providing an overview of our draft report on Medicaid in Puerto Rico, which we will include in our June report to Congress on Medicaid and CHIP. This chapter includes the information we've presented and discussed at prior meetings and responds to some of the feedback we've heard from Commissioners.

So I'll provide the congressional request language and then get into the report's main sections, including the introduction, background, overview of the Medicaid program and the major challenges it's facing, and then the data on Medicaid spending, as well as the financing and spending issues coming up for FY 2020 and their implications.

The House Committee on Appropriations requested that

MACPAC examine possible options for ensuring long-term sustainable access to care for Medicaid beneficiaries in Puerto Rico. This request has no due date and does not require recommendations.

The introduction to the report outlines some of the main points that Commissioners have made as we have discussed this issue over the last several months. Puerto Rico's Medicaid program is operating in a challenging environment that's been worsened by Hurricanes Irma and Maria in September 2017. The Medicaid's financing structure, which is a capped allotment structure with a fixed federal medical assistance percentage, has resulted in chronic underfunding of the program.

While Congress has provided some infusions of federal funds on several occasions, these have always been time-limited and have reacted to immediate rather than long-term needs.

The uncertainty about future financing has made it difficult for Puerto Rico to plan, manage, and maintain an effective Medicaid program that provides reliable, sustainable access to care for beneficiaries.

We've included background information on Puerto Rico's

relationship with the federal government, its economic and population decline over the past couple of decades, its accumulation of debt. We also describe some of the economic indicators which are significantly worse for families in Puerto Rico than on the mainland. In response to Commissioner feedback we have also included some information on the cost of living in Puerto Rico, which is higher in the San Juan metropolitan area than the average for U.S. metropolitan areas and is especially high for public utilities and supermarket items.

In terms of population health, Puerto Rico's population is aging, in large part due to outmigration of younger individuals, and it has very high rates of certain chronic conditions such as hypertension and diabetes.

Overall, the health indicators are worse in Puerto Rico than on the mainland. However, health insurance coverage rate is high so Puerto Ricans generally report being able to afford health care services.

The chapter goes on to describe Puerto Rico's Medicaid program, the role it plays in the health care system, and the main challenges that it's facing.

So Medicaid is a central part of the safety net and

health care system in Puerto Rico. It covers almost half the population. Its subject to most federal Medicaid requirements and shares many of the same roles, responsibilities, and administrative structures as other state Medicaid programs, although there are some differences in eligibility and the benefits offered.

Recently, Puerto Rico has made some significant changes to the program. Specifically, it's in Year 1 of a major managed care restructuring, which involves a reorganization of the delivery system as well as some additional requirements and responsibilities for MCOs. It has also made some improvements in its administrative systems and processes, notably through establishing a Medicaid Management Information System certified to report information to T-MSIS as well as establishing a new Medicaid Fraud Control Unit, and these are steps that both Congress and GAO have asked Puerto Rico to take.

So the financing structure is the most significant difference from state Medicaid programs, and as I mentioned it's a capped allotment structure, meaning that Puerto Rico can only access federal Medicaid dollars up to an annual cap. The cap was set in 1968 and grows with the medical

component of the CPI-U. It is not clear what factors Congress considered when setting the amount for the cap.

Puerto Rico's statutory FMAP is 55 percent, which is significantly lower than it would be if determined using a similar formula as the one used for states, which would give it the maximum allowable rate of 83 percent, and this arrangement has led to chronic underfunding of the program.

I'll note here that while the other four territories share the same financing structure and they too have experienced challenges with their caps and their FMAPs, their Medicaid program features vary and so we've included in the chapter a box that describes the other programs.

The chapter goes on to outline the additional federal funds Congress has provided on a temporary basis to make up for the funding shortfall created by the cap. The most recent sources, which Puerto Rico has been using since 2011, include ACA Sections 2005 and 1323, the Consolidated Appropriations Act of 2017, and the Bipartisan Budget Act of 2018. The funds provided by the BBA were provided in part to respond to the effects of Hurricanes Irma and Maria. They have a 100 percent federal matching rate and are available for FY 2018 and 2019. So Puerto Rico does

not need to put up a non-federal share for those funds.

To respond to some Commissioner comments about Medicaid's role in responding to other disasters, such as Hurricane Katrina, we've also included a box in the draft chapter that discusses this.

So even with these infusions of funds, Puerto Rico's Medicaid spending has been constrained, and this is reflected in their per-enrollee spending. So this figure, which you saw at the March meeting, and is the same as the one shown in the March meeting, shows the distribution across states of projected Medicaid benefit spending per full-year equivalent enrollee, after we adjust for enrollment mix and take out spending on long-term services and supports, which Puerto Rico does not cover.

You can see that Puerto Rico's spending, both federal and total, is lower than in any state. It's represented by the green Xs at the bottom. Its total spending per FYE, represented by the green X, at $2,144, is even lower than the federal spending per FYE in all states, meaning that even if the federal government paid 100 percent of Puerto Rico's Medicaid it would still spend less per FYE than it's currently spending in any state.

So the chapter then goes on to raise some of the main issues the Medicaid program in Puerto Rico is facing, and these include access to health care facilities, physicians and specialists, which is uneven across different regions of Puerto Rico. Also, as we've discussed before, Puerto Rico does not provide long-term services and supports as a Medicaid benefit.

Puerto Rico's program has struggled with chronically low provider rates. We've included some more information about this in the chapter, including some comparisons to states. Like other states, Puerto Rico has often turned to provider payments when faced with budgetary decisions, but program administrators and other stakeholders have indicated that the system is now at a point where it can't sustain another rate reduction, given the existing access issues.

And then lastly, Puerto Rico has been under pressure to further reduce spending from the Puerto Rico Financial Management and Oversight Board. The board has imposed substantial mandatory spending reductions, citing some of the managed care reforms and changes to the capitation rates as the main generators of savings. However, the

board and the government of Puerto Rico have disagreed over the amount of savings that are achievable, and they are working right now to revise those targets.

So shifting gears to talk about the data on financing and spending that we include in the chapter, we include this graph here to show Puerto Rico's total Medicaid spending. There are a few differences from the last time you saw it. We have tweaked the data to reflect the latest information available. We also have actual data from 2018 now, rather than projected spending, so now 2019 is the only year on here that is projected.

You can see here the degree to which Puerto Rico has been reliant on the additional funds provided by Congress, and they have tapped into it every year since it became available. Over time, spending has grown and especially in FY 2018 and 2019 the share of funding that's federal has grown due to the 100 percent matching rate on BBA funds.

One thing that Commissioners were interested in at the last meeting was the effect of Hurricanes Irma and Maria on Medicaid spending, and you can see here that spending did increase slightly between 2017 and 2018, and Commissioners were interested in why that was, given the damage to Puerto

Rico's infrastructure and the disruption that occurred in the provision of health services.

So in the chapter we've discussed this. Essentially, Medicaid did experience a dip in the number of claims made and in enrollment in the couple of months following the hurricanes, which was in September of 2017. However, both enrollment and claims began to tick back up within one or two months, and they both increased slightly in 2018.

Puerto Rico did suspend eligibility redeterminations, so anyone who lost eligibility between September 2017 to June 2018 were automatically enrolled.

In terms of the effects of outmigration on Medicaid enrollment, there is no data to specifically look at outmigration among Medicaid beneficiaries. However, Puerto Rico has indicated that it expects declines in Medicaid enrollment to mirror overall outmigration trends but with a one-year lag.

So although Puerto Rico's spending in FY 2011 through 2018 were matchable due to the supplemental funding provided, Puerto Rico still contributed a greater share than it would have been required to make under the usual FMAP formula. So to respond to some Commissioner feedback,

we've included this table to show what federal spending was under current law and would have been if Puerto Rico had the 83 percent FMAP, in dollar amounts and in the percent of total spending.

I'll note that although Puerto Rico's statutory FMAP is 55 percent, the federal share has been different in some of these years. Specifically prior to July 1, 2011, the FMAP was actually only 50 percent, and then beginning in calendar year 2014, Puerto Rico was able to access the expansion state FMAP for adults without dependent children, which ranged between 78 and 90 percent during that time. So that's why the overall share is higher than the 55 percent FMAP that's in current law in recent years, and it's the same reason why the federal share under the 83 percent FMAP policy is not always 83 percent.

You can see here that over the whole 2011 to 2017 period federal spending would have been $2.9 billion higher with the increased FMAP. We did not include FY 2018 and 2019 because we assumed that Puerto Rico would have used the BBA funds at 100 percent.

Okay. So now turning to the issues that Puerto Rico is facing after FY 2019. As we know, BBA and other

supplemental funds will be expiring and Puerto Rico is expecting a Medicaid funding shortfall for FY 2020.

So without additional federal funds, Puerto Rico must increase its own Medicaid spending or reduce total spending, and it's unlikely that Puerto Rico could increase territorial share at this point. They may actually need to decrease it. So it's likely that substantial benefit and enrollment reductions would need to occur.

The slides that follow are the same ones you saw at the March meeting. We included these figures in the chapter and provide some analysis on them, and I'll just go through them briefly today because you've seen them before.

This slide shows different scenarios for what could take place. It shows spending assuming that Congress provides sufficient federal funds to fully match all projected spending in FY 2020, at the 55 percent FMAP available under current law, and then at the 83 percent FMAP. It also shows scenarios in which Congress does not provide additional federal funds and Puerto Rico either maintains its expected FY 2020 contribution or it reduces that contribution to only the amount that would be matched.

This slide just shows the makeup of Puerto Rico's

projected FY 2020 spending by service category. You will recall that without additional funds Puerto Rico would need to reduce spending. It would be by a little over $1 billion if it maintains its expected FY 2020 contribution, or about $1.5 billion if it contributes only enough to draw down available federal funds. And this slide is just intended to illustrate what that would mean in terms of benefits. You can see that even by completely eliminating the prescription drug benefit, its largest category in terms of spending at $808.6 million, it would not achieve the level of savings needed.

Puerto Rico could choose instead to cover fewer people instead of reducing or eliminating benefits, and assuming no reductions in benefits and no additional federal funds Puerto Rico would need to reduce enrollment by between about 450,000 and 700,000 beneficiaries, or 36 to 53 percent, depending on whether it maintained or reduced its own contribution.

So looking ahead, as I've mentioned, Puerto Rico is now coming up on the expiration of their additional funds, and is expecting to exhaust the funds that are available for FY 2020 by March 2020, and for FY 2021 by December of

2020. However, the Medicaid program is likely to be affected earlier because of the uncertainty about future availability of funds. Both the government and MCOs expect this to affect upcoming rate negotiations, which will take place this summer. Additionally, they are concerned about whether providers will remain in the program.

And so wrap it up, the actions taken by Congress in recent years, including the additional funding but also other decisions, like extending the expansion state FMAP to Puerto Rico, have helped Puerto Rico to strengthen its Medicaid program through expanding Medicaid, adopting MMIS and the MFCU, and continuing to provide services to beneficiaries. However, significant uncertainty and financial pressures remain, which make it difficult for Puerto Rico to continue to operate a program that ensures long-term sustainable access to care.

So I'll stop there and I'll look forward to your feedback on the chapter.

CHAIR THOMPSON: Thank you, Kacey. This has been a challenging chapter, and the Commission has peppered you with questions over the last few months and you've done a fantastic job in trying to pull together, in a digestible

format, a number of different points that I think are really important for congressional consideration.

I really think that the additional information that you've provided, that basically tries to say, well, what if we had been in a different world where instead of going through a lot of emergencies and adding funding at various times that we had just simply created a different kind of funding structure? What would that look like and then how does that compare to what would happen if Puerto Rico had a financing structure that looked more like a state?

Those are helpful reference points. It's not necessarily true that we would say that's what it should look like for Puerto Rico, but I think it helps put some of the spending and some of the challenges and some perspectives, in terms of how that relates to other kinds of situations.

I had one question about the chapter, and I don't remember if it was in some of the earlier materials or not, and so I apologize if I'm just picking it up at this point. But we talk about the Financial Oversight and Management Board, and we mention that they have a fiscal plan. As part of that fiscal plan they have spending reduction

targets.

Can we say more in the chapter about what that looks like? I know we make the point that many people think that, you know, those measures are too aggressive, but I think it would be helpful for people to understand what the board has asked for and thinks is possible.

So can we categorize what the board has said about what it's looking forward to in terms of Medicaid, how it believes the program needs to respond?

MS. BUDERI: Yeah. So I think one of the challenges with that, the board approved a certified fiscal plan that included some specific targets and outlined some of the areas where they think the spending reductions can come from. That was approved in October 2018. But it's my understanding that there has been some back-and-forth with the government of Puerto Rico about revising that plan and the targets.

And the board has signaled that it's open to revising them, and I think those discussion are ongoing. And this all came up kind of between our last meeting and today, where Puerto Rico submitted a revised plan, their proposal to revise those targets, and then the board came back and

said, you know, here are our issues with some of the ways that you set this up and made your projections.

So I think the problem, I think, that we've been wrestling with is how much to include, because the situation is dynamic. And I think because the board has been open to revising those targets it's not necessarily true that the targets that were approved in October will still be the targets for this year.

CHAIR THOMPSON: Okay. So I appreciate that, and I don't want to necessarily include information that will likely be out of date two seconds after we publish it. On the other hand, I do think that if we can characterize -- at least at a broad level -- what the board has said, what the negotiations are about, and the state of those -- right now we say, well, they did something in October 2018 and a lot of people are worried about what they said. And I just think that to the extent that we can characterize the facts of what they said, I think that's helpful as people read later in the chapter about how we look at some of these data points as well. I think that would be useful.

Okay. Commissioners. Kit and then Sheldon.

COMMISSIONER GORTON: So really nice work, and I

particularly appreciate the work that was done to update the spending projections from our conversation last time. It was helpful, and I'm much more comfortable with where we ended up.

I want to raise three points that maybe we can address briefly in the chapter, although two of them are questions, so if we don't have answers, we may not be able to.

The first is I think you've done a lovely job comparing and contrasting Puerto Rico's situation with the situation of a typical state, and as Penny said, setting some of the context for comparison. I just wanted to add to that. I checked with Rob yesterday, so Puerto Rico is not eligible for DSH, which we know is a major component of funding hospital care and physician care in typical states. I think it's worth saying that. And Rob's impression, which obviously you should validate, is that in terms of the other supplementals, which we know are also a major funding component for hospitals, he thinks they're constrained by the cap. So if those things are true and accurate, I think it's worth just adding it to the list of ways that Puerto Rico is different.

The second thing, I think in the chapter you did a

lovely job in talking about how on the ambulatory side, Puerto Rico is much more reliant on their system of community health centers. I think it would be worth noting, if we can pull the information out again and compare and contrast, how does the HRSA funding -- whether it's, you know, FQHC grants or rural grants or whatever else, how does the HRSA funding compare? Because that is another funding stream. And to the extent that the HRSA funding is also constrained in Puerto Rico, I think given their dependence on it, I think that is worth mentioning.

And then you talked in the section about the FOMB about part of the plan -- and I think this gets a little bit to Penny's point -- for the Medicaid program was to push the MLR rate up to 92 percent. I'm assuming that means that there's a clawback provision. If there is, I think it would be worth sort of noting that for people who are concerned that, you know, there's always been an undercurrent of concern in many sectors of the health care financing scheme in this country that the health plans are being overpaid. And I think setting MLR requirements and putting clawback provisions in place gives people a level of comfort that that's not happening. And I think if those

controls are in place, it would be worth mentioning.

CHAIR THOMPSON: I think those are all good points. Sheldon.

COMMISSIONER RETCHIN: I actually had the same interest that Kit did about the FQHCs and how they seem to be more prolific on the island than on the mainland and how the funding stream goes and whether there's room in that to expand. But I had another issue.

First of all, terrific chapter, and I know -- I'm gaining more each time we have the discussion, and I think the chapter helps me.

One thing that I guess I would say would be under the health indicators and insurance coverage, as we talk about Puerto Rico and the other territories, but particularly Puerto Rico, which I guess is about 95 percent of the population in territories, I almost would have -- I would have thought that we would see evidence, like a health care dashboard, that would show and reflect the desperation. And the numbers here are a little misleading.

So, for example, one thing that we use, or one indicator we use to compare countries and states is the infant mortality rate. But here the infant mortality rate

we compare with the entire mainland on average of 5.9. But the infant mortality in Puerto Rico is actually like 100 basis points better than Mississippi. And I don't know whether it’s worth pointing out that there is a range here rather than using the mainland average, which averages infant mortality rates from the states that do much better, and whether there are other measures that we should be following so that we don't run up against a catastrophic event.

But, in general, I guess as I look at that, it certainly reflects a population that has issues with unmet needs and higher prevalence of chronic disease. But I guess I would -- I don't know. I almost wanted to see a table or something that would show a dashboard of population health.

CHAIR THOMPSON: Yeah, and I think we've talked a little bit about that point, too. It's sort of trying to understand the Puerto Rico situation in terms of a variety of potential other states that are facing challenges, not just the country as a whole, right?

COMMISSIONER RETCHIN: Well, and to be fair, we're trying -- this reflects the rearview mirror where the

island has gotten a bolus of funds, where we're trying to look out in the future what's going to happen, and I think following a dashboard like that, but also with realistic terms that may be -- instead of just 5.9, we should see a range.

CHAIR THOMPSON: I think that's a great point. Okay. Melanie.

COMMISSIONER BELLA: Thanks. Thanks, Kacey. Can you go back to your last slide? The last bullet is really compelling to me because it raises the issue about, you know, kind of stepping back from the short term, how are we going to fix this right now, and there's a big cliff coming, which seems to happen over and over, right? There's a theme here.

I would like to spend time on this as a Commission to think about, as the Payment and Access Commission, what do we need to be looking at with Puerto Rico or any of the other territories to ensure that there is access and that we're able to fund the program in a way that meets the goals of the program. And so I would ask that we make a pretty solid point in the report about while we're giving you the here and now about the upcoming current crisis,

there is a long-term question of sustainability here, and perhaps there would be an opportunity for the Commission to do more work in that area.

CHAIR THOMPSON: I think that's well said, Melanie, as well, and I think the Commission in prior meetings has been clear kind of that the pattern of continuing as we have, at least from 2011 until now, of trying to step in and avert these crises and supplement dollars is probably the worst of all possible worlds -- well, maybe the worst of all possible worlds is not doing that, but the second worst is being in a situation where it's an ongoing and constant crisis that needs attention and kind of emergency and urgent response rather than something that puts the island on a better footing going forward so that it can have more certainty and understanding about what it needs to be doing to build its health care system and respond to the needs of its residents.

Darin.

COMMISSIONER GORDON: Great job, Kacey. Very helpful. I think it might be worth at least considering. There's a lot of explanation on prior spending trends in here, but we're talking about the funding issues that are going to be

created in 2020, and we have a projection for 2020 that, based on their projection for 2019, they got a 15.9 percent increase in spend, and it's unclear to me what's driving that, but giving some context -- you know, we talk all the way up to, I think it is, 2017 or 2018, some of the things that are contributing to the trend. But jumping 15.9 percent probably is worth giving some explanation of what might be driving some of the higher growth trends that we typically see in Medicaid, just to add some context to what's on the horizon for 2020.

CHAIR THOMPSON: Any other comments from the Commissioners?

[No response.]

CHAIR THOMPSON: Let me pause and take any public comments on any of our discussions this morning that we should take into consideration in finalizing this chapter for our June report.

PUBLIC COMMENT

* **[No response.]**

CHAIR THOMPSON: Okay. Anything else, Commissioners?

COMMISSIONER DOUGLAS: I do have one.

CHAIR THOMPSON: All right. Toby, yes.

COMMISSIONER DOUGLAS: Just a specific question. The Commonwealth-only Medicaid program, what's the spending? Do we list how much spending is on that program outside of Medicaid?

MS. BUDERI: I think we can find that out.

COMMISSIONER DOUGLAS: Because I just wonder if that would be good, it's a small thing, but just to add in terms of context since it does cover, and how many are covered under that program.

MS. BUDERI: I think it's about 200,000 covered by that program, but I can get the details that include more information.

COMMISSIONER DOUGLAS: Okay, just as another context since it's part -- I mean, in other states that would be part of Medicaid. I think it's a good contextual piece to know.

MS. BUDERI: So 145,000 enrollees covered with Commonwealth-only funds in 2017, and we can get the --

COMMISSIONER DOUGLAS: What was the total in the rest of the --

MS. BUDERI: Oh, so 1.6 million in 2017; 145,000 of those are Commonwealth-only. And we can see if we can get

the spending information on them.

COMMISSIONER DOUGLAS: But those are not included -- those are not included as part of the -- they're not matched, you said?

MS. BUDERI: Yeah; they're not matched.

COMMISSIONER DOUGLAS: So they're not in these numbers that were --

MS. BUDERI: They're not in -- Chris, are they in -- they're not. They're not in any of our analysis, but they're included in the overall figure of 1.5 million enrollees. But their spending is not included in any of our analysis or any of the graphs that are in this presentation.

VICE CHAIR LAMPKIN: Just following on, if we go down that path, some of those are income eligible and some of them are employment eligible. Is that right? If we go and provide that additional information, can we see if we can get that stratification?

CHAIR THOMPSON: All right. Seeing no more Commissioners wanting to weigh in, Kacey, again, thank you very much. Thank you for being patient with us and helping to construct, I think, a chapter that's going to be very

useful to people as a reference point in understanding of the challenges that are facing Puerto Rico and some of the possible ways in which to think about that challenge. So much appreciated.

Okay. Let's go ahead and move on to our next session. Moira is going to talk about a proposed rule to promote interoperability in federal health care programs.

REVIEW OF PROPOSED RULE TO PROMOTE INTEROPERABILITY IN FEDERAL HEALTH CARE PROGRAMS

* MS. FORBES: All right. Thanks. Good morning.

On March 4th, CMS issued a Notice of Proposed Rulemaking to promote interoperability among health care data systems and to improve patient access to health data. The proposed rule isn't Medicaid-specific. It affects policies for programs that are administered or regulated by CMS, including Medicaid, CHIP, Medicare, and the federally facilitated exchanges.

It is paired with a companion rule that was issued the same day by the Office of the National Coordinator for Health Information Technology. That rule proposes technical updates to interoperability standards that will apply to the health care industry and to health information

technology developers, and we're not going to talk about that rule today. But I'm going to talk about the CMS-issued rule. I'll highlight a few potential areas on which the Commission may wish to comment, although, as a reminder, your statutory authority invites but does not require the Commission to comment on proposed rules. If you do want to, comments are due on May 3rd.

In the preamble to the proposed rule, CMS describes the need for the proposed requirements and incentives that they propose. A major challenge in the U.S. health care system -- this is their rationale -- is that people cannot easily access their complete health record. Pieces of information are stored in various systems. They're unconnected. They don't accompany the patient to every health care setting. We've all experienced this.

CMS wants patients to have the ability to "move from health plan to health plan, provider to provider, and have both their clinical, and administrative information travel with them throughout their journey."

For providers, having interoperable health information technology, or HIT, should make it faster and easier for them to access patient data, which may lead to improved

efficiency and quality, although we don't have research making a direct link between that yet. In addition, improving interoperability among payers will support benefits coordination and transitions and help payers share information with providers to facilitate coordinated care.

However, to get fully operable health data, everyone needs to agree on common data standards, have an interface with a secure exchange to actually share the data, and everyone has to be willing and able to both provide and accept data. So this rule and the companion ONC rule try to address some of these issues.

This is the latest step in a long-term effort to computerize health data. In 1996 -- it goes back farther than this, but in terms of some of the major efforts, in 1996 the Health Insurance Portability and Accountability Act, or HIPAA, created health interoperability standards and specifications, including standardized transaction sets. Then the Health Information Technology for Economic and Clinical Health Act, or the HITECH Act, which was part of the American Recovery and Reinvestment Act in 2009, did a couple major things. It promoted health information exchange among providers, and it also provided financial

incentives for the adoption of electronic health records.

Several years after the HITECH incentives went into effect, there was still not significant adoption and meaningful use of health data by providers, and the lack of interoperability was identified as one of the road blocks. So in 2016, Congress tried again to move the ball forward, putting provisions in the 21st Century Cures Act that defined interoperability and prohibited information blocking, which are practices that prevent access to electronic health information.

This proposed rule implements parts of the Cures Act relating to interoperability. So while by definition interoperability will affect stakeholders throughout the health care system, this rule directly affects state Medicaid agencies, Medicaid managed care plans, and providers participating in Medicaid. It also affects Medicare Advantage plans and plans in the federally facilitated exchanges. By applying these requirements to the major federal health care programs, CMS estimates that 169 million patients will be directly affected.

The changes don't directly apply to employer-sponsored insurance or plans in the state-based exchanges. Those

aren't regulated by CMS. But because many of the plans that participate in Medicaid managed care or Medicare Advantage or the federally facilitated exchanges have parent companies that also offer commercial insurance, CMS anticipates that many patients who have commercial insurance will also be indirectly affected by this rule.

So I'll walk through the six provisions, some of which can sort of be grouped together. All of the six provisions affect state Medicaid programs or providers that participate in Medicaid.

The rule also contains many requests for comment or requests for information which cover a number of issues that CMS says that it may address in future rulemaking. I'm not going to go through a lot of those. They're generally pretty technical. They cover a lot of things that the Commission hasn't done work on.

Just to give you a couple examples, though, CMS asks for comments or suggestions on how to increase information sharing in settings that did not receive financial incentives to adopt EHRs under the HITECH Act. So that includes post-acute settings, behavioral health providers, long-term care providers. These providers are significant

providers in the Medicaid program, and they now lag behind other types of providers in terms of participation in health information exchange and EHR adoption.

CMS also asked for comment on how it could enhance the operability of its existing processes to share Medicare data with states; how it can provide timely, integrated eligibility and enrollment status across Medicare, Medicaid, and the Social Security Administration; and how to streamline provider enrollment across Medicare and Medicaid.

So in terms of the specific provisions being proposed here, the first two provisions address the exchange of data between health plans and health plan participation and health information exchange; you need that participation in order to exchange information between health plans. These provisions support the electronic exchange of data for transitions of care as patients move between different plans or payers, including Medicare, Medicaid, and the exchange: Specifically, Medicaid and CHIP MCOs -- as it applies to Medicaid. Medicaid and CHIP MCOs will be required to provide and accept electronic patient health data for up to 5 years and incorporate it into a patient's

health record. So if a person became Medicaid health eligible -- sorry, eligible for Medicaid and enrolled in a Medicaid health plan or if they were in a Medicaid MCO and left it and got employer-sponsored health insurance, the Medicaid MCO would have to accept claims records from their prior insurer or give their claims data to their subsequent health insurer for up to 5 years so that the complete patient record would be available.

In order to do this, MCOs must participate in a trusted health information exchange network that meets interoperability standards. A lot of that is what is being discussed in that companion ONC rule, and this goes into effect by January 1 of next year.

The third provision applies to both state agencies and MCOs. It takes a little explaining. As part of the broader effort to make health data accessible to patients, this provision will require payers to make the data they hold, which includes claims, encounters, provider directories, any clinical data they have, lab results, that sort of thing, and make those available through something called application programming interface, or API, technology. This technology allows third parties to access

data securely without having to go through the data owner each time.

It works by having whatever that industry is have a standard set of data specifications, security standards, and interfaces, and then the data owner, which in this case would be the payers, the state agencies, the health plans, making available a data set that then has to be continually updated and making it available through a secure interface.

The idea is that third-party developers will have an incentive to create apps or software for patients and providers to access and use health data if they know the data are available and they don't have the hurdle of having to work with every payer out there, you know, figuring out their unique data dictionaries and establishing a bunch of one-off connections.

The Medicare fee-for-service program has already made several years' worth of data available through an API. They have six years of data out there. They've been working on this pretty diligently since last year, and there are several apps now available on the Medicare website. And, actually, if you go to the App Store or Google Play, there's one app available there. You search

on Blue Button, and it lets you get your -- if you have a Mymedicare.gov account, you can actually get your Medicare records on your phone now.

So this provision would move the ball pretty far in terms of making health data more accessible. There are lots of ways I am sure we can imagine that patients and providers and insurers could use health data and integrate it with other data or other apps as part of delivery or care coordination or, you know, how we use our data at home or whatever. This is obviously going to be a heavy lift. The proposed rule has a very short time frame for implementation. This would go into effect next year, and this is also, you know, not an area where state Medicaid agencies have a lot of expertise. It's not really a core competency of a state Medicaid agency.

The next two provisions apply more broadly to providers, including those that participate in Medicaid. Congress identified information blocking, which includes practices that unreasonably limit the availability, disclosure, and use of electronic health information as one of the road blocks to greater interoperability. The rule tries to address that and limit information blocking by

publicly reporting the names of providers who attest to certain activities such as blocking their information from being shared in certain public directories.

The other provision requires hospitals that participate in Medicare and Medicaid that have EHR systems that generate certain types of notices to send those notices to other facilities and providers when a patient is admitted, discharged, or transferred. And the goal of this provision is to really increase information sharing in real time when a patient enters a hospital or is discharged or transferred to really help increase the use, the meaningful use of information by hospitals that have the systems to use that data.

And this last provision is very specific to Medicaid. CMS and the states exchange data on who is enrolled in Medicare and Medicaid so that they can coordinate premiums and cost sharing for persons who enroll in both programs. The current requirement is that states exchange data with CMS on a monthly basis.

Right now, about half -- actually more than half of the states submit buy-in data to CMS daily, and more than half get daily response files from CMS.

There's another file that states have been required to submit for a while that supports coordination with Part D and the low-income subsidy program, and the buy-in data, states are required to submit this file monthly. Many submit it weekly, and 13 submit it daily because they find it useful to have information on who's enrolled in Medicare for a variety of coordination reasons, to have that more frequently.

It's in rule that it's required monthly. A rule change is required to make that daily for the rest of the states. The states would get 90/10 systems change funding to make this change. They have three years to implement the change for the half of states that aren't already doing it. So this is part of what's being proposed here.

So, again, this is part of broad changes being made that affect more than Medicaid (except for that last provision) as part of ambitious things that have been promoted for the health care system. What's being suggested here support a lot of important goals. Having better data, more transparency, and more interoperability supports a lot of things that are important in health care.

These are not areas that the Commission has done a lot

of work in. So beyond what I've said here, there's not a lot of additional information that I can provide.

Where the Commission does have some expertise, some track records around thinking about the administrative burden in terms of cost and time, so I did try and provide some information in your materials on that.

And, again, you're not required to comment on the proposed rules, but if you do want to comment, we can prepare a letter based on your discussion today and get that submitted by that May 3rd deadline. But I'm happy to try and explain further where I can.

VICE CHAIR LAMPKIN: Thanks, Moira.

I do have a question for you, not a technical question. I think it was on Slide 5, and you were talking about the provision that there be data transferred as patients move from plan to plan. And that was applying to Medicaid, MCOs, and CHIP MCOs, but not the fee-for-service environment or not Medicaid and fee-for-service. Was that Slide 5?

Right. So that second sub-bullet under the first bullet, what is the rationale for not extending that to the fee-for-service environment to complete the package for an

individual who may be in fee-for-service for some period of time? Do you know?

MS. FORBES: When I read it, I don't know that they said why they did not include the fee-for-service program.

They're requiring that health plans participate in the HIE networks, and that is sort of a precursor to being able to exchange the data. And states are not required to participate in those networks, but they didn't say why neither of those things were applying to states.

VICE CHAIR LAMPKIN: Okay. Thanks.

MS. FORBES: I'm sorry. No, they didn't -- I don't think they explained why.

VICE CHAIR LAMPKIN: Okay. Thanks.

Do other Commissioners have questions or comments for Moira?

Toby and then Darin and Martha.

COMMISSIONER DOUGLAS: The only comment, obviously I think this is, over a long haul, the right direction in terms of ensuring that Medicaid beneficiaries have access to their health information, but balancing that with just the administrative burden, the timelines for some of the stuff for states in terms of the API, just a question --

maybe we can comment. Given other priorities on eligibility systems and other IT efforts, is the timing appropriate for states and the burden on states to have to implement this, given other necessities and priorities?

CHAIR THOMPSON: Darin and then Martha.

COMMISSIONER GORTON: Toby and I don't only share a haircut, we also share some more thinking on this.

[Laughter.]

COMMISSIONER GORDON: The timing, just talking to folks in the Medicaid agencies that do this, that's been a concern, you know, even in isolation. I'm not even thinking about some of the other things that they have going on because their first step is even just assessing some of the different systems and their capabilities to do some of the things that are being asked. That's step number one, and that's not a quick step in and of itself because they're also interacting with different folks in the industry that don't commonly interact with Medicaid in order to make those assessments of what needs to be done.

I do think acknowledging that challenge from pulling this off for early 2020 should probably be thought about in the context of really the degree that a state will have to

do. The added match is great, but there's just physics involved here from a time perspective.

COMMISSIONER CARTER: Thanks, Moira.

I imagine that other organizations will comment on this, but germane to our conversation on substance use disorder, I've got a concern that the whole issue of Part 2 regulations is still not taken care of.

Most electronic health records don't have a way to sort out or keep separate SUD records, and then if they're shared in a multidisciplinary practice, which is more and more common, then that patient's whole set of records wouldn't be able to go through the system unless there were specific individual patient consents.

So we're concerned about the population with SUDs, and until all those pieces are fixed, EHR changes, which is going to take time, and the Part 2, which seems to still not be fixed, we would still have problems of sharing records of this population that actually is one of the vulnerable populations that you'd want to be able to share.

VICE CHAIR LAMPKIN: Melanie and then Alan and then Bill and then Brian.

COMMISSIONER BELLA: Thank you.

I have a question about -- or a question/comment.

CMS released another rule last week on the D-SNP integration standard, so integration standards between D-SNPs and Medicaid as part of the attempt to continue to raise the bar.

Starting in 2021, the states will either be able to continue enrolling people into a D-SNP, so that's the dual eligible special needs plan. They'll have to either have a contract with the Medicaid agency for capitated behavior health and long-term care, or the second piece is they'll have to develop a mechanism to share information on hospital and SNF, admission and discharge to the state Medicaid agency. They'll agree on a subset of that population.

And that piece, whether it's going to need to be a data exchange from a health plan to a state, I think is giving people some pause about how the states are going to take that data and use that data.

So I mention it because I think there's some relevance here. A D-SNP -- Medicare Advantage plans will be required to do all of this, correct?

MS. FORBES: Yes.

COMMISSIONER BELLA: Okay.

MS. FORBES: This all applies to Medicare Advantage. Wherever it says "health plan" here --

COMMISSIONER BELLA: It's all Medicare, Medicaid. Okay.

But then as far as the discharge notification, that's tagged at the hospital level; is that right?

MS. FORBES: The ADT, yes.

COMMISSIONER BELLA: Yes. Okay.

So all I would ask is to keep in the back of our mind that there is this other final rule that is going to impact Medicaid agencies with regard to data sharing and plans and think about whether there's any -- I guess whether this helps with any of that.

I'm not asking for us to do any work. I'm just asking to be aware of this other thing that also is trying to promote data exchange in the context of trying to further integration in a place where I think it's going to be a lift for the states and the plans to be able to do those sorts of notifications.

COMMISSIONER WEIL: I'm not quite sure how to say this, but I'll do my best.

This is very interesting, and I can easily imagine us writing a letter that begins "This is a really great goal, and here are 30 problems with achieving it." And I suspect that is what the vast majority of interested parties will put in their letter.

And I guess I want to offer a slightly different perspective, although I'm not sure practically how to apply it. Using public program participation as leverage for policy change is a big deal. It's why hospitals in the United States are integrated, because of Medicare prohibiting participation of hospitals that are segregated by race. I don't want to suggest this is the same level of importance, but this is part of an effort to give patient -- to effectuate the notion that patients own their own clinical data.

And we have been saying that and funding it and not getting it, and the notion that the federal government might use its leverage to actually drive aggressively toward that end seems quite consequential to me and not one I want to say "but, but, but, but," because there are always a lot of reasons that it's harder than it sounds.

So I just would ask that as you -- if we do a letter,

which is what you're asking, that we don't fall into sort of the trap of this is hard; therefore, although we appreciate the goal, we think you should move carefully. Although that is true, I think it's easy to lose sight of the goal if we overemphasize the challenges associated with doing this.

COMMISSIONER SCANLON: My thoughts are very similar to Alan's. I mean, this is an important goal.

I would sort of point out that the two dates you mentioned in your presentation were 1996 and 2009, and so there's some time that's passed.

This particular regulation, the details may be new, but the idea of the concept is not a surprise. I mean, people have been anticipating this for a long time.

The importance of it, the question is, How does the importance of this relate to all the other priorities? And I agree with Toby and Darin that there are these other priorities that people have been given with obligations and due dates, and the question is, if you were to say take those into account, where are the tradeoffs? Would the suggestion be do this as opposed to that? That's the kind of remedy I would be more in favor of when you recognize

that something else is lower priority and that this deserves a higher priority.

Now, having said that, that's a hypothesis that this deserves a higher priority. That would require an examination of sort of what the tradeoffs are.

The other thing about extending deadlines, I think our reality is that when we have a deadline, what our observation has been, we have partial compliance by the deadline, and then we have sort of further participation and more compliance sort of over time.

The question about moving a deadline out further into the future is we get partial compliance at that future point, and then we get sort of fuller compliance even later than that.

I'm not that disturbed. I don't buy sort of the fact that we are putting out another priority out there, because I don't think we're capable of sorting out what the priority should be in terms of the order in which some of these things are done.

I'm very much on balance -- I don't know how to write a letter that stresses the importance but also doesn't interfere with the process.

VICE CHAIR LAMPKIN: Okay. I have Brian, Penny, and Darin.

COMMISSIONER BURWELL: So I guess I'll follow up a little on this providing information about your health care use and to beneficiaries.

There's a paragraph on page 5, Moira, about the number of Medicare enrollees who have downloaded their health records, which is 200 out of 53 million. So that's an important piece of information, although it's a ramp-up situation, I'm sure.

And the next section, there are currently 20 apps available on the CMS website, and only a few thousand beneficiaries have "shared their claims data with production developers." I don't know what that sentence means? If you could explain that?

So I think there's a lot more to -- I mean, just the mission of being transparent and getting access to your own health care records, I think is a laudatory one, but I'm much more in the devil is in the details as to kind of what kinds of information.

I have an electronic health care record with my health care system. It is not particularly useful to me. I get

overloaded with information that's pretty useless to the point where I ignore most of it.

I mean, making information to Medicare enrollees as a total population is a good one, but I know a lot of people are also enrolled in Advantage plans. They may have a separate electronic health care record from their Advantage plan. So do they go to Medicare -- you know, My whatever? What's the name of it? The website for Medicare from CMS? So that would be a separate access point, would it not?

MS. FORBES: Well, I will say the intent of making the data available through this is you can go to one place, and the app that's actually available on the app store right now, it can integrate data from TRICARE, the VA, and Medicare, which I will say could be immensely beneficial for people who receive benefits from those programs or for caregivers of patients who receive benefits from those programs.

That said, there have been very few takers so far, as shown in the data, and I don't know how much of that is a result of just publicity and the newness of it, and it may be in 10 years, everyone will be using this. I don't know.

But I did provide that information to sort of say that

there's an assumption in this rule that if the data are made available that app developers will take advantage of it, and there will be a marketplace of ideas. And that there will be an uptake of users, sort of the way that when the app store became available on iPhones, there was a proliferation of apps in ways that we couldn't envision, and everyone uses them now.

And that in the year and a half that Medicare has invested in this, that it has been a slower uptake. That was sort of the point of showing that, as just a piece of evidence that it's not maybe quite as straightforward in this space and given what else this Commission knows about sort of health literacy and access to technology of the Medicaid population in general, just things to keep in mind.

COMMISSIONER BURWELL: But my point is this is one access point where there may be multiple access points for me as a consumer to get access to my information.

MS. FORBES: That would be the goal of making the data available is that developers would be able to create ways for you to have one access point, which you as a consumer would find easier than the current system provides now.

That would be the end goal of this, yes. That it would be able to integrate Part D -- for Medicare, integrate Part A, Part B, Part D. For Medicaid, as a consumer, it could integrate your -- if you are in a program with carve-outs, it could pull all of that. If you change between different health plans over time, it could aggregate things.

COMMISSIONER BURWELL: And to follow up on Martha's point, say I move from one thing or another -- I switch health plans -- there's a consent part to exchanging my data from one plan to another, is there not?

MS. FORBES: Well, you are the owner of your own data.

COMMISSIONER BURWELL: Right.

MS. FORBES: So it depends on what we're talking. I mean, there's different parts of this rule. I mean, one plan exchanging data for another, things are governed by a lot of different rules here. Things are governed by HIPAA. Things are governed by Part 2. So it depends on what we're talking about.

And if we're talking about a patient accessing his or her own data, you have access to your own data.

If we're talking about payers or providers exchanging and sharing data, they are governed by other rules,

including HIPAA and Part 2 about what they can exchange and when.

So everything is governed by the existing rules, but if we're talking about you getting your own data, you always own your own data.

COMMISSIONER BURWELL: No, but I'm also talking about giving permission between health -- you know, my providers or my insurance companies to share information about me.

MS. FORBES: That's governed by the rules that govern that now.

COMMISSIONER BURWELL: Right.

VICE CHAIR LAMPKIN: Okay. Penny and then Darin.

CHAIR THOMPSON: I'm going to make an argument that we not write a letter. I mean, my views are not incredibly strong on this point.

I think if this is a really important topic, I'm going to sound like the letter that Alan says we shouldn't write, which is without the "buts."

But I think this is a really important topic, and I really think I commend the administration for really thinking about this and trying to move and advance this ball.

I think there's a lot of details in these rules. They are very dense. They can become very technical. I don't know how much we contribute to the dialogue by making very high-level statements. We haven't done a lot of work in this area.

I think Brian was starting to get at something, which is I think it becomes really interesting to think about use cases.

I agree, Moira, exactly with you about, to some extent, we have built a health care delivery system that works around some of the barriers and impediments, and we don't know exactly what that new health care delivery system looks like when we start to take down those barriers and impediments.

In terms of thinking about the impact on states and administrative burden, I've become a little concerned about sort of just saying it's a lot to accomplish. I actually am not exactly sure where every state is and what it would need to do. I don't know the possibility for multistate solutions, for national solutions.

Interoperability has been an element of enhanced funding requirement for state MMISs for seven or eight

years, including some discussion with states and their technical directors on APIs. So I don't know how much reuse there may be for existing capabilities.

So I just think there's a lot that we don't know. There are interesting questions. I think they're worth thinking about potentially in the future.

In terms of writing commentary by the end of this month, I just don't know that we would have the content and the substance and the perspective and the understanding to make that a really meaningful set of comments.

I think it's good that we're having the discussion. I think it's important that we get briefed on these kinds of matters and think about the extent to which we want to potentially embed some of these questions into ongoing work, but my view would be, at this point, given the work that we've done this far and the focus of the rules that I'm not sure any commentary from us at this juncture would be a significant contribution to the dialogue.

VICE CHAIR LAMPKIN: Okay. Darin.

COMMISSIONER GORDON: Well, that kind of makes my comments, I guess, a little less relevant in that situation.

I mean, I agree with Alan's comments. I mean, this is important. There are a lot of challenges around it.

But I was responding to Bill's comment about deadlines. I hear you about what we see -- you put a deadline and then people move and all that -- but there is a basic fact, and we continue to ignore it when federal rules are developed, which is states have procurement laws that take, in many cases, six months. And so here you have a deadline of January 1, 2020. They don't have all the answers of what needs to be done yet to even develop what bids they would need to have developed to get the work done. And so, I mean, there's a difference between encouraging and pushing and having a deadline and then just recognizing that this is not going to get the desired results, and, quite frankly, that have some unanticipated results of taking people off those other projects to focus on this thing that is unrealistic to begin with.

So, you know, I get if we're not writing a letter but every time we have these deadlines we just have to have that -- we can't say, well, if we move the deadline other people are going to move it. The reality is there are some basic things that they are required to do, by law, that you

just can't get around.

CHAIR THOMPSON: And I agree with that completely. I mean, I always think that there is a lack of appreciation for the planning, operational, contracting, effectuation, execution steps that are necessarily.

I don't -- I mean, in this case, when we talk about developing an API, my assumption is this is within scope for every state's MMIS contract today. They don't have to do a new procurement. I am saying that without knowing that -- I am just making a presumption that that is the case. You have existing systems and contractors that are supposed to be meeting certain standards and conditions, and part of that is going to be connections and interfaces and APIs, and that's the state of technological activity today. So would that be true for every state? I don't know, right. Generally speaking, when you say would that be true for every state the answer is no.

So I can imagine that this is going to be easier for some states and harder for other states, and it's going to conflict with some direction that some states are going in, and it's going to align with some direction that other states are going in.

And so, you know, if we felt like we wanted to make that general point in a letter, I mean, I think that would be fine. You know, at some point a federal regulation is going to establish a federal deadline and it's not going to be state by state and it's not going to be customized based on state-by-state readiness. But surely we do believe that it should be realistic and achievable, and, you know, that should be an element of all rulemaking.

COMMISSIONER GORDON: I totally agree. I mean, this is just such a sensitive subject for me because I made these same warnings on the exchanges and the new eligibility systems and what ended up happening, because we all rushed very quickly to get there, was not necessarily the desired result for many, many months. And so every time I see us marching in that same direction we've got to give that warning, and then when we have the problems we can all just, you know, shake our heads and not understand why it happened and we'll repeat it again another time, or eventually we're going to continue to help emphasize the point that we've got to learn from those lessons.

CHAIR THOMPSON: And, you know, if we think that's the point that we want to make in a letter -- I mean, I think

we can lay out the kinds of steps that need to be taken. First of all, I have to have a partner to do it, so I have to decide if my contract is in scope. I have to do a development activity. I have to do a testing activity. And, you know, I may want to, for purposes of efficiency, try to gather with other states, especially if we share vendors or, you know, technical architectures, and that would take some time.

So I have no problem on that's the point that we need to make, that, you know, the government should take a look at those kinds of steps and ensure that their deadlines are consistent with, you know, something reasonable on that basis.

COMMISSIONER GORDON: And to Alan's point, and the point you made, there is no doubt in my mind that they are going to hear that elsewhere so I don't know if adding our voice to it is super helpful. But I think this is just a good opportunity to just think about this every time we see these kinds of deadlines out there, to be thinking through, for those of us who have run these things in states. It isn't just, well, it's an arbitrary date. It really does redirect a lot of what's going on, and then sometimes

there's not even, you know, sufficient expertise to do this in 50 states and 6 territories in that time frame as well, and then there are some negative repercussions.

VICE CHAIR LAMPKIN: Sounds like we are working our way towards the conclusion that we don't need to comment here. We have some concerns, but recognize that the direction is one we approve and we have no comments. Okay.

Thanks, Moira.

MS. FORBES: It doesn't hurt my feelings. That's fine.

CHAIR THOMPSON: Let's see if the public has any comments.

VICE CHAIR LAMPKIN: Of course. Any public comment on this.

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Okay. Great.

CHAIR THOMPSON: All right. So four our last session of the day, we're just going to keep plowing through. Individuals should get up as they need, if they need to take a quick break, but I'm just going to keep going and move into our last session of the day on integrated care.

And, Kirstin and Nisha are going to walk us through where we stand in terms of this project, looking at the literature.

EVALUATING INTEGRATED CARE: REVIEW OF RESULTS FROM LITERATURE

* MS. BLOM: Thank you, Penny. Good morning, everyone. So we're going to talk with you today about integrated care for dually eligible beneficiaries, as Penny mentioned. We will do a quick review of the models that states and the federal government are using in this area and also recap our recent contract work.

The bulk of our presentation, though, is going to focus on an inventory of integrated care model evaluations, in spreadsheet form, that the State Health Access Data Assistance Center, or SHADAC, at the University of Minnesota, developed for us. This work is the third of three contracts we've recently completed on integrated care. And then we will wrap up our presentation by talking about possible areas for future work.

As you know, integrated care models are designed to align delivery, payment, and administration of Medicare and Medicaid services to improve care for beneficiaries and

reduce costs. There are three primary models that states and the federal government are using to do this -- the Financial Alignment Initiative, which uses a capitated model and a managed fee-for-service model and allows for a third alternative model. States using capitated models enter into a three-way contract with CMS and Medicare - Medicaid plans. Managed fee-for-service models allow for an agreement where a state is eligible to share savings that may be generated through the demonstration.

There is also contracting with Medicare Advantage special needs plans, including D-SNPs and FIDE-SNPs, to coordinate Medicare and Medicaid benefits, and, in some cases, aligning those with state-managed long-term services and supports programs. And the PACE program, which has been around for a long time, offers a day center with comprehensive medical and social services for adults age 55 and older, most of whom are dually eligible. PACE providers receive capitated payments for both programs.

Integrated care is a topic that the Commission has been working on over the past meeting cycle, and as you know we've let three contracts to investigate different aspects of integrated care. At the January meeting this

year I talked with you about contract work with Mathematica to identify primary and secondary factors that influence enrollment in the Financial Alignment Initiative. And then at the March meeting Kristal reported on the results of contract work with Health Management Associates, examining care coordination standards across several models, including the Financial Alignment Initiative, D-SNPs aligned with MLTSS, and FIDE-SNPs.

So for today I'll turn it over to Nisha to walk through the third contract that we've let, with SHADAC, which is to compile an inventory of evaluations that are existing today.

Nisha?

* MS. KURANI: Thanks, Kirstin.

As Kirstin stated, I will go over our recent contract work examining evaluations on integrated care models. In the past, the Commission has asked us questions on what we know about these models.

We've found that there is a limited body of evidence examining the effects of integrated care on Medicaid and Medicare spending and outcomes for dually eligible beneficiaries. Findings from the available evaluations can

help shed light on the successes, challenges, and outcomes associated with integrated care and can, therefore, help inform future policy.

We contracted with SHADAC to compile an inventory of existing evaluations. We would like to thank Lacey Hartman and the team from SHADAC for their hard work on this project.

The inventory includes federal- and state-funded formal evaluations as well as evaluations from researchers, some grey literature, and other reports, all published between 2004 and November 2018. Currently, we have 47 evaluations focused on the Financial Alignment Initiative, PACE, and D-SNPs. In this presentation I will go over key findings from these evaluations, by model type, and then overall across models. We will be publishing the inventory and a companion issue brief later this spring.

To begin, the duals demos: we have 20 evaluations in our inventory on the Financial Alignment Initiative. There are 13 states participating in the demonstration, but we have evaluations for a select number of those states. The key findings from the evaluations include findings on use of services. Broadly, the study found that

hospitalizations and emergency department use was lower for individuals enrolled in the demos compared to those who were not enrolled.

There were mixed findings between studies on other services, such as nursing facility admissions. In terms of care coordination, beneficiaries reported varied experiences. For example, in California, some beneficiaries were unaware that they had a care coordinator, or who in their team, was their care coordinator. However, beneficiaries who had a coordinator were more likely to have disruptions in their health care resolved.

Finally, some analyses estimate savings to Medicare but do not include changes to Medicaid spending, due to a lack of data.

We identified nine evaluations on the D-SNP model, none of which specifically look at FIDE-SNPs. Among these studies, most examined care coordination within the program. Findings were mixed. In some cases implementation of care coordination was not associated with a change in beneficiary outcomes.

Several evaluations of D-SNPs did examine the use of

services. Evaluations of D-SNPs in California, Massachusetts, and New York found evidence of a decrease in hospitalizations, readmissions, and nursing facility admissions. But much like the evaluations of the demos, those of the D-SNPs did not include data on Medicaid spending. A couple of the studies did find a reduction in per-person, per-month Medicare spending, however.

We have 12 evaluations of PACE in our inventory. The evaluations for this model differed slightly in scope compared to other models and examined a variety of outcomes, including hospital and nursing facility use as well as spending and mortality. Much like the other models, PACE was associated with a reduced risk of hospitalization. However, use of nursing facilities were varied, and in some cases PACE participants had more or less nursing facility use, depending on the comparison group that was used in the study.

We identified evaluations for PACE that included spending on both Medicaid and Medicare. However, findings were mixed across these evaluations on the effects of the program on Medicare and Medicaid spending.

And that brings me to the summary findings across

models. Looking across the different integrated care models, we found that most evaluations pointed to a decrease in hospitalizations and readmission rates for enrollees, compared to those who were not enrolled. However, across models, findings were mixed for other service use, including emergency department use, nursing facility use, and beneficiary experience of care coordination.

Broadly, several studies pointed to savings within Medicare. However, most of the studies did not examine changes to Medicaid spending.

We noticed some gaps and limitations across studies. While integrated care models all generally aim to improve care for beneficiaries and reduce costs within Medicaid and Medicare, it is difficult to draw conclusions regarding the effectiveness of any given model in accomplishing its goals. This is, in part, due to the small number of evaluations per model, as well as the relatively few number of people participating in certain programs.

Furthermore, each model varies slightly due to state design on eligibility, included services, and geographic region, making it difficult to compare findings across

models. The evaluations themselves vary in their design and methodology, often with different patient populations and different comparison groups.

With regard to specific models, research is limited. For instance, there are a few studies on D-SNP alignment with MLTSS. To note, some states have chosen to align D-SNPs with MLTSS, but this is a fairly new approach and implementation varies widely by states.

Finally, state-specific evaluations on the Financial Alignment Initiative have not been published for all states.

Overall, the evaluations as an aggregate do not tell us much about how effective the models are at achieving their goals. There are a number of areas where we need more research on integrated care to better inform policy around these programs. Research can be targeted to evaluation outcomes for different populations enrolled in integrated care, since these groups often have different health care needs. For instance, the group of dually eligible beneficiaries under 65 is different than that over 65. Studies could also examine populations with different chronic conditions, such as diabetes or Alzheimer's.

Also, since the stated goal of integrated care is to reduce spending both Medicaid and Medicare we could use research on Medicaid spending. This particularly applies to D-SNPs in the demonstrations.

In terms of research design, evaluations could be strengthened by looking at how state decisions on who to include or what services to cover affect outcomes. And finally, it would be useful to have studies that compare the effectiveness of different models.

And with that I'll hand it back to Kirstin to talk about the next steps.

MS. BLOM: Thanks, Nisha.

So as you just said we are planning to publish this inventory spreadsheet and an issue brief, which you have in your materials a draft of. We are planning to publish both of those in the next few weeks.

So now that you've heard about the work that we've completed we'd like to lay out a few potential areas for future work. We have developed questions around several different areas, including enrollment mechanisms, the role of brokers, communication with beneficiaries and providers, and managed fee-for-service. Several of these are things

we've kind of discussed here before. We would be happy to hear your thoughts on any or all of these, or new ideas, and then if there are any here that you're interested in pursuing we would begin developing these into projects over the next meeting cycle.

And with that I'll stop. Thanks.

CHAIR THOMPSON: Comments or questions from the Commissioners? Reactions to the suggestions about additional future work?

Brian.

COMMISSIONER BURWELL: So I'm really glad we're doing this work and it's nice to see. I don't think I've seen, you know, an inventory of evaluation research put together in one place and I think it will be a very well-received document.

I think -- I mean, you recognize it and we all agree that kind of the findings of the evaluation seem to be highly varied all across the place. This is a very kind of high-level review of findings without a whole lot of in-depth critique or analysis of the methods used in the evaluation studies.

I think at some point it would be good -- I mean,

because it's all like reduced, you know, reduced increase -- compared to what is the real important question. And I think there is opportunity for a more advanced review of the methods used in these evaluations and their strengths and weaknesses, et cetera. I'm not saying we do this right away but in looking at any kind of results it's important to look under the hood.

Having said that, I do think that we should express some enthusiasm about the fairly consistent findings around reduced hospital use in these models. That seems to be a very strong finding. In some cases the reductions were very dramatic. I mean, I don't think we can come to any great conclusions but it does certainly seem that among this population there is at least a very significant potential to impact the use of hospital services. I would just like to see that emphasized.

I'm a little concerned that there's almost too much focus on comparing, you know, this model versus that model versus that model. You know, the model that is used to integrate services is an important factor in driving results, but there are many other factors, even within models. It's not the model itself; it's the execution of

the model. So even within the same model in the same state there may -- you know, I think we should expand, in future work, our scope to see what are the other really key elements that drive positive results, other than the model itself.

And then the last thing is just a really small thing. You talked about there were 20 FAI reports, evaluations. It would be good to have some kind of -- I mean, I assume there are more still pending, or going to come out? I would like to see kind of a total body of research that's going to come out of the demonstration evaluation, and do they intend to extend the evaluation until T-MSIS data are available, or is that not going to be part of the evaluation?

MS. BLOM: Well, I think obviously there are lots of evaluations that are -- the evaluations are very delayed, right?

COMMISSIONER BURWELL: Right.

MS. BLOM: And so those are still coming. They are trickling out. Recently several new ones were published, so as far as I know the expectation is that those will ultimately be published once, you know, once they're ready.

COMMISSIONER BURWELL: Some kind of chart of ones that are still expected to come out, would be great.

MS. BLOM: Okay.

CHAIR THOMPSON: I had Melanie next and then Stacey.

COMMISSIONER BELLA: Thank you for this. I'm super excited because these are really hard to evaluate and the numbers have been relatively small, and we've been challenged by not having Medicaid data. So I think directionally these are showing us important things, and it's timely because CMS is pondering what it can do to try to help states get into this game and have new models. And so the more we can help educate and kind of shine light on some things, I think the better.

I do share Brian's concern about trying to do any sort of head-to-head FIDE versus MMP. I mean, I just think that's inherently problematic. But I wanted to actually talk a little bit about some of the other things we might look at, so I have three, not surprisingly.

First is I want to put a strong push for doing something around enrollment mechanisms. So, you know, what happens right now is if we can't find ways to continue to enroll, to continue to grow these programs, they just sort

of peter out. And I think there's a lot of mechanisms that are -- there are tools in states' toolboxes. But some of them they're just not aware of, and some of them they just need a little bit of help figuring out how to use, and that could have a huge positive impact on integration and on aligning people in plans. So I think that's a really important one.

The second piece is the rule that just came out that I mentioned earlier that does set standards for how D-SNPs and state Medicaid agencies are going to work together is significant. And there is a lot of work that's going to need to happen for both states and plans, and it's going to start in plan year 2021. But it means that the contracts with state Medicaid agencies have to be in place in July of 2020. So there's not that much time, and I think if we could figure out -- you know, I'm not suggesting we become a technical assistance arm, but let's not lose sight of these new standards, and how do we as a Commission feel about where we're going to try to advance integration and how it could or could not contribute to those goals, and it will allow us to see things like this. We'll make the issue that we've talked about lookalikes. This will, you

know, create more market pressure for things if states can't get mechanisms in place quickly enough to meet these new standards. And I just think we need to be aware of that.

And, lastly -- and this relates to your point about managed fee-for-service -- I think managed fee-for-service is attractive if we know we have some states that aren't going to be managed care states, and we know a big barrier is shared savings for the states. And so this is an important thing to look at, but I think what is interesting about the state-federal dynamic is just the relationship between Medicaid-funded LTSS services and Medicare-funded post-acute services in particular.

Chuck, when you were at Hilltop a thousand years ago, you guys did something looking at the correlation between well-funded Medicaid programs and the impact on Medicare post-acute spend. And so as we think about ways to support shared savings arguments, I think an analytic exercise would be to look at that correlation because it helps make a statement about the relationship about when Medicaid is funding richly or poorly, what impact that has on Medicare, positive or negative, in those areas. And so I would

suggest that that's something we could consider.

And now I will shut up.

CHAIR THOMPSON: So good fodder. Stacey.

VICE CHAIR LAMPKIN: I'm just going to chime in with an interest on some of this in particular around understanding better the states that have not chosen to go deep on integrated care models. They're either passively participating in D-SNPs, you know, without really trying to push it necessarily. Does that relate to the second two sub-bullets there? You know, how to get at that a little bit better and understand those barriers.

MS. BLOM: Yeah, that was definitely part of our thinking around the managed fee-for-service questions.

CHAIR THOMPSON: Chuck, respond to "thousands of years ago."

[Laughter.]

COMMISSIONER MILLIGAN: That's okay. Everybody now knows I'm at least a thousand years old. And I'm sorry I missed a chunk of it in sort of doing the day job stuff. And forgive me if this came up while I was out of the room.

I'm going back to kind of the panel we had a few months back around approaches to dual eligibles and

different ways of thinking about things like geoaccess and provider networks and thinking about how to relate to the Medicare side of the bid cycle and compliance. And a lot of state Medicaid agencies lack that capacity, understanding infrastructure.

I remember Tom Betlach from Arizona commenting on one of his staff people that he had hired was full-time doing Medicare advocacy, because to expand integrated care on the D-SNP side meant you had to comply with the Medicare geoaccess and network adequacy standards, which varied quite a bit, typically didn't accommodate telehealth, typically didn't accommodate non-emergency transportation that Medicaid uses to get people to providers who may not exist where they live.

And so to me, one area of future work that would be interesting is just how different states administer internal to the Medicaid agency some of their approaches to trying to advance integration. It kind of gets to what Melanie was touching in and around, you know, are states ready for this new integration rule that was just released last week? Are they ready from a data side? Are they ready from an IT side? Are they ready to use Medicare

encounters? Are they ready to receive D-SNP or Medicare Advantage files or care coordination or appeals and grievances? And how are they staffed to administer approaches to integration and the different flavors?

So I think that would be a helpful way of understanding the extent to which state infrastructure is correlated to delivery system models.

CHAIR THOMPSON: There might be something, too, Chuck, because it comes on the heels of the conversation that we just had, kind of our evergreen comment about how we have to think about operationalizing something that comes down from the federal government to the states, and we've got to think about a series of issues around contracting and staffing and skill sets and systems and testing and collaboration and all of those kinds of things.

So, you know, I also wonder if we can begin to think about some kind of model of these are kind of the dimensions and domains of the things that you have to think about whenever you're doing something and the kinds of things that you should think about in terms of what's necessary and what time does it take and, you know -- and maybe this is an example where we could apply that, but it

also might be a kind of template that could be useful for other kinds of conversations and discussions.

Toby.

COMMISSIONER DOUGLAS: Just building on this third bullet around communication with beneficiaries and providers on integrated care, I think it would be good to dive a little deeper on the coordination and challenges with carved-out services, whether it's behavioral health, whether it's home and community-based services, personal care services, just the challenges that occur and ways that some states are able to overcome those to truly promote integration.

And the same on the provider side, diving a little deeper on how to -- what incentives and approaches to really bring physicians both from an infrastructure and financially more incented into the integrated delivery structure given the challenges on opt-outs that states have seen, driven in some cases by physicians. Are there opportunities, approaches, lessons learned?

CHAIR THOMPSON: Darin and then Brian.

COMMISSIONER GORDON: Along the lines -- not too far off of that, looking on the enrollment side of things, I

think one thing that you have to look at in that whole broad context, you know, about people opting in or opting out of these different models is the overlap of the networks in a particular market between Medicaid and Medicare, you know, to the extent there is overlap. But then also I think there's a component in there as well, is how states -- what they -- how states reimburse for a crossover payment. I think all those are directly related to kind of what's happening when a provider -- you know, if a provider isn't in the network on the Medicaid side, then, you know, there's going to be some challenges there for the member.

If that particular provider feels that every dual-eligible that they see ends up -- they only get the 80 percent from the Medicare side and nothing on the Medicaid side, that influences their level of interest for participation -- not to make the enrollment piece more complicated, but that is -- I just think that's something we have to be aware, whether we look at that or at least acknowledge that there are some other factors at play here.

COMMISSIONER BURWELL: I just want to follow up on Stacey's comment about why are some states doing this and

others not. To me, there's definitely kind of a sequencing. I mean, this is really about -- not just about integrated models, but also two separate markets, just the MLTSS market and the Medicare managed care market and the melding of those. So, you know, it's clear that the states that are more moving towards integrated models are those that have done MLTSS for a long time and then realize that they need to connect with the Medicare side. So like Arizona, which had mandatory MLTSS going way back to '88, you know, has a very mature strategy around integrating with D-SNPs and kind of other states like that. And then there are other states that may want to participate in integrated care models, but they really don't have a Medicare -- or a D-SNP market in their state, whether they are too rural or whatever.

So, I mean, I think that's just part of the story. It's not like whether states want to do it or not. You can only do it if you have those suppliers available.

VICE CHAIR LAMPKIN: So I'm glad you said that because I hesitated to ask a question earlier in the context of the evaluation where it seemed to me like a big -- for instances where these integrated care models are enrolling

nursing home certifiable level of care individuals, you know, the success of the integrated care model in delaying entry into a nursing home seems like it would be a huge evaluation question. But then I wasn't sure whether that was too narrow of a question because it was just maybe more PACE-oriented than FIDE-SNP. But do your comments about the maturity of the MLTSS environment is what prompts or can be part of what prompts the focus on integrated care mean that it is related to keeping people in the community?

COMMISSIONER BURWELL: Why we haven't seen more [off microphone] would respond if you asked them why haven't you done integrated -- you know, they say, well -- and I know a number of states had ideas about doing more integrated care, but said, "We've got to get the MLTSS part down first." You know, so it's a sequencing.

VICE CHAIR LAMPKIN: So it's more of priorities?

COMMISSIONER BURWELL: Yeah.

VICE CHAIR LAMPKIN: Okay.

COMMISSIONER BURWELL: There's a natural evolution.

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: Maybe this is a naive question, but I'll pose it to Kirstin and Nisha, and actually maybe

Melanie. But as I recall, those who opted out on the alignment initiative, there was favorable selection, and that is that those who opt in had less institutionalization rates. Was that the direction of the -- my underlying question is: In these evaluations, was there a follow-up on those who opted out as well in terms of hospitalization rates? And the selection...

MS. BLOM: I don't think that the ones we looked at had any follow-up on the people who opted out. But that's not to say -- it could be that there are other studies in process that would be looking at that.

COMMISSIONER RETCHIN: Do you, Melanie, on the selection [off microphone]?

COMMISSIONER BELLA: Well, they did, but they didn't look at utilization for that. They looked at -- I think it varied by state. Your state in particular, yes -- well, when you were in Virginia, yes.

COMMISSIONER RETCHIN: Yeah, that is that those --

COMMISSIONER BELLA: You had really aggressive nursing homes opting people out like crazy.

COMMISSIONER RETCHIN: That's right.

COMMISSIONER BELLA: They were like opting them out

and the people didn't even know they were opting them out. And so, yes, you had -- in Virginia there was very low participation of nursing facility folks.

COMMISSIONER RETCHIN: And I would say, you know, one thing that's not surprising to me is that the early -- I mean, this is early. This is a marathon, not a sprint. And I would say the integrated models of care are going to take much longer for the de-institutionalization much less the avoidance of institutionalization than it is for the acute-care aspects, which I think is check the box, it's almost spike the ball. I think that's a very positive finding.

I am interested in seeing -- I don't know whether Toby or someone mentioned this, on the variations among the different initiatives, but the state initiatives on the FAI in particular, because I do think it'll provide some insights into best practice.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: I just want to come back, Stacey, to your comment. Part of the success to MLTSS linking to Medicare is, you know, access to the Part D and pharmacy. It's access to primary care and specialty care,

because there's a lot of predictors of being able to safely and stably stay at home in HCBS, including the full linkage to Medicare, making sure that, you know, all of those other -- the medical side.

But the other thing I wanted to mention, Medicare is moving in the direction of Medicaid in many kind of important ways. The CMS call letter for 2020 Medicare Advantage plans is really expanding the scope of what you can file in a bid for, I mean, environmental modifications, pest control, transportation, personal care services, meals, I mean, it's like the Medicare version of HCBS. And so there is a convergence happening that will lend itself to further expansions around integration, and it's going to be interesting to witness on the Medicaid side the extent to which there is some substitution for duals. It's going to be interesting to see the extent to which states, in signing their MIPPA agreements to allow D-SNPs to operate, leverage, try to leverage Medicare as primary for some of those kinds of benefits.

So not to say that this is part of what I'm proposing for the work plan here, but there's many trends right now that are in both programs lending itself toward better

integration.

COMMISSIONER BELLA: Can I just say something?

CHAIR THOMPSON: Yeah, jump in.

COMMISSIONER BELLA: One last comment. I mean, that piece about how do Medicaid and Medicare work together with Medicare's allowance of a lot more flexible benefits is really important, and it creates an opportunity, an unintentional opportunity for cost shifting, which is not what we want to see. So that piece, and then what is going on in the market with the D-SNPs. And, again, sorry to say this again, but with the lookalikes, those are both areas that legitimately MedPAC and MACPAC should be working on together. So I don't know how often we can talk to them about those things, but I'd put a plug in, too, for having a joint agenda on a couple of these things, because those -- we can't look at them in isolation, and those are kind of very real things that I think we could both make an impact on together.

CHAIR THOMPSON: I have to confess, myself I made note, Chuck, of the point that you're making about what's in the call letter and how that starts to move in the direction of social determinants and community-based and

personal care. But I did not think about the issues of the intersection in terms of substitution and effort. Yesterday afternoon's conversation about TPL, it sort of scares me to think about some of those details.

COMMISSIONER MILLIGAN: Well, but that has existed -- I mean, you can do supplemental benefits of Medicare around dental, vision, I mean, that issue has existed in that whole space, and what is interesting, and kind of going back to the D-SNP comments, is they're not part of the core benefit. And so there are selection issues, offering or not offering, unlike Medicaid where typically every plan in the market adheres to the benefits, and there is some value-added stuff, but it doesn't drive enrollment quite the same way.

So all of these dynamics are going to be in play in terms of -- alignment is affected if a D-SNP tries to use benefit design for selection in ways that may or may not align to their Medicaid dual enrollment.

CHAIR THOMPSON: Okay. Any final commentary?

[No response.]

MS. BLOM: I'd just like to say that those comments were very helpful, so thank you, guys.

CHAIR THOMPSON: Good. And from the public, any comments on this part of our discussion this morning?

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Okay. So this meeting concludes our 2018-19 cycle of public meetings. The public should look for our June report, which we've spent a lot of time in this last meeting discussing. We'll have five chapters: drug policy, Medicaid shortfall for DSH, program integrity, therapeutic foster care, Medicaid in Puerto Rico. And it contains six recommendations that we voted on in this session.

As the Commissioners and staff know, this is also my last public meeting as Chair, and so I will publicly thank my fellow Commissioners and staff, and particularly, Anne, I wanted to say thank you to you for your partnership and support during my term.

So look for our June report, and we are adjourned.

* [Whereupon, at 11:18 a.m., the Commission was adjourned.]