PUBLIC MEETING

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

Thursday, February 27, 2020
9:02 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
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TRICIA BROOKS, MBA
BRIAN BURWELL
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P R O C E E D I N G S

[9:02 a.m.]

CHAIR BELLA: Good morning. Welcome, everyone. We are going to get right into it with our first panel, and I will turn it over to you, Martha.

PANEL: STATE MEDICAID INITIATIVES TO IMPROVE MATERNAL HEALTH

* MS. HEBERLEIN: Thank you.

So the Commission has been talking about Medicaid's role in maternity care for the past several months, and we are going to continue the discussion at this meeting by reviewing the preliminary findings from an inventory of Medicaid efforts to address maternal health in the states and territories and then hear from a panel of state representatives directly.

As is our custom, the Commission will then continue its discussion of the findings and next steps. Based on the work over the last year, we are planning on producing two descriptive chapters for the June report an overview of Medicaid's role in providing maternal health services and a more focused examination of pregnant women with a substance use disorder and neonatal abstinence

syndrome.

MACPAC contracted with Mathematica to compile an inventory of state Medicaid initiatives to improve pregnant women's access to services and the quality of care they receive. Mathematica began with a review of publicly available information and then verified the accuracy of the data with the states and territories.

They examined efforts across a number of areas, including eligibility in enrollment, education and outreach to providers and beneficiaries, covered benefits, models of care, payment, managed care contracting, performance measurement, and other initiatives.

They focused on Medicaid-led initiatives and policies that were specific to pregnant and postpartum women. Overall, they cataloged almost 350 efforts across the states and Puerto Rico, although no initiatives were found in the four other territories.

A quick overview of the preliminary findings. The greatest number of initiatives was in the category of covered benefits and included coverage of services such as screening for postpartum depression and home visiting.

A large number of Medicaid programs also focused

on payment models or policies, most often on encouraging the use of long-acting reversible contraception immediately postpartum.

About a third of programs had a policy to reduce payment or not cover procedures that do not follow clinical guidelines such as early elective delivery.

A considerable number of Medicaid programs also focused on beneficiary education such as contacting pregnant women for case management services or education regarding maternal health issues. Fewer states had initiatives to educate providers such as how to identify high-risk women.

Large numbers of Medicaid programs relied on managed care contracting strategies, such as requiring quality measure reporting or tying capitation payments to outcomes. Many also established performance improvement projects to improve outcomes among women enrolled in managed care.

Mathematica found that more than half of the Medicaid programs have adopted policies related to eligibility or enrollment such as the option to cover lawfully present immigrant pregnant women without imposing

a five-year waiting period or the use of presumptive eligibility.

Thirty states with policies in the other category use strategies such as screening tools or health risk assessments to identify women whose pregnancies were at high risk.

Fewer numbers of states adopted particular models of care, which include states that have a pregnancy medical home or provide group prenatal care. So, Commissioners, a table in the appendix includes additional details and provides a list of states that have adopted these various initiatives, and we are working with Mathematica to finalize the information and plan to include high-level findings in the June chapter. We also plan to publish the full inventory as a resource on our website later this spring.

So based on the findings from this inventory, we have asked representatives from Michigan, New Jersey, and North Carolina to discuss Medicaid efforts in their states to improve maternal health.

Kate Massey is a senior deputy director for the Medical Services Administration with the Michigan

Department of Health and Human Services. In this role, she also serves as Michigan's Medicaid director overseeing several health care programs, including the Children's Health Insurance Program and the Healthy Michigan Plan. Massey has nearly 20 years of operational and policy experience in Medicaid and other insurance programs, having served most recently as chief executive officer for Magellan Complete Care of Virginia.

Jennifer Langer Jacobs is the assistant commissioner for the New Jersey Division of Medical Assistance and Health Services. In this capacity, she leads the state's Medicaid and CHIP programs. Before leading the largest long-term care plan in Florida, she spent 11 years in leadership at Amerigroup New Jersey, most recently as the chief operating officer.

Shannon Dowler is chief medical officer for North Carolina Medicaid. She was formerly the chair of the Physician Advisory Group for Medicaid, an independent nonprofit organization whose purpose is to advise Medicaid on clinical policy. She's also past president of the North Carolina Academy of Family Physicians and has spent her career in public and community health, including providing

care at a local health department and a large federally qualified health center.

With that, I will turn it over to the panel to discuss what's happening in their states.

* MS. MASSEY: Good morning. Kate Massey from Michigan. So excited to be here, and thank you so much for indicating interest in what Michigan is doing to improve maternal health outcomes.

For this morning's discussion, I thought I would focus on three main areas that I think would be relevant to the Commission. One is our work around health equity, particularly as it pertains to maternal health. Second is to talk about our home visitation program, which we refer to in the state as MIHB, or the Maternal Infant Health Program; and then the third is to talk about what was recently released within the past several weeks, which is our FY21 budget. Governor Whitmer included a new initiative in the state that she is proposing to the legislature called "Healthy Moms, Healthy Babies," and it actually complements a lot of the work that is already under way in the Medicaid agency.

So when it comes to health equity, I thought it

would be helpful to just provide a little bit of context in terms of how we got into this work in the first place. Years ago, the state actually partnered with the Center for Health Care Strategies on a pilot that had to do with racial and ethnic disparities and found that the results were interesting and that it was a commitment that the staff really wanted to undertake in better understanding our population and what we can do to effect change within Michigan.

As a result of that partnership with the Center for Health Care Strategies, we actually began publishing a Health Equity Report. So if you actually go on to the website, we have published this report for several years, and it sub-selects a number of HEDIS measures and then kind of gives a racial and ethnic breakdown so that we can actually see what's happening below the surface. And you will see this in some of the HEDIS measures that I would like to highlight here this morning.

Let's kind of transition to some of those HEDIS measures so that I can talk to you about how it's kind of operationalized and how it informs our quality strategy. If we were to look at measures such as the timeliness of

prenatal care, you would find in Michigan that we are actually lagging in terms of our performance relative to national indicators. So we are currently performing at below the 50th percentile for HEDIS. We are performing at 77.9 percent. Whereas, the 50th percentile would require 87.06 percent.

So we recognize areas where we are very blatantly kind of lacking in terms of national trend and then think about how to address that through our quality strategy, but there are other measures where it would seem on the surface we're doing quite well.

So if you were to look at our HEDIS measure related to postpartum care, we're actually above the 50th percentile. So the 50th percentile would be about 65.2 percent. We're performing at 66.4 percent. So it would look on the surface as if everything is going fine.

But when you actually dig a layer deeper and we actually look at the racial/ethnic breakdown, we find that there is more work to do. So when you look at groups like whites or Hispanics, you'll find that we're in the mid to high 60s, but if you actually look at the performance of African Americans, we are at 54 percent. And that's really

what we want to address through our quality strategy is making sure that we're kind of reducing those disparities through very intentional policymaking, and I'll talk a little bit more about our response.

But there's another measure that I'd like to highlight before I go into that, which is low birth weight because this was another startling statistic that we identified as we were engaging in this analysis.

If you were to look at commercial performance in Michigan for low birth weight, they're averaging about 6 percent of births are at that low-birth-weight threshold.

When we look at the Medicaid program, we're at about 8 percent. So it doesn't look like it's that bad, but when we actually start looking again from a health equity lens at the performance, we find that whites and Hispanics, particularly whites, are performing at commercial levels, but African Americans are actually experiencing levels of 10 to 12 percent. So that requires more assessment and analysis from our team.

What we did, in particular, with low birth weight was we looked at regional variation. For those of you unfamiliar with Michigan, we are a pretty diverse state.

The Upper Peninsula, for example, is extremely rural, Detroit extremely urban, and we've kind of got everything in between. So when we look at a regional level, we can really kind of target by the regions that we use for the purposes of managed care contracting exactly where to focus.

When we look at the responses that we have adopted and incorporated into our managed care contracting, there are several important things that I think might be of particular interest.

The one is that for HEDIS measures where we're below the 50th percentile, we incorporate those measures into the performance withhold. So that is a very explicit and pretty clean solution.

For priorities of the states, of which maternal infant health is one, we also require plans to submit to us a performance improvement project. So it is up to the health plan based on their regional performance to decide which measure they want to focus on. We usually give them a selection of several to choose from, but of the plans that selected maternal infant health as a focus, we find that they're doing more targeted interventions oftentimes

that focus on social determinants of health that we can then monitor through our contracting oversight processes.

So examples of performance improvement projects include smoking cessation programs that are targeted towards pregnant women, making sure that we are referring to other public assistance within the state, such as WIC or food assistance, and then also making sure that we're targeting food insecurity.

There were several performance improvement projects that collaborated with food banks to make sure that food boxes that took into account the nutritional needs of mothers were provided. Or we have a hospital in the state that is one of our biggest DSH hospitals they have a food pharmacy. And so they're partnered around referrals to the food pharmacy to make sure that we were targeting that food insecurity issue.

The other thing that we've done in Michigan that I think is a little bit different is that we actually have collective quality measures, and that is when we look at some of the regional variation that I was talking about before, we set standards and benchmarks that we like all health plans to work on jointly and collaboratively, and

then we evaluate them on their collective impact in reducing health disparities. But from a contract oversight perspective, we monitor them from a process point of view so that we're still able to take that activity into account when we're doing our annual reviews, but we feel like the impact of the community is more strongly felt if there's more embedded kind of institutionalized collaboration amongst the plans, which we usually can't get to unless we were to introduce a concept such as this one.

I want to turn to the Maternal Infant Health Program. I had mentioned earlier that this is our home visitation program. We've done something a bit different in Michigan in that we have incorporated -- and I hope you will forgive me because we are addicted to acronyms in Michigan and in Medicaid. I'll just call it "MIHP" going forward. We have incorporated MIHP into the Medicaid contract, and so the requirement contractually is that health plans are required to refer pregnant women who are meeting the eligibility criteria to the MIHP program.

MIHP is actually built into our capitation rates. So it's Medicaid funded, and it's one of the main drivers of home visitation within Michigan. It follows the

evidence-based protocols that have been set nationally.

On average, a normal or healthy pregnancy would be eligible for, on average, eight visits. Some of those visits are for the pregnant mother. Some are for the child. There are two professional visits that are included in the package -- one prenatal, one postpartum. But if the woman presents as high risk, you can have actually up to 30 visits.

The providers are community-based home visitation providers, and they have been participating in this program for a number of years.

I want to talk a bit about the opportunities because there have been some challenges in our MIHB take-up. If you actually look at data over time, the number of MIHP visits in Medicaid is falling, and that was actually somewhat deliberate in that we were finding that the quality of providers was inconsistent.

We operate those programs in partnership with our Public Health Administration. So they actually took some of the providers offline so that we could work on the quality problems in a more targeted, constructive way, and so as a result of that, access actually decreased. But

we're putting those providers back online this coming year, and so we expect those numbers to bounce.

The other thing that is interesting about home visitation is that there is a real diversity of home visitation programs in general. Part of that is due to federal grant structures, where they will have specific home visitation programs that have eligibility criteria that are varied.

Nurse-Family Partnership, for example, is for first-time moms. Parents as Teachers is another program that we've got in Michigan, and then Healthy Family America focuses on families that have potential adverse childhood events affecting them.

The last programs that I mentioned are outside of the Medicaid program. They are grant funded, but it creates some confusion, especially in the referral, to make sure that the health plan is referring to the most appropriate place of service and the most appropriate care setting. So we have begun conversations with our health plans to kind of figure out if we can sort through that.

We're also interested in making sure that the infrastructure of home visitation is clearer. That's

actually a good segue into the governor's budget because MIHP is one of the components of our Healthy Moms, Healthy Babies initiative.

In response to some of the challenges that we've had with MIHB, we really want to focus on program effectiveness as well as quality. One of the proposals that we have in Healthy Moms, Healthy Babies is to initiate a randomized control trial pilot and study of MIHP so that we can look specifically at that program effectiveness question. We think that that will help us in the future make targeted improvements that will help our beneficiaries and their associated outcomes.

We also have two initiatives related to coverage in Healthy Moms, Healthy Babies. One is a reinstitution of our family planning benefit. When we in Michigan implemented Medicaid expansion, part of the negotiation with the legislature was to wind down our family planning waiver because the notion was that Medicaid expansion would cover the majority of people covered there and would provide a comprehensive benefit. And so there wasn't much interest in making sure that family planning was adequately addressed.

What we have found actually is that there is a gap of coverage of approximately 30,000 individuals who fall between the income ranges of 138 and 185, and we want to make sure that they have access to family planning services, and thus, it is included as part of our budget request.

The last major component of Healthy Moms, Healthy Babies is extension of the postpartum benefit. Right now, as per usual, we cover 60 days postpartum. We'd actually like to extend that coverage up to 12 months, and part of that is based on some of our data analytics and some national studies that indicate that there are still pregnancy-related deaths of about 12 percent from the 43-day mark to the 12-month mark. And that's what we really want to address and target by providing more consistent coverage through that period.

So those were a few items that I wanted to cover this morning. Thank you for your attention, and I'm looking forward to your questions.

* MS. JACOBS: Good morning. Jennifer Langer Jacobs from New Jersey. Thank you so much for inviting me to join you today.

I'm excited to take off, actually, from where Kate just left off, because we have a lot of similar themes and findings in New Jersey. We talk about it in different ways and we use different acronyms, but I think that's common across the states.

So I'll talk about a few of the things that Kate discussed, maybe just a little bit differently. For example, as a starting point, New Jersey is a place that struggles with this racial disparity in outcomes for our moms and kids, and we have found that a mom in New Jersey who is African American is five times more likely to die in childbirth than another mom. And that's something that puts a pit in my stomach and gets me out of bed in the morning.

So it's fundamental to the work that we're doing right now to address health equity challenges across the board, and the First Lady, in particular, has made this a focus of her work during the Murphy administration.

I became Medicaid director in New Jersey last July, and I came head-to-head with a list of initiatives focused on moving the needle in maternal-child health, and it's been an exciting ride during that time.

So I have initiatives to describe to you that are just getting out of the gate, I have a few that are farther along, and some that are moving towards being able to measure success. So I want to talk to you about each of those things. And if I have a few minutes I also wanted to talk a little bit about Medicaid agency leadership, which some of you are very familiar with, but maybe not everyone in the audience, and some of the challenges that we face from a policymaking and regulation point of view.

On the initiatives that we've been working on, they fall into kind of all the categories that you spoke about at the beginning, so I want to highlight some. There is certainly a lot of work that's always gone on, for example, the managed care contracts that Kate described, performance improvement, high-risk OB case management. I could talk to you about all of that, but all of that plays into my status quo. So what I want to talk to you about is the ways that we're trying to change the status quo.

And in particular, the initiative I've been most involved in since my arrival in the role is the development of the doula service for our Medicaid moms. And our focus with the doulas has really been around the community doula

model, which is very different from the private-pay doula model. So I'll go into a little bit more detail on that. But the other services that I wanted to describe to you include the group therapy, the centering program for moms. You know, there is an awareness that there are times when people will receive information and share concerns differently because of the group setting that they might be in. There might be a comfort level there that they don't have when they're solo with a doc or a midwife. And so we're rolling that out in New Jersey.

We did roll out our family planning benefit in October, so we have about 1,000 people enrolled in the program that Kate was describing to you a minute ago, that is meant as secondary coverage. So often there is some other coverage available to them that's not covering family planning, and those are the folks we're seeing sign up. But also, it's there for them. And as you may know, CMS has been pretty specific about what can fall into that benefit.

We are applying for a 6-month postpartum eligibility. Kate described a 12-month request. And the one thing I would point out to you on that is our initial

analysis shows that of the people that would qualify, who were on the 60 days postpartum, and who would qualify for the 6 months, if our amendment is approved, about half of them are coming back to Medicaid eventually anyway, if you look at the two years that follow the pregnancy.

And so to the extent that they are avoiding the costs of care because they don't have coverage during that post 60-day period, about half of them are having an experience that's going to come right back to our program anyway. So we think it's the right thing to do, to cover women up to six months postpartum, at least, to Kate's point, but it also makes sense from a programmatic point of view, because about half of these women are coming back to us anyway.

We're doing some episode-of-care work, which I know is a significant topic across states these days, and in particular we've got a perinatal episode of care that we are working on. Something that's interesting with the episode of care is are you looking to move the needle on cost or are you looking to move the needle on quality, or are you looking to do both at the same time, and how stakeholder involved do you want that process to be?

In New Jersey, we have said we want to do both at the same time, and we want it to be a very stakeholder-involved process. And so there are dynamics around how we get that done. At the end of the day, we hope that we will use this stakeholder process and the facilitation of that process, some technology investment that we're plugging into it, to build infrastructure that will support the rollout of multiple episodes of care, but starting with the perinatal episode.

We will no longer pay for early elective deliveries in New Jersey. We recognize that this is a significant factor in the quality outcomes that we're looking for, and so across Medicaid and the state health benefits plans we are looking to eliminate payments for early elective deliveries.

The challenge of that is technical. How do you identify an early elective delivery? And as you can imagine, people have a lot of things to say about that. But we are working through the technical questions and the IT factors involved with that.

Working on postpartum insertion of long-acting reversible contraceptives, we talk in our team about

technical challenges and adaptive challenges, technical change and adaptive change. So the technical change involved with LARC is making sure that it is easily available in hospital for a postpartum insertion, and there are complexities too, that we don't have time to talk about. We are researching a number of partnerships with pharma and frankly with some new tech to see if there are ways we can get that done. We've got some old-tech ideas about that too.

But then there are adaptive challenges that go with that, right? So far, we've only talked about the technical challenge of making it available. But adaptive challenge is about hearts and minds and people actually wanting to do it. And so there is a whole other piece to that discussion that's underway.

Some work around the perinatal risk assessment, which is, you know, performed in the states using electronic data exchange to make sure that we have a first trimester assessment and also have the last assessment and driving payment around that.

And then finally, making sure that we're getting our rates right for midwives. New Jersey was lowest in the

nation for reimbursement of midwives relative to OBs, and so we are correcting for that in the governor's budget this year.

And an important piece of this that, you know, kind of -- it comes at the end because it's not a massive initiative, but I think it's really important from a public health perspective. We're looking at implicit bias training in our health care facilities and other community clinics. We recognize that that is probably a piece -- seems to be a piece of the outcomes that we see in addressing those racial disparities.

So with one minute left I just wanted to sort of circle back on some of the challenges that we face, from a leadership point of view, from a policymaking and regulatory point of view, and then maybe we could talk a little bit more about that in Q&A if you're interested. I think that effective dates on legislation give us a sense of urgency as much as wanting to do the right thing in our hearts. And we push hard to get things done quickly because we want to make the difference. We want to be compliant with those effective dates. We want to do it all right now. That makes it difficult sometimes to stop and

listen to what our stakeholders are telling us, and we've worked really hard, especially with our community doula program, to make sure that we're bringing the stakeholders to the table and hearing them.

Compliance is absolutely critical to everything we do. As you all know too well, there are 100 rule books to follow. And the complexity of that is raised to the power of however many regulatory agencies are involved. So as we think about social determinants things become far more complex. That makes us seem rigid, and we have to challenge our own thinking. We have to interrogate our reality of the things that we know and believe are required. We have to ask ourselves, are they really required exactly that way in order to try to do things differently out here on the frontier, right? We're innovating.

Patient centeredness and the cultural competency, the ideal of health equity. It sometimes runs counter to the outcomes focus that is very data-driven, and we want to make sure that we are finding the sweet spot between the rich conversations that can happen, for example, between a doula and a member in her home and the data collection that

would give us the evidence that that happened. Right? We don't want to turn that conversation into a box-checking exercise, and we don't want to regulate the heck out of it either.

And then finally, we have to be willing to embrace these frontier questions that make us a little bit uncomfortable, and so we're thinking in terms of building infrastructure that doesn't exist, developing workforces of community health workers like doulas that are brand new, and then developing regulatory processes that will bring them into the program in a way that's authentic for the communities that we serve.

So I know I've gone over my time. I'm sorry about that. But thank you for the opportunity to share.

* DR. DOWLER: So I'm gratified to hear that New Jersey and Michigan are working on a lot of the same things that we're working on in North Carolina.

I'd like to start off by telling you a story that transformed my career. Early on in my third year of medical school, I was in my first clinical rotation on OB when a woman was rushed into the labor and delivery suite in active labor. As she was hooked up to the monitors, we

learned a few really important things. One, this was her fourth baby, which means that she was probably coming fast, two, she had had no prenatal care at all, and three, she didn't know when the baby's due date was but she knew it was late.

With that, with only moments of being in the room, she started pushing, and the head was delivered, covered with meconium, a sign that the baby was in distress. After several pushes it was clear the baby was not making progress and not moving out, and my third-year resident's forehead was dotted in sweat and I could tell that we were in a really tense moment, even though I didn't know much yet.

He announced a shoulder dystocia and the room launched into a series of rapid activities of going through the maneuvers to reduce that shoulder, to move it under the public bone so that the baby could be delivered, and none of the maneuvers were successful. The baby's heart rate was dropping. With every contraction it would drop and take longer to recover. And the attending came in and repeated all the dystocia maneuvers, going as far as to break the baby's clavicle to try to collapse the shoulders

to move them under the pubic bone, and called for us to move to the OR.

We rushed the woman to the OR while paging for anesthesia STAT, and as we got there we lost the baby's heart rate. The mom was yelling to please save her baby, save her baby, and the attending leaned over her and said, in a very calm voice, "We need to deliver your baby by C-section. The only way to do that right now is to do it without anesthesia. It's going to hurt. You're going to feel it. Do you want us to proceed? And she said, "Yes. Save my baby. Take my baby."

And so we did, and luckily anesthesia arrived about a minute after the first incision, and hopefully the anesthesia was good enough that it blocked her memories right before that time.

We ultimately performed a Zavanelli maneuver, which is the maneuver of last resort. It's what you do when there's no other chance, and it involves pushing the baby back through into the uterus and delivering the baby through a C-section. So we ultimately delivered a 12-pound baby, who was not breathing when it came out, although resuscitation efforts were successful.

That was 20 years ago. So in those 20 years, North Carolina has seen a steady improvement in maternal mortality and severe maternal morbidity, although I will admit that our measure of severe maternal morbidity is still in development. It's a challenging measure.

Low birth rates have increased across the country, at 9 percent, on average. In North Carolina, they've only increased at 4 percent. Health disparities persist, I think like they do in every state, but certainly in North Carolina. African American women and American Indian woman have much higher rates of low birth weight and preterm labor.

Reductions in racial disparities of maternal mortality have changed significantly. Twenty years ago, black women, like the woman that I described earlier, was 5.6 times more likely to die in childbirth than white women. That rate is down to 1.6 times. So while there is any disparity, we are not taking our foot off the gas and we're continuing to work on it. But one of the interesting reasons for the change in the disparity is actually a counter-increase in white maternal mortality over the last several years.

In 2018, 54 percent of the women that delivered children in North Carolina had Medicaid. And additional 6 percent had emergency Medicaid, meaning they were undocumented women who didn't have any access to prenatal care but were covered by Medicaid for their deliveries.

About a decade ago, CCNC, Community Care North Carolina, in partnership with North Carolina Medicaid, developed an innovative model to deliver care differently through something called a pregnancy medical home. It's a unique model in that it was organic and grew up from inside the trenches, from the providers who were taking care of the patients. So it wasn't a top-down program that we at Medicaid said you need to do.

It's actually an interesting dyadic model where the OB champion, which is a family physician, an obstetrician, or a maternal fetal medicine, is paired with a care coordinator in each region of the state, and they work with a whole team of care managers through the local health departments and our OB care management program. The care managers are then embedded in the practices often, and they really encourage face-to-face visits, home visits, and really engaging with the patients.

Doctors who sign up to be in a pregnancy medical home, though, they get an enhanced reimbursement rate but they have to commit to doing some pretty significant things. They have to agree to completing a risk assessment at the first prenatal visit, which does come with an enhanced reimbursement. They have to commit to getting postpartum care by 60 days, but the goal is really between 15 and 42 days, and there is also a bonus payment for getting that postpartum visit.

They have to completely decline to do elective deliveries before 39 weeks. They have to offer progesterone therapy from their offices for women with a history preterm birth. They have to maintain a primary C-section rate of less than 16 percent. They have to agree to partner with care managers actively. And they have to agree to review their outcomes data on a regular basis. So that's provided through care, so that continuous quality improvement is part of everybody's work structure.

The program has grown to include 465 practices in North Carolina and over 2,500 providers. I was one of them back in the day when I was taking care of pregnant women. They are present in 94 out of the 100 North Carolina

counties. And, in fact, in North Carolina, 95 percent of all the providers of prenatal care accept Medicaid patients.

The pregnancy medical home has also shown an interesting improvement that women in the pregnancy medical home have 20 percent lower rates of low birth weight infants than Medicaid women that are not in a pregnancy medical home. We have seen an increase in the use of postpartum LARC, that was just discussed earlier, and that was through the work of the OB champions who pushed us to change the DRG codes to cover the cost of the devices.

Interestingly, it has not taken off as much as we had hoped because the hospitals still don't want to stock the devices, because private payers haven't followed suit in North Carolina. So interestingly, Medicaid is leading the commercial world on an innovative care, so we are working on that.

If you look at our HEDIS measures for timeliness to prenatal care, it looks disappointing. It looks like we're just under 40 percent. But, in fact, if you pull out the pregnancy medical home women and you look at their birth certificate data and you do so further claims

analysis, it's clear that almost 70 percent of women in the pregnancy medical homes are getting care in the first trimester of their pregnancies.

In the last two years, the program has developed a risk stratification tool called in the MIIS score. It's the Maternal-Infant Impactability score that predicts how likely it is that a woman is going to benefit from care management. So they have taken risk data that we have been collecting for the last decade, analyzed it to say these are the factors that make a woman likely to be impacted by the use of care management in a program. At any point in time, 30 percent of pregnant women are served by care management in North Carolina Medicaid.

In addition to the other benefits, this group of OB champions and their care coordinators have worked to establish statewide standards to reduce unnecessary care variation and really get us to the quadruple aim. Some of the standards they have developed that are then taught throughout the state, and pregnancy medical home providers are expected to follow the standards, include workaround pregnancy hypertension, preterm labor prevention, induction standards for first-time moms, perinatal tobacco use,

substance use in pregnancy, multi-fetal pregnancy, postpartum well care, and reproductive life planning.

Of course, our gains in North Carolina in maternal care are more than just the innovative work of CCNC. We've got lots of ongoing initiatives that complement the pregnancy medical home work. Our perinatal substance use collaborative partners Medicaid with the Division of Mental Health and Public Health. Maternal health innovation grants pull partners together across all of human services as well as thought leaders around the state with a focus on reducing disparities in health. And we have maternal health and maternal mortality review committees that analyze the data and try to inform our practice moving forward.

As we move on to the next decade of improving maternal care in North Carolina, there are some important levers that we're working with. One is our planned transition to managed care, should we get a budget, and we hope to do that for a few reasons. One is to improve the flexibility of the program and have more incentives for pregnant women to receive more value-added services. It would actually introduce some competition to the state, and

it would allow for innovation projects like Healthy Opportunities.

We have a Healthy People 2030 statewide initiative that has got several goals around increasing access to contraception care, extending coverage in the postpartum period, which you heard my colleague share; addressing maternal health behaviors; and broader populations goals such as eliminating HIV infection.

Our exciting statewide platform, which many of you have heard about, NCCARE360, provides linkages to patients to address their unmet social determinants of health needs, and we hope by doing that we will improve the overall health of the people of North Carolina, but also reduce toxic stress.

Efforts to explore value-based payment programs outside of our bundled payment for pregnancy are ongoing in North Carolina, and the governor's Early Childhood Action Plan has a big focus on healthy babies, which means healthy moms.

Unfortunately, one of our challenges we have to acknowledge is that climate change in North Carolina disproportionately affects women and men of lower

socioeconomic status and communities of color, and so we have a lot of work to do to prepare for natural disasters that are coming more frequently and making sure that vulnerable populations are cared for.

Finally, and some might say most importantly, is the need to expand Medicaid in North Carolina. Eight labor and deliveries in rural communities have closed down in the last five years. Just over half of the counties have a labor and delivery unit in the State of North Carolina. Medicaid expansion is more important than ever to help our rural hospitals stay open and provide care to the most vulnerable of North Carolina's populations.

When I think of that very brave woman I started off talking about, I'm humbled. She was willing to undergo a C-section without the benefit of anesthesia to save her child. But why didn't she have prenatal care? Did she live in a really rural community where there just simply wasn't access and she didn't have the transportation to make it into the big city? Was she in an abusive relationship? Maybe she had a controlling partner who didn't want her to go see a doctor. Did she have trust issues? Maybe in her prior pregnancy she was treated

poorly and felt judged and shamed by her health or her overall status, and maybe she didn't trust us to take care of her. Regardless of what the reason was, it's incumbent on all of us to create a system of care that has room for everybody.

I'm humbled and privileged to be in a leadership role with North Carolina Medicaid, and I'm looking forward to building on our existing successes and make further gains to improve our maternal care in North Carolina. I appreciate MACPAC's interest in hearing about some of our work today and look forward to questions and answers.

CHAIR BELLA: Thank you all. It's always a highlight, at least for me, to hear directly from states. So this is really, really valuable. This is a very important area for us.

Let's go to questions. Martha.

COMMISSIONER CARTER: Thank you so much. It was really encouraging to hear all the wonderful things that you all are doing around equity, around alternative models. I think those are all really important. And it's great to hear that Medicaid programs are leading the way in some of these initiatives.

Some of you have already answered one of my questions. Care by certified nurse midwives and freestanding birth centers for low-risk women and doula support are evidence-based strategies that have shown good outcomes and good patient satisfaction. Evidence from other countries where midwives provide the majority of prenatal care show that when midwives are well integrated into the health care system, outcomes are better. So Medicaid programs are in a good position to advance these models of care. What has your state done to advance these alternative models? And, Jennifer, of course, you talked about making sure that midwives are paid appropriately for the care they provide, and I applaud New Jersey for that move. Any takes on the record of that?

MS. MASSEY: Sure, so I can start. So we actually already provide reimbursement for certified nurse midwives. On the question of doulas, that is something that we've been considering as part of the Healthy Moms, Healthy Babies initiative, and so it's on our list to follow up, and the team has been working on it. And so that is something that we're very interested in pursuing.

DR. DOWLER: I can speak to North Carolina. We

have two freestanding birth centers. One was just opened in Asheville, which is where I've spent the last 20 years, about two years ago. It's run completely by midwives. The oversight is by family physicians who partner very closely with them, and their outcomes have been exceptional. And it has been very well received in the community. There's also a new one opening I believe any day in Pinehurst, so in the central part of the state. So there is a move to, I would say, get back to nurse midwives. North Carolina actually has a rich history of nurse midwifery that somehow got lost at some point. And so I think we're moving back to that.

I will tell you as a family medicine resident, every Friday afternoon in labor and delivery, the midwives cover the entire L&D floor because that's when the OB residents have their didactic sessions. So that was part of my rotation. Every Friday afternoon I got to train with the midwife, and it was such an important part of our training. But I don't think that's standard necessarily across all training programs.

MS. JACOBS: Can I jump in real quick on doulas? Two technical challenges that are really important as

states move in this direction, at least what I'm finding in New Jersey. I go back to the old refrain from Tennessee. Members get services, providers get paid. Right? I always break it down that way as we're thinking about implementation. From a members get services point of view, I've got to do workforce development. We can do that. From a provider point of view, how do you credential a doula? And how will they bill and get paid? And the more you want to build a community doula program that is authentic to the communities that we serve, the more challenging those questions are.

COMMISSIONER CARTER: New York has done some work in that area as well.

MS. JACOBS: They have. And we're trying to take the learnings from other states that have been a little bit ahead of us on this.

COMMISSIONER CARTER: And my point was actually also about paying appropriately, so you might offer the service, but can you pay at a rate that is sustainable for the midwifery practices, the birth centers, the doula practices?

MS. JACOBS: And maybe with a value-based

component. Don't take your eyes off that.

CHAIR BELLA: Kisha.

COMMISSIONER DAVIS: Two things, actually, to you, Jennifer, that you could build on. You mentioned the community doula program and really wanting to expand that, so I'd love to hear a little bit more -- you just touched on it -- about how to build that, how to create enough certified doulas even to meet the challenge for that.

Then also, for everybody, value-based care in maternity care, have you started doing anything in that area? What does that look like, especially in terms of Medicaid?

MS. JACOBS: Do you want me to start [off microphone]?

MS. MASSEY: Sure.

MS. JACOBS: So a couple of things. In terms of the buildout in our state, and I think in most states, there's not yet a significant infrastructure of support for a community doula program on a statewide basis. We recognize that that's something we have to create. That's not something we have a lot of water under the bridge with, right? We don't have that experience. But we do have some

grant-funded programs in some key metro areas, and those programs have developed infrastructure of their own. And so we are pulling from the lessons that they've learned and the work that they've done to try to develop a network across the state that will help us develop a workforce across the state. That's Thing 1.

Thing 2 is making sure that as we're building out community health workers across other areas that we're keeping in mind that somebody might, in fact, be able to do both. So the example I would give you is we're building out peers for opioid recovery. And so we may have people who can do the peer work, lived experience with opioid recovery, and who also are interested in the doula work. And other community health workers obviously can play in that same way so that maybe we can put together kind of a mosaic and ensure that we're using the experience that people have the best way we possibly can.

From a value-based point of view, I'm really interested in doing the work that helps the doula and the mom reconnect with the doc or the midwife after the delivery for that postpartum visit that we know is so important. And so to the extent that we can build that

into our reimbursement model, we're looking to do that.

DR. DOWLER: So I can speak to North Carolina on the value-based component. Right now we have a bundled payment for obstetrical care, but we're looking at some more focused bundles based on gestational diabetes or pregnancy-induced hypertension, and we're actually going to be joining a consortium that Duke is going to lead across the state to explore some value-based initiatives.

In our managed care plan, we have at-risk quality metrics, and several of those are related to maternal care, and they'll actually become withhold metrics, so they'll have upside and downside risk for the plans and the providers moving forward. And we're working on developing Medicaid ACOs.

MS. MASSEY: And then from Michigan's perspective on value-based, similar to the other states, we pay a maternity bundle. We're interested in looking into episodes of care, so we're in the nascent stages. As far as we've gotten is establishing a data use agreement with an outside partner who we think can help us with the data analytics because we want to make sure that we see the opportunity before we get too far down the road.

And then another component of the governor's budget was the establishment of a Medicaid transformation office, and one of the priorities of the transformation office is to really focus on one of our strategic priorities in Michigan, which is kind of diving deeper into value-based purchasing. And so through the transformation office, following in the mold of Ohio, Washington, and other states, we'd like to bring in some resources to make sure that we're thinking about value-based purchasing and its opportunities in the right way and really trying to facilitate conversations among the health plans as well as the providers to make sure that we're pointed in the right direction.

You know, we have heard very clearly from the provider perspective that they have a lot of incoming, and we also have a fair number of plans in Michigan. We have ten plans. And so we want to see if we can kind of enter into that space and create some focus and direction so that we can increase the take-up of our value based.

One more thing on value based. It's interesting because the team that we've got working on it is super invested, which is no surprise. Everyone in Medicaid is

passionate about the project and the focus area that they have. But when we look at the data that the health plans report to us on value based, we have kind of divided into what we call the big numerator and the little numerator. And so the big numerator makes it seem kind of similar to the HEDIS measures that I was talking about, that everything's fine in the sense that we've got a huge amount of dollars kind of tied up in value-based arrangements. But then when you actually look at the little numerator, it is an opportunity for improvement. I guess I will put it that way. The dollars fall off of a dramatic cliff, and you actually see the -- in our case, we have more quality-oriented, more upside arrangements, and there's a dramatic difference between the two.

CHAIR BELLA: Tricia.

COMMISSIONER BROOKS: Thank you all. It's always great to hear what states are doing that's innovative, particularly on this subject. I have two quick questions, one for Jennifer and one for Kate. You would make the Annie E. Casey Foundation proud talking about adaptive and technical challenges and implicit bias that is all part of leadership and needs to be more of it in this country. But

you mentioned that New Jersey was applying for -- I thought you mentioned an amendment to do six months postpartum. Is it a SPA or a waiver?

MS. JACOBS: It is an amendment to our demonstration.

COMMISSIONER BROOKS: Okay, got it. And then, Kate, you mentioned that in your home visiting program where you could identify high risk and get as many as 30 visits, that you had determined that the quality wasn't -- the quality of the service wasn't there. How did you get that feedback and make that determination?

MS. MASSEY: Yeah, so our public health partners would be kind of better positioned to respond. We've been tracking and focusing on quality metrics of our home visitation providers for a while, and all I kind of have picked up on is that there were concerns of such a nature as we really did need to take a couple of providers offline. So I can follow up and kind of get the specifics in terms of exactly what those triggers were that our public health partners were able to see and to observe in order to kind of make sure that we were kind of correcting that.

COMMISSIONER BROOKS: Well, it's great that you were able to figure that out, because I think we hear home visiting now, at least if you're in the child and maternal health world, and you think, oh, this is great, you know, but it can't go on autopilot. And so what you're learning in terms of that evaluation, even before you've had the time to get the data, is really important.

DR. DOWLER: I'd just jump in and say that I spent five weeks in England when I was a resident learning about socialized medicine, and their system of providing home-based services to pregnant women and new children is amazing, and their ability to go into the home -- the midwives would go into the homes and provide the visits and save mom from having to come into the office unnecessarily, and then would go do immunizations in the home. It's just such a patient-centered approach to care.

We also in North Carolina cover some of those home visiting services, but not nearly to the extent that would benefit our patients. And physicians doing home visits -- I used to do them 20 years ago, but it's impossible in our current structure of fee-for-service to justify spending the time to do home visits.

CHAIR BELLA: Fred, then Chuck, then Darin.

COMMISSIONER CERISE: Thanks for the great information. I've got a couple questions.

Shannon, first, for you, you talked about the risk assessments and the number of factors that went into that. I wonder if you could comment on kind of the breakdown of how many of those are clinical risk and how many of those are social risk and then comment a little bit on what you do with that, what the interventions are. And then I want to ask the entire group about substance use disorders and what network -- what your provider options are and what did that look like as you identified people and how do you -- you know, with the intent to get people treatment and maintain them in treatment, how easy or difficult is that for you to do across the state. But Shannon first.

DR. DOWLER: Yeah, so the prenatal risk assessment is a somewhat comprehensive risk assessment that is a combination of medical risk factors, prior preterm births, other comorbid conditions that a woman brings into the pregnancy with her, family history that might be at risk, but then there's a lot of social determinants --

access to needed food and transportation services -- and then substance use disorder features prominently. Actually, when you look at that MIIS score, the impactability score, there is a real clear indicator that women that have substance use disorders are clearly impacted by care management in a way that's meaningful and critical.

To the other question, I will say that we are doing a lot around substance use disorders. One of the standards of care that the CCNC OB champions brought up was how to manage substance use disorders and pregnancy. Still having enough prescribers to handle opioid use disorder with medication-assisted therapy is a challenge in the state. We are now across -- not all the residency programs but many of the residency programs, through the leadership of Blake Fagan, who is a family physician, are getting trained -- all the residents are getting trained in MAT and getting that waiver so that when they go into practice, they can prescribe. And then we also are doing pregnancy group home visits, and a lot of the residency programs where MAT is one of the offerings that's offered through the Centering Pregnancy models and other models like that.

So there's a real focus on new doctors, training them, OB and family medicine, on managing substance use disorder. But I would say we're not nearly where we need to be with that.

MS. MASSEY: Yeah, so behavioral health is a challenge in Michigan. When you ask about SUD, I just want to spend a couple of minutes kind of explaining the fragmentation that we've currently got in our Medicaid program because it kind of speaks to how challenging it is for plans to manage SUD and maternity together.

So we have what we call the comprehensive health services contract, which is the ten health plans that I had referenced previously, and they cover moms, kids, seniors, persons with disabilities. When it comes to behavioral health, if the individual or the beneficiary has what we call a mild to moderate concern, then they stay in the Medicaid health plan, in the comprehensive program, and then their total care is addressed. But if they have severe behavioral health needs and that's SMI and SUD and IDD, then they are carved out, the services are carved out from our comprehensive contract, and they are referred to a robust publicly led behavioral health system that is still

managed by PIHPs and that is anchored by our provider network of community mental health providers. And so these are experts that are locally led. There's local governance. This is kind of codified in Michigan statute where it is really kind of embedded deeply in the community.

And so SUD being a trigger for service by our CMH system means that there is bifurcation of care, and so that has been absolutely a challenge for us. And we are working very hard in Michigan right now to try to address some of those issues. We have behavioral health transformation efforts underway. This has been one of the top priorities of the director of the department, and we're really kind of trying to address this, recognizing that the fragmentation leads to suboptimal outcomes.

The only other thing I'll say related to this issue -- and I haven't touched on it previously -- is that Michigan is working really closely with the Centering Healthcare Institute. We have been communicating with them as early as Monday or Tuesday of this week -- I can't remember which day -- and they have -- because they see Michigan as such fertile ground, no pun intended, for the

kind of promotion of this particular model, they have a consultant who's actually embedded in our state. So we have about, I think it is, 12 to 14 sites. She's working very closely with us on expanding those sites. And then we are facilitating conversations between CHI, the Medicaid agency, and the health plans to make sure there is more widespread adoption of Centering Pregnancy, to the extent that that's a solution to SUD, which is, again, kind of not really a solution given the systematic fragmentation that we have.

MS. JACOBS: Ditto. And I would just add we've worked very closely with our community partners to build out trainings for office-based addiction treatment and to support navigators for OBAT providers who are helping members to coordinate across a complicated system with some bifurcation involved and to also addressed social determinates. So our community providers have been really supportive to us as we've been trying to train more docs to be able to provide the service, and our centers of excellence have really led the way from an academic point of view.

We also removed prior authorization with our

plans for medication-assisted therapy.

CHAIR BELLA: Thank you.

Chuck?

VICE CHAIR MILLIGAN: Thank you all. This has been a really strong panel. I really appreciate it.

I have two questions. The first one, I think, Kate, maybe to you first, and, Jennifer, you might have stuff to add about family planning, family planning waiver.

I was the Medicaid director in Maryland when the Affordable Care Act was going live, and we had similar debates. I'm curious about the need for family planning waiver to get restored in light of the fact that presumably the women would qualify for exchange-based essential health benefits. It should have those kinds of services between 138 percent of poverty and up.

I know that when we were debating this in Maryland, part of the concern was individuals might just pursue the family planning waiver and not a more comprehensive benefit package to address the totality of their medical needs by getting a qualified health plan on the exchange.

So I'm interested in kind of the thought process

about the need to restore family planning waiver, and is it because the cost sharing on the exchange is too high and people don't pursue services, that the network is different? I mean, I'm curious about why you have to do this workaround.

MS. MASSEY: Yes.

VICE CHAIR MILLIGAN: So if you could start that?

MS. MASSEY: Sure. I mean, really, it's the perception that there's a barrier to service. If we look at a lot -- and this Healthy Moms, Healthy Babies initiative was really informed by Michigan statistics and close collaboration with stakeholders within our state, and that's what we hear.

So when we ran the data in order to formulate the budget proposal, there was a segment of the population, granted, much, much lower than it had been when we had the family planning waiver in existence prior to our Medicaid expansion, which we call Healthy Michigan Plan.

There did seem to be a sliver of individuals who could benefit from the service, and so, ultimately, I think our governor and our department in general has a more aggressive stance, which is to say let's make those

services available, even if there may be other options or even if it might only cover kind of a smaller number of individuals than we had anticipated or estimated. But having it there is a benefit.

VICE CHAIR MILLIGAN: I'm doing this from memory. My memory could be wrong, but my recollection is that when women qualify for pregnancy-related eligibility, the benefit could be limited to pregnancy-related conditions, treatment of pregnancy-related conditions. It's not necessarily the full Medicaid benefit package. The eligibility pathway doesn't lead to full Medicaid benefits necessarily for the pregnancy-related eligibility category.

Most states, I think, have given full Medicaid benefits in the prenatal part of this. The question is around the potential that that's not a categorical set of benefits, full Medicaid benefits, and that a lot of potential adverse birth outcomes are related to SUD, as Fred mentioned, or other kind of conditions that can exacerbate pregnancy and risk chronic illness and all kinds of other things.

So I'm curious if you all have any comments around not just the postpartum period, but the pregnancy-

related, Medicaid-eligibility-benefit-design piece of this.

DR. DOWLER: Well, I can speak for North Carolina. Of course, we didn't expand. So the family planning waiver is a critical tool for us in our toolbox still and actually, increasingly, an opportunity for us to find ways to improve health.

From the pregnancy eligibility, so of our pregnant women who have Medicaid, 60 percent qualify for full Medicaid, and 40 percent quality for that limited pregnancy Medicaid benefit.

But we've been able to work in all the opioid use disorder treatment and full dental care. It's a pretty generous benefit, and so we're not seeing limitations to care for pregnant women.

The problem is that we get them in good shape. We work really hard with them, and we get them to -- you know, they're not smoking, and they're not using opioids, and they deliver a baby. All of a sudden, they lose that coverage in 60 days, and they still have ongoing needs for treatment. They're particularly vulnerable in that time frame.

When you look at trends of opioid deaths,

unintentional opioid deaths, you see it peak in women postpartum at four months to eight months, and this is exactly that period. So I think our number one priority is not so much, at least in North Carolina, the package of pregnancy Medicaid but how do we expand that time frame to be a more meaningful time frame to keep those moms with their babies, because we're seeing that DSS is getting involved. Moms are losing their babies, and then even worse, when that child goes into the foster care system, that parent who might have still had access to Medicaid loses it because that child is not in their home anymore. So it's that postpartum period that I think is our biggest risk.

CHAIR BELLA: Jennifer or Kate, did you want to comment this?

[No response.]

CHAIR BELLA: Tricia, on this?

COMMISSIONER BROOKS: I wanted to comment on Chuck's because we ask about full Medicaid in the 50 State Survey that we do every year, and there are only five states -- North Carolina is one -- that do not provide full Medicaid package, full package to all pregnant women. The

five offer it up to the AFDC level, the hold TANF levels, and above that is pregnancy only. But the majority of states are covering full Medicaid.

COMMISSIONER CERISE: But that is not emergency Medicaid.

COMMISSIONER BROOKS: No, no, no, no.

VICE CHAIR MILLIGAN: So old AFDC, it's like 30 percent of the poverty level in most places.

COMMISSIONER BROOKS: Correct.

VICE CHAIR MILLIGAN: Tricia, I just want to elaborate further. That income cohort above, let's say, 30 percent of the federal poverty level, kind of old AFDC on average, most states, up to pregnancy-related eligibility, in five states, the services are pregnancy-related services only, not full Medicaid. What that means is treatment of chronic conditions that might lead to a bad birth outcome but are not pregnancy related conditions or potentially behavioral health may not get any Medicaid coverage in that prenatal period of time.

Is that accurate, Tricia?

COMMISSIONER BROOKS: I think so.

The question is -- and this is what states were

tasked with when looking at MEC, et cetera, and many states clarified that they really were giving more than pregnancy-related services. I think it depends on whether the doctor believes that the woman's hypertension affects the baby's outcome or not. So I think there's still some big questions there, at least in those states.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: First of all, I would like to echo everyone's comments about what a great panel, some of the more impressive, thoughtful leaders of Medicaid. I really appreciate you all being here.

I really appreciate how every one of you all focused on data as the source of all of your programmatic interventions. So I think that's a good example of how a lot of states try to approach this.

The one thing, Kate, that you had brought up that I'm just curious what data led you to pulling back was on the home visitation.

MS. MASSEY: Yeah.

COMMISSIONER GORDON: You were talking about the quality of the home visitation providers. What were you looking at that provided that insight?

MS. MASSEY: Yeah. This gets back to the earlier question, which is I need to kind of come back to you guys and be more specific about it because that was something that the Public Health Administration took lead on, that we were kind of happy to partner with them on, because it was prioritizing care for our Medicaid beneficiaries.

But they've been tracking quality, and it's been a real challenge. The term that I use is trying to get a "hard grip on Jell-O." So their struggles with data and some of the concerns that they were having on outcomes was really what precipitated us including in the budget a randomized control trial for MIHP in particular.

I will say that that did take, from my perspective, some courage from the department's point of view in requesting that because it's 100 percent general fund, because what we're doing is really kind of trying to focus on high risk. And it's a subset of the population where it's violating statewide-ness and whatnot, and so this is kind of something that we feel is an important state investment. So then we're hoping that we'll get really good outcomes and data from that, presuming that it gets funded.

But I will definitely follow up with you in terms of some of the concerns that the Public Health Administration was having on home visitation.

COMMISSIONER GORDON: That would be helpful, just, again, helping states think about it as they're going down that path or, if they've already gone down that path, different ways to measure the quality of the actual services being carried out.

MS. MASSEY: Mm-hmm.

COMMISSIONER GORDON: The next question is really for Anne. The Mathematica table with all the analysis, I found it very helpful. Is that being put out there for public consumption?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, it will be. That's the plan.

COMMISSIONER GORDON: Yeah. Because I think looking at just some of the variability and hearing this but then looking at some of the different interventions that some states are doing that others aren't, I think some of that may just be out of lack of understanding what some other states have done and have found success in doing. It doesn't really necessarily give that aspect for the data,

the performance of those different programs, but it does give you a good sense of all the varied approaches states are taking to have an impact here.

CHAIR BELLA: Fred, Martha was before you, but are you on this?

COMMISSIONER CERISE: Yeah. I just wanted to say real quick, I know even within the different programs, the home visitation programs, you will have variation among the implementing agencies, and I don't know if that's some of what you were talking about it.

MS. MASSEY: Yeah, it is.

COMMISSIONER CERISE: Within local public health agencies that are implementing a program, their caseloads may vary widely. Some of the quality stuff has to do with individual implementing agencies where you're spending state funds and you're not getting your bang for the buck. So there's some readjustment that has to be done.

I know I've seen those things. I'm not sure that that's what you're referring to.

MS. MASSEY: It is. That's part of it.

COMMISSIONER GORDON: Well, I'd say there's variation in all providers, any that I've seen. It's just

this is one that I couldn't think in my own mind what kind of --

MS. MASSEY: What the data was?

COMMISSIONER GORDON: What kind of data source you could be looking at to help really measure the effectiveness.

COMMISSIONER CERISE: For instance, just caseload. If you're getting funded to manage, to enroll people and put them in the program, and you're not putting people in the program, then that's an issue with that agency.

CHAIR BELLA: Martha?

COMMISSIONER CARTER: So the Commission is considering whether we have room to make recommendations to Congress on potential changes in the Medicaid program.

One question I had for you, Jennifer, one of the areas that we could potentially look at would be recommendation to extend postpartum coverage to a year, which is what's generally talked about. First, I wanted to ask why you were talking about six months. We understand that there's going to be more impact in states that haven't expanded Medicaid to do an expansion. So that's sort of my

first question.

My second is more general. Do you have ideas about what you would want to see us recommend? Do you have some recommendations for us?

First, why did you think about six months instead of a year which is what most people talk about?

MS. JACOBS: I think we were trying to read the tea leaves of what might be approved, just to be honest with you, Martha. I think 12 months is a great idea.

MS. MASSEY: So I guess we didn't read the tea leaves.

[Laughter.]

MS. MASSEY: You're more ambitious with your tea leaves.

COMMISSIONER CARTER: Well, that's okay. You can always shoot for what you think is best and then settle for what you can get.

MS. JACOBS: Yeah.

DR. DOWLER: I would think a year would be idea. Six months, I would take it, you know, reading the tea leaves. You would take six months because its' better than two months, but I think really to meaningfully impact a

woman and to reduce that interpregnancy, to change that interpregnancy interval and make sure that women are intentionally involved in the reproductive life and planning, to have their next pregnancy at their desired time to have a pregnancy, and to resolve the issues from the pregnancies that have just finished. They might have had complications or other health issues that need to be resolved and for their wellness and benefit.

The other one is dental care. Every state is a little different, but we can do a lot of work in that pregnancy on dental care for pregnant women, but then we lose the ability to do that afterwards. And there's often a lot of dental work that still needs to happen. We, of course, know that periodontal disease leads to other comorbidities.

I think that one-year time frame would be ideal.

CHAIR BELLA: Kate, were you going to speak?

MS. MASSEY: I was just going to go to the second question.

CHAIR BELLA: Oh, great.

MS. MASSEY: I think what was reassuring to me kind of sitting on the panel was hearing from my colleagues

and understanding that we were all coalescing around similar ideas and similar themes.

I think that any recommendation that you might consider related to postpartum, in all seriousness, would be something that would be greatly appreciated.

We have conferred with CMS, and they have indicated to us through technical assistance that we would need a waiver which I think kind of directly responds to an earlier comment.

I think any clarification around coverage of doula services would also be helpful. When we started those conversations internally, we actually came across the same issue that Jennifer hit on, which was the certification. So I will just kind of leave it there. There are operational issues related to the provision of that service.

The other thing that I would say is a take-it-or-leave-it. What we have found is that even if we from a payer perspective make something possible, it doesn't necessarily mean that there's take-up. What I'm specifically talking to is your earlier question on midwifery, but then also LARC adoption.

When we have really tried to understand why, even though we provided reimbursement and responded to stakeholder concerns about the availability or access of that particular service through reimbursement policy and whatnot and we have made that corresponding change, that it's really about practice transformation and provider adoption. That is very challenging for a Medicaid agency to effectuate.

To the extent that CMS has been very invested in different types of grant programs, innovation models, and what have you, to the extent that they can provide resources to states to more deliberately focus on targeted practice transformation, provider education, and things like that to kind of really help increase the take-up of certain of these initiatives, I think that would be helpful from my state's perspective.

DR. DOWLER: Yeah. I think any focused attention on immediate postpartum LARC provision of services, not just the DRG that reimburses for the device for the hospital to not lose money on stocking the device in their hospital, but the professional fees for the provider who is doing that.

There's some really good literature now on the immediate postpartum LARC where baby comes out, IUD goes in, and then it's not painful for the woman. There are even more benefits to that. So I think we're making a lot of progress on providing women's reproductive choice, desired choice, but it does take a groundswell. And it requires the hospital administrators who are wearing their financial hats to recognize that this is not going to be a loss for every patient that walks in the door.

MS. JACOBS: There are a hundred things I want to say to you about doulas because my doula colleagues have taught me so much in the time that we have been working together and really taught my staff, too, what it means to develop a program that is authentic to the community it is serving.

The one thing I would say to you is there are training programs, some certifications, but there are training programs that are kind of obvious go-to's for doula service, not large national organizations that may or may not have that community focus, that cultural sensitivity, the lived experience, the health equity focus that we are really dedicated to. So it's an important

factor as we consider what is a doula, how do you train a doula, how do you credential a doula, what is the training that you would expect them to have. There are very small programs that are doing a great job of that.

So I would just ask you, as you're thinking it through, to make sure that you're looking at that whole landscape, as we have been trying to do.

COMMISSIONER CARTER: What would your recommendation around doula -- clarification of doula services -- what is a doula? This is probably a longer conversation than we can have today, and Martha, I can take it up with you.

CHAIR BELLA: Yeah. Why don't you bombard them on the break about that as you guys think about that?

I was going to ask the same question about if you were us and we could wave our magic wand, what would you want, and I think you've answered that, but last shot if there's anything else that you haven't put in front of us. Be bold.

MS. JACOBS: The spirit of innovation in these programs requires some hypothesizing, some experimenting, some trying it out and letting it go, and supporting that

innovation spirit in an official way, codifying the value of that, I think is really important.

We've codified the value of outcomes. We've codified the value of audit trail. We've codified the value of the value-based question. Is there savings attached to it? But we haven't always codified the value of the innovation spirit, and I think that's really important as we talk about being out here on the frontier and trying new things in these programs.

MS. MASSEY: The last thing I would say, just as kind of like a final shot -- and this wasn't a focus of my comments, but I actually think that it's highly related and correlated -- really is social determinates of health, and that's not just the maternal health issue. That's kind of a Medicaid beneficiary issue.

We have been trying to address SDOH as one of our strategic priorities in Michigan, but I would kind of encourage us to be thinking about SDOH and its intersection with maternal health outcomes because some of our health plans have kind of turned to that as one of the potential solutions.

I look at MACPAC as an opportunity to make firm

recommendations, but sometimes even sub-regulatory guidance or even just policy positions or points of view are kind of highlighting statutory flexibilities that are available to us that we might not be fully utilizing or leveraging. Those signals are really important, and so I would just kind of put that out there for your consideration.

CHAIR BELLA: So do you feel like there's more states that could be doing social determinates and they're not recognizing it, or are you looking for more flexibility on what can count as medical spend?

MS. MASSEY: More flexibility of what can count on medical spend, yes.

CHAIR BELLA: Okay.

DR. DOWLER: And I think this is sort of a nebulous request, but when we think about health disparities and our intentional reduction of health disparities, we have to frame it in the health equity lens. So not everybody needs the same thing to lift them up and to reduce the disparities, and yet because of our rules around Medicaid and statewide-ness, sometimes I don't know that we're able to give those extra resources in a really intentional way to bring along health equity. So I'm not

sure if there's a way we can look at the Medicaid program with that lens of building equity.

CHAIR BELLA: We could keep peppering you with questions forever, but we won't. We'll end a little bit late, but thank you.

We're going to take a short break. I'm going to say 10 minutes. People come back at 10:35, and we'll have some Commission discussions and see where we want to take all these great ideas that we've heard.

But thank you, all three of you, again, very much for being here.

[Applause.]

* [Recess.]

COMMISSION DISCUSSION AND NEXT STEPS

* CHAIR BELLA: If everyone could start taking their seats we are going to reconvene, please.

All right. Clearly there is a lot of buzz created by that panel, which is fabulous. Martha, thank you for putting it together, and I'm going to let you make any opening remarks, or you're ready to hear from Commissioners? Yep? All right.

So the purpose of this next 20 minutes or so is

to talk about what we've heard and where we would like to go as a Commission.

Where is my go-to person, Martha, to start? She must be out in the hall. Who -- Tom and then Kit.

COMMISSIONER BARKER: I just want to -- so I thought the panel was excellent, Martha. You did a great job putting that panel together. I sort of wanted to follow up on a question that Fred asked, that I was going to ask except he beat me to it, and that is about SUD. And I'm just wondering if, as we are preparing our thoughts on maternal health in Medicaid if there is a way to incorporate SUD as part of that discussion.

CHAIR BELLA: Okay. Can you say a little bit more about incorporate how?

COMMISSIONER BARKER: Ensuring treatment for pregnant women. Ensuring -- so, for example, if there is a move to bundled payments and medical homes, making sure that for women with SUD that there is adequate funding for treatment. The woman from North Carolina, whose name I've already forgotten -- Shannon, Shannon, right -- Shannon talked about the DRG carveout for, I couldn't remember what technology she -- or I didn't hear her say what technology

it was for. But the point being that in bundled payment models there are sometimes needs for -- there is a need for carveouts. And so for treatments for SUD, for example, I think that would one important consideration we could look at.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: So two things, Martha. In the briefing materials we got, the Mathematica work is focused very much on coverage, and that's important, but it's necessary and not sufficient. I mean, the Commission knows, but I think we need to be certain whenever we write about this sort of stuff that covering something is nice but it doesn't provide access, right? A card in your pocket is a card in your pocket.

And so each of the panelists this morning, in one way or another -- and I think all of them on multiple occasions -- reference workforce and access question. So I think we need to either, in the context of the June chapter, say we don't have anything to say about this yet but we're going to, and people shouldn't forget about it, or we should see -- I mean, if there's information that's readily available to us then maybe we can think about -- I

don't think it needs to be, you know, 60 pages, but I do think that if we can get some sense from, you know, ACOG or the family medicine people, or, you know, about what's available, or if Mathematica has a minute to repoll and just say to people, okay, it's covered but, you know, can you get it? If you have 100 counties in North Carolina, how many of them -- I mean, we heard Shannon say half of them don't have, you know, an OB suite. So covering it, if you have to go to the next county.

So I won't belabor that, but I do think that we -- if we're not going to describe something about access, because we don't have the data to do that, I think we at least need to remind people that coverage is only, you know, the beginning.

And then the other thing, you made a comment about there were initiatives in Puerto Rico but not in other territories. And I just -- I guess that that may be, in part -- it's not because other territories don't care. It's that the other territories, as we know, operate on a different basis, right? So they're using a public health, government-operated health care delivery system in order to do Medicaid.

And so I wonder if there -- if the provider side of things isn't dealing with -- and I just think that we should be careful not to just say, you know, the bald statement nothing in the other territories. We could also say there's nothing in several of the states, right.

So I just think we need to be fair about that, and to acknowledge that because their delivery systems are so fundamentally different from the states and the District, and Puerto Rico, that they may have a different way of approaching this that we just didn't tap into with our questions.

CHAIR BELLA. Fred.

COMMISSIONER CERISE: Great Panel, Martha. Thank you.

A couple of points. One, I think it's come up again, the immediate postpartum issue, and I think we should do something to clarify that. You know, I went back and asked our guys, because I got called out as they administrators that's got to be willing to do something. But I checked on that and there's confusion about what's allowable and what's not, do you have to create an outpatient claim while they're an inpatient? It's not

clear to a lot of people, and I think if we could clarify that and simplify it, beyond sort of the will to do it, there is a technical piece that I think we could all benefit from having some clarification on.

The discussion about risk assessment, particularly as it pertains to home visitation, I think is an important piece. You know, you're probably not going to do that for every pregnancy, but trying to identify where those more high-risk pregnancies are. I was probing to try to understand a bit about what, besides the medical factors, feed into that. You know, we've done some preliminary work to show, like just block-level data, where you live predicts preterm birth at a higher degree than a lot of clinical factors.

And so I wonder, you know, I think there's work to do around identifying those high risks and then trying to match programs that are evidence-based to go along with it. We heard some discussion about whether programs were producing outcomes you desire or not. But I think looking at evidence-based programs, particularly around home visitation, and being able to appropriately target that to the high-risk women.

Third, postpartum coverage. There is a fair amount of discussion around that still. When I reviewed the report from the Texas maternal and mortality data, over half of maternal deaths happened after 60 days, so higher than the other numbers quoted. And it was drug overdoses, suicides, homicides, intimate partner violence, those types of things.

And so I think a combination of going out longer -- we heard discussion of, you know, you've got women while they're pregnant, in the programs -- and I think Shannon made that point -- but then to extend it out to a year and to be able to really sort of couple that with some robust behavioral health, substance use program would be something important to look at.

I'll stop there.

CHAIR BELLA: Thanks, Fred. Tricia?

COMMISSIONER BROOKS: Yeah, sorry. So a couple of things. I thought the point about additional guidance from CMS would be helpful in various areas. LARC might be one of those, although I think it needs to happen at the state level as well.

The statewideness issue, because you can use

targeted case management to do high-risk or targeted populations with additional services. So, you know, it seems that maybe that's another area that's ripe for, you know, further clarification.

I think, getting to Kit's point, that Jennifer, you know, when we asked about, you know, what more could be done, where could we make recommendations, you know, having better information about targeted practice transformation, or how, you know, states that are making gains, how is that occurring?

And then I think, from the perspective of additional research, that, you know, I think we need more information on doulas and where they are being used effectively and what the challenges are to using them that could be addressed, you know, in federal or state policy.

VICED CHAIR MILLIGAN: I wanted to just comment on the extension of the postpartum coverage beyond 60 days. I'm curious if we could capture a little bit more of the current approach, which is waivers. If it's a budget neutrality play, what's the source of savings and how is it getting funded? I think it would be helpful.

Jennifer sort of commented a little bit about

that when she referenced the fact that so many people come back onto Medicaid that presumably some of the savings is you're going to end up dealing with pent-up demand issues. You're going to dealing with unmet need when they do come back on and some of the savings could be reinvested in the waiver budget neutrality.

I want to -- my policy inclination is to want to have that extended, for Congress to make it a state plan option to go beyond 60 days, but before, personally, I want to get there, personally, I want to understand better the source of the budget neutrality savings that states are using inside their waivers.

CHAIR BELLA: Please focus on that point for just a second. It would be helpful -- this is obviously an area of interest. We've had many conversations about extending postpartum coverage. We heard it from all three of our guests. What else do Commissioners, similar to what Chuck just said, here's what I would like to know before I'm ready to do that, what other things do we want to ask Martha to bring back to us so that we can continue this discussion? Martha.

COMMISSIONER CARTER: One of the issues that I

hear from my colleagues is inadequate reimbursement for nurse midwives and for birth centers. Now birth centers were required -- Medicaid was required to reimbursement birth centers under the Affordable Care Act, but that doesn't mean that they are reimbursed adequately. So I think those are two pieces of information I'd like to see, and I'm not sure how we get to that, but there's probably a way.

CHAIR BELLA: Okay. Toby, then Kit.

COMMISSIONER DOUGLAS: Well, on the expanding the coverage to 12 months, just understanding a little bit more of the intersection with the Medicaid expansion and how much -- I'm still not completely clear why, for those states that do have the expansion, why it's still needed. So understanding what the gap is there, which also gets to states that don't. Just what are -- are we -- is that the option that would be available already, rather than solely focusing on this?

And then the other piece, which we heard so much around changing workforce or culture and the environment, and I want to understand a little bit, just at a federal level, of how maternal-child health block, or the

intersection between MCH and Medicaid agencies. Just like we've talked about with SAMHSA or others, what's going on at that level? Because Medicaid can only do so much, and then there are these block grants that have a lot more flexibility to provide resources, and is there the right intersection going on in alignment at a federal level that's going down to the states?

CHAIR BELLA: Martha, did you want to say anything about the expansion states, or do you want to hold that until.

MS. HEBERLEIN: I'll hold it.

CHAIR BELLA: Okay. Kit?

COMMISSIONER GORTON: So I agree with Toby. Before I would be willing to go with the extension I would want to know more about sort of the churn and where people are going and what's happening in that gap. Does the fact that the coverage, even in the expansion states, is no longer mandatory and there are out-of-pocket costs associated, even to get the essential benefit package, right. And here you can't get your LARC because you didn't get the insurance because you can't afford the premium.

So I would just like to know a little bit more

about the market dynamics and what gets crowded out if there's a Medicaid eligibility extension.

And then the other piece I'd like to know more about is what the state of play is with the majority of states who are giving the full benefit, what that looks like, and in the states that are not giving the full benefit, are using the pregnancy related, how they're defining pregnancy related, are they really very strictly enforcing it, are the plans doing an end around? And if it’s not knowable, it's not knowable, but I think I would like to have more comfort knowing what problem I'm fixing before we go and fix the problem.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: So I just want to comment on this, you know, expansion versus non-expansion states, you know, being able to go into the marketplace. Illinois is the only state -- well, Jennifer can correct me if they've actually filed their 1115 waiver amendment for six months postpartum? They have not. So Illinois is the only state that has actually filed a waiver amendment, and they are looking to only do pregnant women's coverage above the Medicaid expansion level. So that's going to be a key

question that we see CMS opine on when they make a ruling on that particular waiver request.

And I think it's the recognition that we have a median pregnancy eligibility level of 205 percent in the country, so there are a lot of women above that. And how quickly they can in, transition into the marketplace, and what those barriers are is that this, just like family planning, which is also at about 200 percent of poverty for the states that adopt it, is really to make sure there's not, you know, any of those gaps in coverage.

There certainly is a lot of activity. ACOG has posted a couple of blogs showing maps, showing where states are in terms of any discussions about postpartum extensions. Someone -- all pregnant women, some only want pregnant women with SUD. So, you know, there's a lot of activity that's going to be happening on that. But we don't have an approved waiver yet.

CHAIR BELLA: Brian.

COMMISSIONER BURWELL: I'd like to see us get more information on how the closure of rural hospitals are impacting access to OB services in rural areas, and also, what new models are emerging in those areas, like birthing

centers or whatever, to fill that gap. There's just a change in the market dynamics that I think is an interesting context to the whole situation.

CHAIR BELLA: Kathy.

COMMISSIONER WENO: I agree with Brian. That was one of my comments. But the other thing I would say, you know, I'm concerned about access and continuity. Shannon talked about dental, in particular, and it's my experience where if a pregnant woman does have dental coverage included with her pregnancy coverage, she can maybe get into the dentist once during her entire pregnancy, and then she would not be able to get treatment for -- you know, she's getting an exam and she gets told what she needs, and then she can never get back to actually having it done.

So that's an issue, and I'm sure that's true with other conditions other than dental.

CHAIR BELLA: Martha, do you want to make any comments?

COMMISSIONER CARTER: Concurring with Kathy on that. Often pregnancy is when you discover oral health problems. I remember, as a midwife, advising my patients to, you know, eat well, and what that entailed, and I found

pretty quickly that a lot of women couldn't do that because they couldn't chew.

And so, you know, it's a really important component of maternity care, and, of course, women who have the practice of going to the dentist then also teach their children, take their children to the dentist. So it's really important, and we could certainly go a lot of places with oral health care and recommendations around that.

CHAIR BELLA: I'm actually going to open it up to the public right now. Does anyone in the audience want to make a comment?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. Any last comments from Commissioners?

[No response.]

CHAIR BELLA: So, Martha, I feel like we have some common themes for you to take back, particularly like a bucket of things where we think additional guidance would be necessary or helpful. And so looking at that, I imagine you may also see where there might be gaps in some authority that might be needed. Also, obviously, there's a

great interest in extension of coverage with some questions to look at.

I would be personally interested, when the score is finished, for whatever legislation is going on on the Hill, it would be helpful, I think, for us to see that. My guess is that the price tag is big, but it certainly mitigates costs in other parts of the system. And so also obviously a common theme around access.

So do you have what you need from us to understand where we might like to continue to take this work?

MS. HEBERLEIN: Yes. Thank you very much.

CHAIR BELLA: Okay. Thank you. Thank you again to our panelists, who are all still there, and we are going to move into our next session. Thank you.

[Pause.]

CHAIR BELLA: All right. Kirstin and Kate, you are going to lead us in the discussion of the Medicare Savings Program. Please take it away.

IMPROVING ENROLLMENT IN THE MEDICARE SAVINGS PROGRAMS: DECISIONS ON RECOMMENDATIONS TO BE INCLUDED IN JUNE REPORT TO CONGRESS

* MS. KIRCHGRABER: Good morning, everyone. So we're back again to talk about policy options aimed at increasing enrollment in the Medicare Savings Programs, or MSPs.

Based on the discussion among Commissioners at last month's meeting, we've narrowed the list to focus on the approaches you seem most interested in, and as we've noted before, each option is intended to increase enrollment, but that also comes with increased federal and state spending.

So we've grouped the options into the three general buckets that you see here. As we've discussed previously, the MSPs, which are administered by states, and the Part D Low-Income Subsidy, or LIS program, which is administered by the Social Security Administration, both provide assistance with premiums and cost sharing for low-income Medicare beneficiaries. So using one set of eligibility rules could make it possible to enroll beneficiaries in both programs simultaneously.

We've outlined three variations on this theme which build from the simple to the more comprehensive. We also offer a couple of options that would simplify the

eligibility redeterminations process, which might be unnecessary if you decide to do a more comprehensive approach. And the simplest option would be to recommend an increase in funding for outreach, which could be done with or without any of the other options.

So our first option would require states to use the Medicare Part D LIS rules for income and household size. So the Social Security Administration transfers LIS program eligibility data to states on a daily basis, but different state rules for what's counted as income and how a household is defined limit a state's ability to use that data. So due to these differences, a determination of eligibility for LIS doesn't necessarily provide enough information for a state to make a determination about an individual's eligibility for an MSP.

Individuals applying for the MSPs might have to submit additional documentation to a state, and even though they may be found eligible for LIS, they may not be found eligible for an MSP.

States currently have authority under Section 1902(r)(2) of the Social Security Act to define income and household size the same way that SSA does for LIS. But as

of 2012, 30 states required reverification of household income and 19 states reverified household size because their definitions didn't match.

Requiring states to adopt LIS definitions of income and household size for the MSPs would eliminate that need to reverify the SSA data and would enable states to process applications transferred from SSA without requiring additional information from beneficiaries. This would make it easier for states to enroll beneficiaries in an MSP. What it wouldn't do, though, is help with redeterminations. Currently SSA only transfers data from the LIS applications, and once an eligible beneficiary is enrolled in an MSP, the states are responsible for reverifying their eligibility each year. So even though SSA reviews continuing eligibility data for LIS beneficiaries every year, they don't transfer that data to the states.

So to really streamline the process and to reduce the administrative burden for states and beneficiaries, the Commission could also consider requiring SSA to transfer continuing LIS eligibility data to states on an annual basis, and that would require an amendment to Section 1144 of the Social Security Act.

So Option 2 builds on Option 1 and would require states to use the LIS definition of assets in addition to the income and household size definitions. So even though MSPs and LIS right now have the same asset limits, states count assets differently, which can prevent them, again, from using the SSA data. As of 2012, 29 states required reverification of assets because their definitions didn't match. And as we noted on the first option, the Commission could add to the recommendation to require SSA to transfer continuing eligibility data to states on an annual basis to help streamline redeterminations.

So Option 3 tries to capture the essence of the discussion at the January meeting where Commissioners seemed interested in making the MSPs as much like LIS as possible and reducing state administrative burden. So the MSPs and LIS both cover out-of-pocket Medicare costs for similar low-income populations of Medicare beneficiaries. But the income levels at which beneficiaries are eligible for a full subsidy and the application enrollment processes for the two programs are inconsistent. So these differences create inequities for beneficiaries, they're administratively inefficient, and they hamper enrollment in

the MSPs.

The LIS program provides a full subsidy to beneficiaries with incomes up to 135 percent of the federal poverty level. The MSPs, on the other hand, provide varying levels of financial assistance to beneficiaries with incomes up to those levels. The QMB program, the Qualified Medicare Beneficiary program, is the only one that fully subsidized Medicare Part B premiums and cost sharing, but it only covers beneficiaries up to 100 percent of poverty. The SLMB and QI programs pay just for Part B premiums, and they cover beneficiaries with incomes between 101 and 135 percent of poverty.

So participation is LIS is high. About 82 percent of eligible beneficiaries participate, including people who are automatically enrolled. Participation in the MSPs is a lot lower. The QMB program, participation is about 53 percent; the SLMB and QI programs are even lower, at 32 and 15 percent. And, again, LIS, almost all beneficiaries who apply for LIS do so through the Social Security Administration, which automatically enrolls them and transfers the data to states with MSP applications. And as we said earlier, states often require individuals

then to submit more information before they can be determined eligible.

So extending QMB coverage to beneficiaries with incomes up to 135 percent and requiring states to adopt LIS income, household size, and asset definitions would simplify enrollment and reduce administrative burden for both states and beneficiaries. It would also simplify the MSPs overall because it would consolidate into one program the QMB, SLMB, and QI programs. It would essentially eliminate the SLMB and QI programs. It would be the most far-reaching recommendation the Commission could make and also the most expensive.

With respect to financing, there's a few options we could look at. The Commission could recommend maintaining the current approach to funding the MSPs, which splits the cost between the federal government and the states at the current matching rate. It could also look at the federal government assuming 100 percent of the costs of the federal program and consider whether maintenance of effort for states like the Part D clawback should be included.

Fully federalizing the cost of the MSPs would be

the most expensive option and would result in increased federal spending for Medicare Part B and could also lead to increased enrollment in the LIS program, because MSP enrollees automatically qualify, so there's kind of cascading costs to consider in the other programs.

Requiring the federal government to assume the full cost of the MSPs would be considerably more expensive than maintaining the current match rates. We've had some very, very preliminary discussions with CBO about this. Their rough estimates of the cost of extending QMB benefits to all eligible beneficiaries up to 135 percent of poverty would be up to about $50 billion over ten years at the current matching rates. Increasing the matching rate to 100 percent would add another $150 to $200 billion over ten years, so the cost of kind of doing both of those things could be as much as $250 billion over ten years.

And so we have some options that are narrower in scope. Federal law requires states to redetermine eligibility at least once every 12 months, and as we've discussed previously, dually eligible beneficiaries simply don't have a lot of fluctuations in their income that are likely to make them ineligible for Medicaid.

We also know that cumbersome enrollment and renewal processes may reduce their participation and not really contribute a whole lot to an eligibility determination.

We looked at a recent study that examined the loss of dual eligibility status, and it attributed coverage losses primarily to a failure to complete Medicaid eligibility renewals. So extending the eligibility redetermination period to 36 months would increase the number of beneficiaries covered by the MSPs and ease the administrative burden for both states and beneficiaries.

Again, we don't have a firm estimate of what this option will cost, but our preliminary discussions with CBO indicate that it could be fairly expensive, largely because it would keep beneficiaries from dropping off of coverage. We did speak with them roughly about if there was an X percent increase in enrollment, what would be the likely increase in cost, and so it's about a one-for-one. So about a 10 percent increase in enrollment would drive about a 10 percent increase in cost. So we could be looking at, if this resulted in a 10 percent increase in enrollment, a cost of about $40 to $45 billion in federal and state

spending over ten years. And based on our conversation with CBO, it could be tough to get a better estimate on this just because they'd have to look at claims data over a number of years, which could be a little cumbersome.

So Option 5 is looking at use of pre-populated forms for redeterminations. It's another way for states to reduce burden and increase retention rates among eligible beneficiaries. Pre-populated forms right now are only used in about five states for the MSPs, but it would eliminate the need for beneficiaries to submit new applications to renew their enrollment, and it would hopefully reduce the number of people who drop out of the program.

States are already required to do this for the population that's eligible under modified adjusted gross income rules, and they've shown that the forms can be easily updated by consumers, and they've produced fairly strong renewal rates.

At the same time, states have had some challenges in getting those off the ground for the existing population, so it could be administratively burdensome for states to expand that.

And last, but not least, low enrollment in the

MSPs might be due to lack of awareness among eligible beneficiaries, particularly about how and where to apply for the programs. It may be especially true among partial benefit duals because they don't normally have contact with the Medicaid program unless they're applying for an MSP.

Existing outreach grant funding is targeted toward improving enrollment in both the MSPs and the LIS program, and this is the program that provides funding to State Health Insurance Assistance Programs, or the SHIPs, the Area Agencies on Aging, and Aging and Disability Resource Centers. That funding has remained fairly stable since it was created in 2008, and it's currently about $25.5 million. So an increase in outreach funding could help increase awareness of the MSPs and support programs that help individuals to enroll.

The Commission made a similar recommendation with respect to CHIP in 2017, recommending a five-year extension of grants to support outreach, without specifying an exact amount of money. So that's another thing we could consider.

So in April, we'll come back with a draft chapter for the June report to Congress, and the Commission will

vote on final language for the selected recommendations. The draft chapter we expect will provide background on the MSPs. It will include a discussion of our earlier MACPAC work related to participation rates, and it will include rational for whatever recommendations are selected.

So, with that, I'll turn it back over to you, and we look forward to the discussion.

CHAIR BELLA: Thank you for laying this out so clearly. It'll make our discussion much more productive.

Who would like to start? Chuck, I'm going with you.

VICE CHAIR MILLIGAN: You all noticed me volunteer, right? Thank you very much for all of that.

So I want to kind of lay out my preference based on how you've laid it out, but I also want to just talk about some of the considerations underneath. And I know this isn't the voting meeting, but I just want to kind of signal where I'm supportive.

I'm personally most supportive of Option 2, which is changing the eligibility criteria for MSPs to align to LIS eligibility, income levels, household size, and eliminating the asset test. I can't kind of go quite as

far personally as Option 3 about kind of raising the QMB standard to 135 because I think that's much more of just like a program change, and so to me, part of this is how do we increase access for individuals who I think are eligible but unenrolled, and I think linking the LIS, which has a much higher take-up rate and kind of what it would take to conform to that is, I think, the best way to ensure that people who are eligible are, in fact, enrolled -- recognizing that some people aren't eligible now by virtue of eligibility, household size, and asset test.

But I want to just also lay out some of the rationale for me, and I think you did a good job. There is an administrative simplification that would, I think, produce higher enrollment and higher take-up. But I want to link it also to a couple of other elements. One is we do have precedents that would allow more portability across states to retain eligibility. I think to me one of the concerns -- and I want to highlight it because it wasn't, I think, drawn out a lot -- is that if every state does their own eligibility rules for MSP, if somebody who is a senior, let's say, leaves one state to go live with an adult child in another state, they need more support, they might find

themselves subject to new eligibility rules, state-based. And I think under the Affordable Care Act one of the maybe undervalued aspects of that was the adoption of the MAGI standards as much more national and much more portable and much more standard. I think that that would be an important element of adopting to an LIS.

Second, most states, except for a handful of 209(b) type states, which I won't go into all those details, most states do accept SSI eligibility from the Social Security Administration now. They don't do redeterminations of disability status. They don't exercise their own independent judgment about does this person meet my state's criteria for disability. They take the file from the Social Security Administration and treat it as Medicaid eligibility. And I think that there are elements in which adopting to an LIS with a file and having a state load it and accept it as MSP and keying it back to QMB, SLMB, or QI based on whatever income level, is a path that has been trod and trod in a successful way around SSI.

The other part I just want to draw out is -- and we're going to kind of get to this tomorrow on a different panel about what's going on with the Medicare Advantage

program. In the Medicare Advantage program, Medicare Advantage plans and dual-eligible special needs plans, or D-SNPs, they can target benefits to individuals based on the LIS standard, so they can say we want to offer a food security benefit or in-home long-term services and supports benefits keyed to LIS. Because Medicare Advantage is federal, it links to LIS; that's the Medicare kind of model. It doesn't allow targeting for D-SNPs based on a given state's MSP standards. And so I think that as we advance integration, as we think about D-SNPs and how integration can be advanced for dual eligibles, the more that the MSP program can align to that from a benefit design and supplemental benefit approach around special supplemental benefits for individuals with chronic illness, I think it would lend itself to advancing our separate objective around dual-eligible integration.

So for those reasons, I am most supportive of Option 2. If the Commission isn't there when we get to the voting and all of that in April, I do think some of the other recommendations that you all presented would be better than nothing, and I would support them at that time. But that would not be where I hope we land as a group.

CHAIR BELLA: Thank you, Chuck.

Darin?

COMMISSIONER GORDON: Generally, I align myself with where Chuck is at, and I think Option 3 is too significant of a change. And the scoring is astronomical.

I don't know if I'm on -- you know, between Option 1 and Option 2, I think in both cases, I know we're waiting to hear back, potential cost impact. I think that could influence. I think we're out of line there, but directionally, generally, I agree with Chuck.

The Option 4 on the redetermination eligibility, I found the cost figure, I felt is -- I'm not sure how they got there. It seems a bit high from what I would have expected, but that is another area. Whether it's 36 months, 24 months, again, part of this -- and the reason I brought it up in a prior meeting is having situations where you're forced to do redetermination and populations where the evidence would show you that there is little to no change, that process in and of itself is not helpful from an administrative perspective. Again, you're finding someone not eligible in this situation by a process you created that you even know is likely to show that they

would continue eligibility if they respond.

So I still think there's something there. whether it's 36 months or 24 months, I don't know where CBO came up with that number.

But, again, I generally align with Chuck. CBO scoring really, I think, would influence where I'm at when we actually get to a true vote.

CHAIR BELLA: Toby?

COMMISSIONER DOUGLAS: I thought Chuck really summed it up beautifully, and I'm great with everything you say.

In terms of 4, while I agree with Darin, I think the problem on that is that there is no precedent. Whereas, going with the alignment is really -- I mean, we have clear precedent on what's going with the Medicaid, and I think the issue on the third, it's something that we should be considering and looking at, but broader than even maybe just this and other populations within Medicaid that are disabled in other groups, that we could be looking at the same question about why we're going through continuous eligibility determinations. And maybe we look at it within that context.

EXECUTIVE DIRECTOR SCHWARTZ: So, Kate, I know we've talked about this, but maybe you can help remind me and then clarify the group.

If you do Option 1 or Option 2, do you need Option 4?

MS. KIRCHGRABER: I think with the added -- I think Option 1, because it's just income, you probably could still do a longer eligibility determination period.

But I think the key for Option 2, even with income asset and household size, is to get that data from SSA every year. So that's sort of the extra add-on that I talked about at the end of requiring SSA to turn over the data so that states can just kind of automatically process.

EXECUTIVE DIRECTOR SCHWARTZ: But if they get that.

MS. KIRCHGRABER: Yeah, if they get that, then yes.

EXECUTIVE DIRECTOR SCHWARTZ: Then Option 4 is not needed.

MS. KIRCHGRABER: Less of a --

EXECUTIVE DIRECTOR SCHWARTZ: Okay. I thought that's where we were, but I wanted to check for sure

because we've been around the bend around this.

MS. KIRCHGRABER: Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: Let me just also then make a point for the group here. So the goal of what we're trying to do now is to get a sense of the group of where you're landing and then try and take options away. I understand you don't want to sign on the dotted line until you see the numbers, but I would prefer not to come back in April and say we're still sort of waffling between 1 and 2 and 4 because of how much the money is, because, A, I'm not sure we'll be able to get CBO to nail it down for us, and B, it's hard to write the rationale for it if you're still up in the air.

So I guess the question is if you're still sort of struggling between the two of those, some discussion about why what you're --

CHAIR BELLA: What we're struggling --

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. Okay. Yeah.

CHAIR BELLA: I am going to make sure that we all get out points of view out --

EXECUTIVE DIRECTOR SCHWARTZ: Okay.

CHAIR BELLA: -- because otherwise we miss an

opportunity to do that.

Darin and Chuck both wanted to clarify something.

COMMISSIONER GORDON: Yeah. There wasn't a waffling, but, I mean, there is a lack of understanding of what that impact would actually be. So I think it would be disingenuous for me to say, "Yes, I like this one," and with not having clarity of what that impact would be on states, because that's a consideration we're supposed to have.

I would tell you that my sense would be that Option 1 would be less impactful. I do agree that if it's Option 1, I do still think Option 4 is still relevant. Option 2, I totally agree does not.

I will say Option 3, if I need to be more clearly, I do not think that's an option for me.

VICE CHAIR MILLIGAN: When we come back in April and part of -- I think you have the data, but I think it would be helpful to have in the public slides -- and, Kate, you mentioned the relative take-up rates, the 82 percent LIS and QMB is lower, SLMB is further still lower. I think, as I said, to me, part of my focus is the eligibility but unenrolled pieces of that, and I think

having the take-up rates or the eligible but unenrolled more clearly in the materials.

And I think the other thing to help distinguish between 1 and 2 that would be really good to have just on a slide in April is how many states actually utilize an asset test.

MS. BLOM: So could I make one clarification on 1 and 2? Two wouldn't actually eliminate an asset test. It would simply align MSPs with LIS. Right now, those levels are the same, but LIS disregards certain things that MSPs don't. So they're not that different. It's just adding that extra piece.

VICE CHAIR MILLIGAN: Thank you, Kirstin. That's helpful.

I think just a sentence or two when we come back in April to nail that kind of stuff down will be helpful to contextualize the options.

CHAIR BELLA: Brian and then Kit.

COMMISSIONER BURWELL: So I can be convinced otherwise, but when I first read the material, I was much more leaning towards Option 3 than Option 1 or 2. The factor of administrative simplification was extremely

important to me, and it just made sense to me that when people go in and apply for Medicare, either as a disabled or elderly person, and they're potentially eligible for LIS and MSP, that it's one process, one program.

I don't understand why we think that coverage -- you know, subsidies for prescription drugs should be at a higher income level than other medical -- you know, Part B premiums and copays and deductibles. To me, it's health care.

I was shocked. I was taken aback by the initial CBO estimate, but I imagine they really -- I mean, these were very preliminary estimates and not a lot of thought put into them, and I would like to see a much more in-depth analysis of those costs.

I always was skeptical that participation rates of 53 percent were real. I thought there's a lot of measurement error in that. I don't think there's as many people who are not participating in MSP as commonly believe. I don't see there's every incentive to participate.

I don't know if CBO took into account that about a third of people who are eligible, not enrolled in MSP,

have private insurance coverage, and that that is the reason they're not participating. I would think that that would continue under a combined program, that people have private coverage, kept their private coverage. So that would obviously reduce the cost.

Other than the costs of Option 3, which I think are dramatically high, I think it just makes sense to me to have one subsidy program for low-income duals to provide coverage of things that they can't afford themselves.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: So I'm pretty much where Darin is.

Intellectually, Option 3 strikes me as being a very pure and ideal approach. I don't see it happening. I'm an operator. So I tend to focus on the art of the possible, sort of like the President's budget. Every year, they say it's dead on arrival. Well, okay. We don't have the role of benchmarking that the President has in order to start the negotiation with Congress which does give recommendations that they actually might take and do something with. So 3 just seems a bridge too far to me.

With Chuck, it does make sense -- and I think

this goes to Brian's argument -- to align eligibility processes with the LIS. So Option 2, I think, makes more sense. It's rational. It's administratively simple. We have precedent for doing that in other parts of the program.

It also means that there's an annual redetermination happening at SSA so that we don't have to -- so that the states don't have to undertake that. So I think it's a huge improvement in terms of state work. They're still on the hook for their piece of the spend.

So I'm more drawn to Option 2 than to Option 1.

I think for me, Option 4 is swimming upstream at the wrong time. I mean, we've got -- the President's budget suggests that they're going to make it possible -- maybe it was not that document, but the administration is looking to allow redeterminations on a six-month basis. Program integrity, we're going to talk about that. And there are reasons for that.

So I think that just suggesting -- and I'm not suggesting it's not an evidence-based recommendation. I just think, again, from a pragmatic point of view, I'm not sure that it happens.

Option 5, states can use the prepopulated forms if they want to use the prepopulated forms. They have the authority, and that seems to me to be too far down in the weeds for the Commission.

So, to Anne's point, I would take 5 off the table. I would take 3, 4, 5, and 6 off the table because they already have outreach funding, and they aren't getting much bang for the buck from it. So let's spend more. That makes zero sense to me.

In response to Anne's question, I would say for me, it comes down to Option 1 and Option 2, and I would like to understand, to Chuck's point, some of the more granular stuff about Option 2 and what really changes there. So I would like to see a double-click on that to say, "In Option 2, here is what we would envision," so the asset test. Here, I am way out of my depth, but if it is a modest change or it is a few states -- I would like to see a more robust impact assessment, both programmatic as well as funding in terms of Option 2, and then would, I guess, fall back to Option 1.

Anyway, so I'm with this also.

CHAIR BELLA: That's helpful.

COMMISSIONER BURWELL: I have a question.

CHAIR BELLA: Of Kit?

COMMISSIONER BURWELL: Am I correct in understanding that Option 1 and Option 2 still would entail two different eligibility processes for the applicant, same, one application process?

COMMISSIONER GORTON: I think 2 for eligibility --

EXECUTIVE DIRECTOR SCHWARTZ: For 1, yes, because you still have to deal with the asset issue, but 2, no.

COMMISSIONER BURWELL: Okay.

CHAIR BELLA: I would like to hear from Commissioners that have concerns with Option 2.

COMMISSIONER GORDON: I don't know if it's a concern until -- if I can get more information on the asset part and what the variation is there, then I'd be less concerned.

My concern is that that's just going to be a higher-priced option than Option 1, but I don't have the data to be able to say.

CHAIR BELLA: You're worried about the state cost. You're not worked about the federal cost.

COMMISSIONER GORDON: Well, I am worried about the federal cost, though, but primarily.

CHAIR BELLA: Okay.

MS. BLOM: First and foremost, the state cost.

CHAIR BELLA: Okay.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. It just seems like, yes, it would be, but we just don't know by how much, because the amount of the disregard is relatively small.

MS. BLOM: The disregard is a burial disregard, and it's up to $3,000. That is the main difference between the LIS assets and the MSPs.

CHAIR BELLA: Say that one more time?

MS. BLOM: It's a burial. So the LIS --

CHAIR BELLA: Oh, whether you can exempt burial?

MS. BLOM: Yes.

CHAIR BELLA: Burial, okay.

MS. BLOM: So it's $3,000 for a couple or $1,500 for an individual. So that is the disregard that LIS allows that MSP does not.

CHAIR BELLA: Fred?

COMMISSIONER CERISE: That was my comment. These

seem like minor differences, and we're putting up barriers to a program based on these relatively minor differences at the federal and state level. I think as public entities, we have a responsibility to stretch a little bit to try to coordinate a program.

I have no problem pushing on something like No. 2 --

COMMISSIONER GORDON: So unlike --

COMMISSIONER CERISE: -- and on 4 as well. I mean, Darin, you -- sorry.

COMMISSIONER GORDON: Wow.

[Laughter.]

COMMISSIONER CERISE: We were doing so good. We got to 11:00.

But, you know --

COMMISSIONER GORDON: Even dress differently.

EXECUTIVE DIRECTOR SCHWARTZ: We were going to do a health policy valentine about that, but we decided it would be too inside baseball.

COMMISSIONER CERISE: If the situation doesn't change, you know, why every year? So --

COMMISSIONER GORDON: The only thing I was going

to say is you may have known what the difference was in the asset test. I did not. I didn't realize it was only a 3,000 dollar thing.

This is my comment with MFAR as well. I don't believe in making policy decisions when you don't have the information, and not knowing that impact, I feel I'd be disingenuous about my position on other issues if I don't have the information.

So the 3,000 thing doesn't seem like that would be a significant change, but I had no idea if it was that or more or greater. So that doesn't seem as scary as I was thinking there's a difference in some cases of not having an asset requirement and the other one requiring one.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: So mine are more questions. I mean, it does seem like Option 2 is far better than Option 1, if I understand that. Then really the redetermination process is alleviated from the states. Is that right? So the federal government is doing it? They're doing it anyway?

So it seems to me that you basically get the benefit of Option 1 and 2 for the most -- I mean 4 and No.

2.

I appreciate Kit's comments about a bridge too far. I'm one of those people who's happy to talk about the ideal and compromise with something less, but it doesn't feel like there's the appetite for it around the table.

CHAIR BELLA: Others who haven't commented yet?

[No response.]

CHAIR BELLA: It's really important that if anyone has any concerns with Option 2, as it's the leading candidate now, that those concerns or questions get expressed right now so that they can bring this back to us in April.

Okay. We're going to turn to public comment, and then I'll wrap this up. Anyone in the audience, would you like to comment? Excellent. Please come on up and introduce yourself.

PUBLIC COMMENT

* MS. KAYRISH: Hi. I'm Ann Kayrish. I'm with the National Council on Aging.

At the National Council on Aging, we've been looking at the MSP and LIS programs and really the take-up rates and the things that impact them for 20-plus years.

A few things I wanted to mention as you all look into your recommendations would be that really we feel that the asset test in general is the real major flaw with the MSP program, given that really it's a disincentive to save. And that's something that people really were trying to encourage them to do. They have a modest nest egg, and then they really don't have any options to receive subsidies for these programs. That's what we feel really is the most restrictive piece of the MSP, and it negatively impacts older Americans.

Also, to answer the Commission's questions, there are 10 states that have eliminated the asset test. Louisiana just eliminated the asset test as of January 2020. So it might be worthwhile checking back with Louisiana as to why they opted to do that.

The second piece I'd like to mention is -- again, full disclosure -- we at the National Council on Aging are a MIPPA resource center. So we are really interested in seeing the continuation of permanent MIPPA funding because our organizations that we support -- the SHIPs, the AAAs, the ADRCs -- go out and locate and help people enroll in these programs. Sometimes the lack of permanent funding or

the question of whether or not funding is available next year is really something that hurts the ability of these programs to make those kind of efforts permanent and keeping staff available.

I'd also like to mention really since the start of 2008 to 2018, the Medicare savings program, the enrollment really increased from 6.4 million to 9 million in June. So you can see that there really was an increase in enrollment in those programs.

Thank you. Those are the comments I have to make.

CHAIR BELLA: Thank you very much.

Can I just ask you one follow-up question?

MS. KAYRISH: Sure.

CHAIR BELLA: Is it more important that you have a permanent funding stream or that you have more funding?

MS. KAYRISH: Well, the answer, only answer, would be yes.

[Laughter.]

MS. KAYRISH: Permanent and more, it would always be. I don't know. It would be choosing between children, maybe. No, don't want to do that.

CHAIR BELLA: Okay. Anything else from Commissioners?

[No response.]

CHAIR BELLA: So I too want to align myself with Option 2, and by so doing, it eliminates most of the other things that we've been discussing.

I think Darin got his answer on asset levels.

I'm really curious. At some point, it would be helpful to know why states are or are not exercising the flexibility that they have today around asset levels. I don't feel like that's something we have to have in order to make this recommendation in April.

What else do you need from the Commissioners to help advance this between now and April?

MS. KIRCHGRABER: I think we have a good sense now of what people are interested in and where we need to go. Chuck is raising his hand, though.

CHAIR BELLA: Yeah. I was going to say one more thing too. I do think we can talk about making that funding permanent, even if we don't talk about increasing the funding. Everybody gets tired of non-permanency things around this population, and so that would be consistent, I

think, with things we've done in the past.

Chuck?

VICE CHAIR MILLIGAN: I think in the materials that we had, you did a really nice job of the impacts on different constituencies, states, and the federal government and so on.

I do think that the impact on consumers on Medicaid-eligible folks is lost a little if we don't put the magnitude of number of people in some of these materials.

I mentioned earlier about the 82 percent take-up in LIS, and, Kate, as you said earlier, kind of very low in some of these other programs. That's in the millions of people, I would assume.

It would be good, if we have it, to say, "Okay. If the MSP programs had a take-up of 82 percent, how many more people would be enrolled?" I think as part of our charge, MACPAC -- "Payment and Access Commission" is the last part of that. I think that "Access" piece is highlighted if we quantify it at the number of potential eligibles who might enroll by virtue of an Option 2 and just put that figure in some of the public materials that

we're reviewing. I just think, in terms of supporting a potential rationale, humanizing it.

CHAIR BELLA: I think you shared some of those data with us when we first started talking about this, right? Presumably, that would be part of the chapter; is that right?

MS. KIRCHGRABER: Yes.

CHAIR BELLA: Okay. Well done.

Oh, Brian.

[Laughter.]

COMMISSIONER BURWELL: Difficult Brian, yeah.

Do we intend to work with CBO some more between now and April to ask them to do more -- if we go back and say we want more detailed analysis for Option 2?

EXECUTIVE DIRECTOR SCHWARTZ: Yes. We will keep talking with them. It's much easier for them if we narrow the range. They're not really available to us to say, "Give us the universe." They were able to share on No. 3 because they had done it for other people. So that's how that goes.

We will do our best. I don't want to promise what they will give us, and we will try to press them for

as much detail as we can get.

You've talked to them multiple more times than I have.

MS. KIRCHGRABER: Yeah. I think take-up rates might be the only thing that might be harder to get from them, not that I can promise anything they're going to deliver. We had a conversation with them, and they just said that's more time consuming. So it just could be a constraint between now and the next meeting of being able to get that, but I think we have enough of our own work where we can do some estimating. If there's a 10 percent increase, it would be this many people, kind of a ball-park number.

CHAIR BELLA: That would be great. Thank you. Thank you for this session.

We are now going to break for lunch. We will resume the public meeting at 1:00 p.m. Thank you.

* [Whereupon, at 11:42 a.m., a Public Session was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION

[1:00 p.m.]

CHAIR BELLA: All right. Welcome back for our afternoon session. We are going to start with Rob and Amy educating us about value-based payments in managed care. Thank you.

STATE STRATEGIES TO PROMOTE THE USE OF VALUE-BASED PAYMENTS TO MEDICAID MANAGED CARE

PART I: RESULTS FROM MACPAC CONTRACTED RESEARCH

* MR. NELB: All right. Thanks.

Today we're going to have the discussion about value-based payment in managed care in a couple parts.

First, I'll walk through some background and methods of our study, and then I'll turn it over to Amy to share some of the key themes and next steps. We'll have some time for Commissioner questions about the report itself, and then we'll turn it over to a discussant panel featuring representatives of some of the organizations that we interviewed. Finally, as has been the Commission's practice, we'll save some time after the panel for Commissioner discussion about next steps for the

Commission's work on value-based payments in managed care.

First, some background. As you know, in recent years, many payers have been trying to move away from fee-for-service payment methods that are based on the volume of care provided and move towards value-based payment models that reward providers for the achievement of quality goals and, in some cases, cost savings.

MACPAC has previously examined a number of different value-based payment efforts in Medicaid, including incentives for patient-centered medical homes, shared savings payments to accountable care organizations, and delivery system reform incentive payments to providers undertaking a variety of projects to improve the delivery of care.

Contractor reports for all of these projects are available on MACPAC's website, and in addition, MACPAC published a chapter about DSRIP programs specifically in its June 2015 report to Congress.

In general from this prior work, we found that there's a lot of optimism about the potential of value-based payment models to promote delivery system reform, but there isn't too much evidence so far about the

effectiveness of particular payment methods. It's still in the early stages of many of these models.

As part of our work, we've also found that state Medicaid programs generally have the authority that they need to implement most value-based payment models under existing authorities. The one exception are DSRIP programs which must be authorized under Section 1115 waivers because states cannot otherwise make supplemental payments in managed care.

CMS has recently indicated that it doesn't plan to continue approving DSRIP waivers and has encouraged states to sustain these reforms by improving the use of value-based payments in managed care, similar to some of the strategies that we're going to talk about today.

This table gives a high-level overview of some estimates about the share of payments in value-based arrangements by payer in 2018 according to a recent survey by the Health Care Payment Learning and Action Network, sometimes referred to as the LAN.

The LAN classifies payments into four categories based on the level of risk that providers take on, and as you can see, Medicaid currently has the highest share of

payments in Category 1, which is fee-for-service with no link to quality.

The LAN in partnership with CMS has set national goals to increase the use of value-based payment models, specifically Category 3 and 4 models, which have more financial risk, because of the view that if providers have more financial risk, it may provide a stronger incentive to change provider behavior.

Specifically, the LAN has set a goal of having 50 percent of Medicaid payments in two-sided risk models by 2025, which is much higher than it is today.

Looking at managed care, which is the predominant delivery system for many Medicaid enrollees, there are two broad strategies that states can use. In contrast to fee-for-service where a state can set payment rates directly, in managed care, states set contract requirements for the managed care plans that then make those payments to providers.

On the one hand, a state could direct managed care plans to participate in specific payment models through an option known as directed payments. As we talked about at the September meeting this past year, directed

payments must be preapproved by CMS and must be compliant with new rules added by the 2016 managed care rule.

The second option that states have is to design their managed care contracts in a way that incentivize or penalize plans based on their achievement of VBP targets. States can make an incentive payment up to 5 percent of a plan's capitation rate, and they can also establish withholds that penalize a plan if it doesn't meet specified targets.

To better understand how some of these different types of VBP models work in practice, we contracted with Bailit Health to examine state strategies in five states. In each of the states we looked at, we interviewed state officials, managed care organizations, external quality review organizations, and actuaries, and then we also complemented those interviews by interviewing several national experts and CMS officials to get a broader perspective.

I want to thank the entire team at Bailit Health for their help on this project, including Beth Waldman and Margaret Trinity, who are here with us today.

This table summarizes the range of VBP

requirements used in the five states we studied. In general, the states ranged from states that took a more prescriptive approach to a more flexible approach.

On the one hand, Minnesota and Ohio had more prescriptive requirements. Specifically, Minnesota requires their plans to participate in an ACO model that they have, and Ohio requires plan to participate in its PCMH model as well as episodes of care for specific services, such as maternity.

In contrast, New Mexico and South Carolina have a more flexible approach in which they set broad targets for plans to meet but then provide flexibility for plans to implement payment models that meet those targets.

New York is a bit of a hybrid. It has a statewide VBP target, but it also has a specified menu of options that plans choose from in order to meet that target.

The states we studied also differed in whether or not they had additional federal funding to help support their efforts. Some of the states we looked at received SIM grants, the State Innovation Model grants, from the CMS Innovation Center, and then New York received DSRIP funding

as well which, as I mentioned, supports provider-level efforts at delivery system reform.

Now I'll turn it over to Amy to talk about some of the main themes from our interviews.

* MS. ZETTLE: Thanks, Rob.

In our review of these different state strategies and through our interviews with state officials and other stakeholders, five key themes emerged. First, we learned that in the study states, states and MCOs are leveraging national VBP frameworks and models, but they're adapting them to local circumstances. We also found that multi-payer alignment was limited.

In the study states that had more flexible approaches, we found that they're using that LAN framework that Rob described earlier to varying degrees. For example, South Carolina directly ties its VBP target requirement to the LAN framework in requiring that MCOs tied 30 percent of their payments to at least LAN Category 2C, which is a fee-for-service payment but with some link to quality.

New Mexico and New York have actually designed their own framework, which is similar to the LAN framework

but not identical.

The MCOs that we interviewed often noted that they do try to align their VBP models across their various lines of business. They found that providers may be more willing to engage if there's standardization.

Turning to the second theme, we found that existing Medicaid authorities are providing states with multiple tools to implement value-based payments. In states that we interviewed, they did not cite federal policy as a barrier to implementation.

What we heard from states, both those that have the flexible approach and the more prescriptive approach, is that the development and implementation of these strategies require significant state effort and stakeholder engagements. Three of the states that we studied -- Minnesota, New York, and Ohio -- received SIM testing grants. Two states -- New Mexico and South Carolina -- did not. Those that did receive the SIM funding, they implemented more prescriptive approaches. Whereas, the two that did not took an approach that was more incremental in their targets for VBP.

In all the states that we studied, state

officials did report substantial stakeholder engagement throughout the development process, but the extents of those efforts varied.

For theme No. 3, we learned that states faced significant tradeoffs when deciding whether to choose a more prescriptive approach or a more flexible approach. States that chose a more prescriptive approach found that it offered greater consistency and standardization for those providers in their state. However, this approach can limit MCOs' ability to tailor models to the unique needs of each provider.

Where states have a VBP requirement, it allows MCOs the flexibility to test and design different models. However, providers then can sometimes be burdened with having to negotiate multiple contracts across multiple Medicaid MCOs. In addition, the use of multiple models can be challenging to know which one is actually working best.

Now for theme 4, in the states that we studied, we found that the contract requirements were generally effective at changing MCOs' behaviors. MCOs were meeting the targets that were set out in the contracts and required of them and implementing the directed models that were

prescribed by the states. However, the contracting mechanisms were not addressing challenges related to provider participation in the VBP models.

Interviewees noted several challenges with engaging providers, specifically provider readiness to adopt these models and provider willingness to take on more advanced payment models and bear more risk in their payment.

New York does use its DSRIP program to incentivize provider engagement in delivery system reform, and the state official that we interviewed viewed this as complementary to its existing MCO contracting strategy.

Lastly, we learned that while states have been implementing these approaches for several years, there is limited data available to assess whether or not it's led to delivery system reform, improved quality of care, or reduced cost.

States with more prescriptive approaches were able to share some early findings from their efforts. In Minnesota and Ohio, the state VBP models were found to result in some savings, and in these states, SIM funding did pay for external evaluations of these programs. It

isn't clear whether or not states will continue to fund formal evaluations absent that federal funding.

In states with less prescriptive models, it is more difficult to assess the effects in part due to limited state monitoring of the efforts. Some MCOs did report more informally, evaluating or assessing the effectiveness of the models. However, in the states that we studied, health plans don't report the specific results of those evaluations to the state.

That concludes our presentation, but we would appreciate any feedback that you have on the draft report, which was included in your meeting materials. We are also interested in hearing from you on whether you'd like us to pursue additional work in this space. If the Commission is interested, staff could pursue additional research on state efforts to implement maternity-related, value-based payment approaches across the states. Other potential work could include issues related to managed care rate setting or multi-payer alignment.

In our interview with CMS, they did note that they plan to release additional guidance to state Medicaid programs to promote alignment with other payers. Staff

will certainly monitor that and any other regulatory-related issues in this space.

With that, I'll turn it back over to you for any questions before we invite up the panel.

CHAIR BELLA: Thank you, Rob and Amy.

Questions on the report, thoughts on publishing it, and other areas of interest from Commissioners?

Kit?

COMMISSIONER GORTON: Nice work.

I think we should publish the report. I don't see the downside in publishing the report. If there is a downside, then I'd like to be educated about what it is, but I think we should publish the report.

I think in terms of additional work, it would be useful to talk to -- so you talked to state officials, MCOs, external quality review organizations, actuaries, national experts, CMS officials. The place that you flag as being the problem area is the provider community, and I think it would be useful to speak with the provider community.

I notice we have America’s Safety Net Hospitals in the room. She's always -- maybe she'll have a comment,

and she can jumpstart this.

But I do think that it's worth putting a little more energy, and it doesn't necessarily have to be this report cycle. But I do think we need to talk to the providers.

My personal experience, having spent the better part of a decade doing this across the table, negotiating these kind of things with providers, is it is very hard to get -- first of all, it's very hard to get one of these things done at all. It's very, very hard to get to the higher LAN categories.

A critical access hospital doesn't have any room to sign up for downside risk. There's the issue of does state law permit hospitals and physician practices and others to assume insurance risk, which if you get all the way down in the end, they are in fact -- they are assuming insurance risk. There are beneficiary protections which are built into health plans making decisions about approving care or not. Those do not exist at the provider layer, and so what do you do when the gatekeeper actually becomes the provider? And what is the due process that a -- so there are all these very complex issues.

I think it would be worth talking to the providers and finding out what informs their hesitancy. I think I know the answer, but it would be improper for me to speak for them. And I think that's a necessary component of this work, maybe not in this report, but then as a next step for that.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: Thanks for the work.

I think the report should be published.

Three comments. I do think on the rate-setting side, it would be important to come back to, if some of the interventions are not encounterable, how do we capture them in rates?

I think we do need to talk a little bit more about the provider engagement part, and I'm going to have some questions for some of the panel about this too.

I think we need to talk about what's different between Medicaid and other payers. I think retroactive eligibility kind of changes with a provider who's been managing a person and then finds out that they retroactively have their eligibility terminated four months prior. Their roster is changing all the time. It's very

much a moving target for providers.

Medicaid members are much harder to locate and engage, and providers don't like to take the risk of tracking down homeless members and how are you accountable for HEDIS and quality scores if you can't find the member?

I think some of the differences -- I think when we look at that kind of table that says Medicaid versus Medicare versus commercial, I think the characteristics that are different across those programs are important illuminate.

I do want to just tease one other provider-related piece. I led a New Mexico Medicaid health plan. It was one of the states in this report. It's a state that used kind of a sanction model, and the sanction to the plan I was involved in was worth about $15 million a year of risk. Providers didn't have to play. So when we had to do our own cost-benefit analysis, we ended up having to pay providers more than Medicaid to avoid the sanction, and it led to really kind of pernicious economic incentives where the providers would say, "I know you need us. You're at risk of this huge sanction. We're going to leverage that to get above-Medicaid rates and rate increases to play."

So the VBC model actually completely distorted the market in a way that was more expensive to Medicaid and the plan certainly.

So how do you engage the providers, the provider play, how the sanctions and withholds or incentives kind of distort the market, I think all of those elements we need to examine going forward.

Thank you.

CHAIR BELLA: Just to clarify, I think the default has been that we will publish the report. You should only speak about the report if you have concerns about publishing the report. Otherwise, we can talk about any additional areas of interest, just to clarify that.

You're up.

COMMISSIONER GORDON: I agree with what Kit and Chuck both said. One thing I didn't see addressed in the report and I don't know how we can account for it is whether or not provider reimbursement levels influence participation. So a little bit to Kit's point, you know, what might be some of the challenges that providers are seeing from their perspective?

And the other thing, which the report, you know,

does distinguish whether or not someone was or wasn't a SIM model state, but whether or not a decision to be more plan deferential versus more prescriptive is primarily influenced by the fact that they don't have access to SIM funding to put up the infrastructure and the backbone to make it happen. But, you know, it just says they have it or they don't. It doesn't necessarily say that that is a barrier to more prescriptive approaches.

CHAIR BELLA: Brian.

COMMISSIONER BURWELL: I have two comments. They're more like observations. In the fee-for-service setting, it seemed like value-based payment initiatives are very much focused on quality improvement at the beneficiary level, quality measures, performance measures. I've done work with CMS and states around value-based payment and home and community-based services, and it's all about, okay, what do we want to change at the beneficiary level? And how do we want to change providers? And what measures do you want to use to tie payment to? It's usually much more in the area of positive incentives, bonuses, you know, extra payments.

When I read this chapter, I mean, value-based

payment in the managed care arena, if you define value as quality over cost, it was much more focused on cost savings, efficiencies. I didn't see very much mention at all about performance measures or quality measures or, you know, what the incentives were in these payment models to actually improve quality. So it just struck me as a very kind of different universe.

My second comment area kind of is related to that in that we've had a number of sessions around the Medicaid scorecard, which is a set of measures on quality that states are supposed to aspire to. They're more state-focused. Some are beneficiary-focused. And you would think that the whole development of the scorecard -- and there has been a lot of effort in that -- would be a set of measures towards which states would want to kind of move towards. And it's interesting to me that the scorecard is not even mentioned once in this report. I mean, it's like it doesn't exist and it's not part of the equation or part of the conversation.

Now, it is a different set of -- I mean, some of them are state-focused, but you would think that states would use their managed care programs as a way to drive

managed care plans and, therefore, the system more towards those measures. It just seems to be two siloed initiatives that aren't connected.

MR. NELB: If it does help, I will say, in talking with the states and the plans, as the plan -- a lot of these states have various quality measures that are also part of their withholds and targets as part of the state managed care quality strategy. And as we were talking with the plans, they would often design their value-based payment models to promote some of those measures that were part of their withhold or quality strategy.

COMMISSIONER BURWELL: They are just not discussed [off microphone].

MR. NELB: Yeah, so we can -- this is a draft report. We could see about elaborating on that a little bit more. But your point is well taken.

COMMISSIONER BURWELL: It's mostly about cost savings, shared savings, you know, those types of incentives to improve value.

CHAIR BELLA: Tricia.

COMMISSIONER BROOKS: So I don't know that there's a downside in publishing the report, but I still

think it's extremely dense. And I think some of our policymakers need things that have a lot more simple clarity in them. I don't know if there's opportunity to try to put the lens that the staff does when you feed us stuff that we don't know a whole lot about. I think there's a lot that could be done to simplify that report.

You know, I'm echoing Brian's comment. We really are focused on high-cost populations. We had Michael Bailit at our conference last year talking about what is or isn't happening for kids in value-based payments, and I don't see a lot about the different populations that this has been associated with. But I think there's this general sense out there that value-based payments are going to save the world, that they're really, you know, going to make a huge difference, and if more states would just adopt them, that's going to take care of a lot of our problems. And I think the jury's still out on that.

CHAIR BELLA: Toby, then Sheldon, then Kisha.

COMMISSIONER DOUGLAS: Partly a question and a comment. I don't know if it goes into much detail on the interaction with FQHCs and how that plays into both kind of perverse incentives related to getting to higher levels of

LAN beyond even -- well, 2 or 3 or beyond. But one area of exploration could be, you know, how both FQHCs, community health centers, the appetite moving towards APM as well as what are the barriers both from a financial -- given the way the incentive payments have to be on top of the PPS, and there's no ability, as Kit said, in other areas to take downside risk based on the rules, what can be changed in that? Given, again, we've got to remember that when we think of the providers, it's different than Medicare and others, is that this is the huge reliance of Medicaid on FQHCs in general. So without those types of changes, it's hard to see going really high levels up the ladder on LAN.

CHAIR BELLA: Sheldon.

COMMISSIONER RETCHIN: Well, first, I just want to lament that I was hoping that I would be able to use the word "pernicious." Chuck took that away from me.

[Laughter.]

COMMISSIONER RETCHIN: So I was struck by a comment in the report that there were some interviewees -- and, I don't know, it say maybe from CMS, or they were at the state level -- who said that value-based purchasing they believed would be unsustainable if it did not involve

basically all payers. And I wondered if you would just comment on that. There is one state that did it. I don't know how sustainable that is given the changes in administrations. But that clearly took -- maybe they're both one and the same, but it clearly took state leadership to be able to do that. I wonder if you would comment on that.

MS. ZETTLE: Yeah, so we did hear from CMS both in our interview and in some public comments that were made, I believe earlier this year, that they are really looking to move these models to be more aligned, and I think that is a stated goal of the administration, and we're expecting guidance to state Medicaid agencies on how they could approach that. But we don't have much more information other than that was indicated to be a goal.

On the second part around state efforts, Ohio, you noted in your comments, is pursuing sort of the multi-payer approach. I think what we heard is that they sort of approached it -- it's still driven by Medicaid through its episodes, but they've gotten some voluntary buy-in from commercial plans to implement the episodes where they can. And that was sort of the extent that we heard, but it was

sort of -- the interviewees that we spoke to really attributed that to leadership from the governor's office at the time.

CHAIR BELLA: Kisha.

COMMISSIONER DAVIS: Thanks. Thanks for this. I want to echo the comment that Kit made about really getting more information from providers and the impact for them down the line.

Specifically looking at the difference between community health centers and hospital systems and how value-based purchasing affects them differently, you know, really when primary care is the foundation of value-based programs, we've seen a lot of success for that, and that doesn't always pan out with hospital systems. And so looking at that differential I think would be really helpful. And just because we haven't said it yet, I would, you know, as we referenced this morning, talking about maternity care and value-based purchasing and, you know, what that looks like and just diving into that a little bit more.

CHAIR BELLA: How about we turn to the panel? Then after the panel we'll come back and have further

discussion about where we want to take this work. Thank you.

Welcome. Thank you all for being here. We're ready, Amy, whenever you are.

PART II: PANEL DISCUSSION

* MS. ZETTLE: All right. Well, thank you. Our panel this afternoon is going to include three representatives from organizations that we interviewed as part of this project. I'm going to just do brief introductions, but their full bios are in your materials.

Dr. Bryan Amick, immediately to my right, is the deputy director of the Office of Health Programs for the South Carolina Department of Health and Human Services. In his role, Bryan oversees a number of divisions, including the Divisions of Managed Care and Quality and Health Outcomes. He has played a lead role in implementing the state's value-based payment efforts.

Mr. Tom Mattingly is the senior vice president of provider networks at CareSource, Ohio's largest Medicaid managed care plan, with over 1.1 million Medicaid members. Tom is responsible for developing strategy and policy for CareSource's networks across its enterprise.

And Ms. Catherine Anderson is the senior vice president of policy and strategy at UnitedHealthcare Community and State. Catherine serves as a member of the executive team and spearheads business development initiatives. UnitedHealthcare serves just under 500,000 Medicaid beneficiaries in New York.

So I'm going to begin by moderating a discussion with our panel about the findings that we have just presented in the previous session, and then following the discussion, I'll turn it back over to the Commission for questions.

First, thank you all for being here today. We appreciate it. Bryan, I would like to start with you. As a state official, you've designed and implemented South Carolina's VBP strategy, which is one of the strategies that we looked at in this report, and it would be particularly helpful to hear your thoughts on the tradeoffs that states face in designing these models, and also some of the efforts that are required to implement them.

* DR. AMICK: Sure, absolutely. First, thank you for including South Carolina and certainly for the opportunity to be here today. I think one of the first

points I would make is at least for South Carolina, but I would imagine for every state mentioned, these sorts of programs are so evolutionary that probably a lot of what we talked about six, eight months ago has already transitioned into a slightly more sophisticated, slightly more nuanced approach to many of these things. So, unfortunately, I think there's such a degree of sort of movement in this current space that it's really sort of hard to take a snapshot in time in trying to understand exactly what the marketplace is doing.

A couple of the specific sort of tradeoffs and I think Medicaid agencies' specific challenges, certainly I would characterize that South Carolina has taken a directional versus a prescriptive approach. A lot of that, quite frankly, has to do with the capacity and the considerable amount of effort it takes from the state Medicaid agency perspective.

There is a tremendous amount of information and sophistication asymmetry across all the players in this market where between the negotiation between state Medicaid agency and health plans there tends to be a gap in sort of understanding and appreciation of some of the

sophistication you hear from the state agency standpoint. There is certainly a gradient of capability amongst the managed care plans in the market across the country, and then once you translate that over to the provider community, trying to develop a scheme that works for both the most sophisticated and the least sophisticated hospital system in the state is really, really difficult. So trying to solve those sophistication and capability asymmetry problems is, I think, key number one and one of the reasons that South Carolina has taken a much more directional than prescriptive approach.

I think the second is much of the knowledge and know-how and sort of the yardstick within this space has largely been based on the work of CMMI and the Council for Payment Reform and other efforts that have really focused on non-Medicaid populations. So within the work that certainly those groups have done, I think you'll considerably more chronic disease, considerably more adult population, and especially if you look at a non-expansion state like South Carolina, you tend to -- upwards of 60 percent of the population being relatively healthy kids, it's tough to know exactly how some of those parameters are

going to translate into that population.

The other thing that I think plays somewhat into the asymmetry problem but certainly is one of the drivers of the evolution here is the considerable amount of consolidation that we've seen in the provider community and how that has really started to tip some of the negotiating factors away from the purchaser space over toward the provider space and exactly how we fight against that tendency toward those pernicious effects that certainly might happen in a marketplace that becomes potentially even more pointed toward the provider community.

I was taking feverish notes as you guys were making comments, and that's all of them that I can read, so I'm going to stop there.

MS. ZETTLE: Thanks, Bryan.

So, Tom, CareSource is in Ohio where MCOs are required to implement patient-centered medical homes and also episodes of care. So if you could talk a little bit about that more directive approach from the plans' perspective, that would be great.

* MR. MATTINGLY: Sure, and thank you all for including CareSource. We're really happy to be here, happy

to represent.

Ohio did take a very prescriptive approach certainly with PCMH, which had been in place for some years, and then with the episodes coming in and the design of those. The result of that and kicking that off really gave us some direction, which I find very interesting. Many programs -- and I've been working in Ohio, among other states, for probably 20 years now, so where there wasn't direction before, where many providers were saying, "How do we do this?" it gave them a framework to understand. So it was a really good jumping-off point for us.

I want to be very careful with providers. I work with them all day long, right? They're some of my favorite people. I've worked for them. So I want to be real careful with that because providers truly do want to understand what we're doing, how we're doing it, and how to do it well. And that's kind of where it's taken us now.

Through the episode program, which is probably the bigger of the two because it's impactful across an entire system, we've seen both success and failure with those. Some of the episodes, like the maternity episode, worked very well, and part of that I think is because that

was an expectation in the commercial space before it was in Medicaid. So providers, health systems particularly, knew how to do that.

Some do not work so well. We continue to refine those and find ways to make them work. And then in PCMH, using CPC as our launch point, providing that additional support funding to the primary care physicians to make all of the necessary moves that they need to make as they move forward, full value-based purchasing I think is a really good starting point.

Where I think we're going based on all of this work and where I have to give Ohio kudos is we're seeing more and more providers coming to us and saying, "What else can we do?" The current programs, the prescribed programs, have just become the expectation now. So it really is are we interested in doing risk? If not, where can we go? And my goal was always to meet a provider where they are, right? And whether you're a very large system or a very small rural system, I want to make sure that there's a place for you at this table because there is a wide spectrum here, and the folks in the rural areas deserve just as much benefit from VBP as those in the urban areas.

MS. ZETTLE: Thank you.

Catherine, so we described New York's model as sort of this hybrid approach where they have these state-defined options on a menu, but then the MCOs can get approval for sort off-menu models. I'm wondering, given that context, if you could talk about United's experience in New York and sort of some of your reactions to the findings that were presented earlier.

* MS. ANDERSON: Absolutely, and thank you, Commission, for the opportunity to be here. Obviously, we have national experience. I'll limit the comments to this question specific to New York, but I anticipate there will be other opportunities just to share our experience nationally.

So in terms of the report's findings in New York, first of all, I think it's important, while the report under its definition said that New York created some flexibilities, I would say that we probably feel that there's a certain degree of restrictiveness in the design because there were specific models that could be implemented. And while there were opportunities to ask for exceptions, we have an exception in to the state right now

for approval, it takes quite a bit of energy and time to actually get to an exception in the State of New York because they had prescribed certain models that they were trying to implement. Specifically, we're looking for an exception to implement a maternity bundle similar to the one that TennCare had designed where we had seen significant improvements in outcomes and quality.

A couple other things that are important from our perspective in New York is that there are -- the incentive to accomplish this is squarely on the shoulders of the MCOs. The penalties are on our shoulders. And I think there is a belief that we'll be able to drive providers to a place where they're comfortable in taking on additional risk. And the reality is there are several challenges associated with that. Some of them have already come up, but I think it's important to not again in the context of New York, and each state is different.

Dr. Amick noted market consolidation. That's a problem across the board. But in New York, there's a significant amount of power that sits within the large hospital systems. And because of that, they're not necessarily completely aligned with our goals of reducing

hospital stays, emergency use, et cetera. And so creating a balanced approach and getting to a place where there's some shared incentive for providers to want to participate in really quite important. While the State of New York allows us to in some ways create a downstream penalty to providers, if we are unable to meet our goals, you can imagine that that doesn't necessarily lend itself to positive negotiations with providers.

The other thing that I would point out that Commissioner Milligan made comment to from his experience in New Mexico, there are several things that stand in our way of actually negotiating with providers and getting to a place where there's positive opportunity to drive shared value, and one of those is that there are simply incentives for us to have providers in network. The actual requirements that both the states and CMS provides to us requires us to have pretty extensive networks, and when providers know that both we have penalties associated with meeting value-based thresholds as well as meeting access requirements, that creates an incentive for them to negotiate not necessarily from a position of wanting to get to shared value, but it puts them in a position that they

can negotiate higher rates. And so we've seen several instances -- New York is an example of that -- where the base rate gets pushed above 100 percent of fee-for-service within the state, and then there are incentive payments on top of that.

The other thing that I would point out is that it's really important to understand that there are providers that are across the spectrum, and Tom pointed on this as well related to Ohio. Not every provider is going to be able to or interested in taking risk, and certainly not in a short period of time. Those providers that are in rural areas, those providers that have small panels, simply are not in a position of doing that. And I think creating what sometimes feels like arbitrary thresholds to meet value puts us in a position of actually pushing those providers farther out in the fray rather than bringing them in, because in many instances they may be the sole provider in a rural area or they may be a provider that's really passionate about providing services to the underserved, and we would not want to see them in a position where there is a disincentive to participate.

MS. ZETTLE: Thank you. So in our interviews

both with MCOs and with states, we learned that generally and in most cases MCOs are meeting these targets. They're implementing the episodes and sort of that's where we are right now.

I think one of the questions or one of the findings that we thought was particularly relevant was that it's still early on the results side, and that we're not -- we don't know quite yet what's working well and where. So I'd be interested in hearing from all of you -- and, Bryan, I don't know if you'd like to start -- sort of how South Carolina approaches that and how you know what's working in your state.

DR. AMICK: Sure. So I think an important sort of contextual note is South Carolina, while maybe not the case three or four years ago, is certainly in a position where we view value-based purchasing as a path to higher quality. And certainly this is a value component; there is a cost component there. But the mechanism with which we incentivize managed care plans to achieve increased levels of value-based purchasing is through our withhold program, which is purely quality driven. So essentially it is the performance on quality metrics that really earns that sort

of bonus payment, some component of that the thought being that we want to engage in a series of MCO activities that are balanced between sort of plan-driven quality improvement initiatives and engagement of the provider community in engaging in that as well. The need to make sure that there was some component of provider activation in that effort is really the spirit with which we landed on having a value-based purchasing threshold within that larger quality improvement scheme, but really from our perspective, value-based purchasing is an avenue to quality improvement, even to the point where we sort of moved all of this out of our CFO's office and now treat it as part of our clinical and quality group.

So that's a long way to say that it is the improvement in those quality scores married with some qualitative information from the provider community that's really making us understand that plans who engage more genuinely and more rigorously in these activities have improved those targeted withhold measure scores. There's a ton of selection bias in that entire exercise, so right now what we see is there's certainly a correlation between plans who engage in more rigorous and higher volumes of

value-based purchasing in terms of improvement of HEDIS scores, certainly not making the claim that that's necessarily the causation. And I think as I sort of mentioned, evolution is a part of this space right now, the evolution of that evaluation is, I think, in its early phases.

So right now I feel comfortable that we're on a track that's worth pursuing because of those quality score improvements. I think we certainly need to continue rigorous evaluation of exactly both whether or not we're achieving our desired aims, but also whether we're producing unintended consequences.

MS. ZETTLE: Thanks, and yeah, Tom, Catherine, it would be great to hear sort of how you, as health plans, approach what is working, and Catherine, this might be an opportunity for you to talk a little bit about maybe the New York versus your national experience.

MR. MATTINGLY: Sure. Sure. So I've always approached any value-based arrangement as a quality program. It has to be. If we're only going for cost, there are a number of pitfalls that we'll hit. And I also believe that you can have either a quality or a cost

program. It's very difficult to get to both.

So in that framework, I agree with everything Bryan said. We really need to look at how do we get to the outcome and what is that outcome that we want? So as we look at programs moving forward, it becomes are we chasing a measure, a HEDIS measure, or are we chasing population health? And where we are starting to focus is how do you chase that population health, where HEDIS is just the expectation.

I've said to providers, and they've said to me, "We are doing these things. We know we are." Fifty-one years of my life, I have never gone in and not had height and weight taken. Right? We can't collect that data if it's not reported. So it really is supporting all of those things to support the quality reporting that are already done to achieve the HEDIS, which then gets us to how do we really impact the population, which impacts the outcome, which impacts the cost.

MS. ANDERSON: Just to add to that a couple of points. First of all, I think it's really important to understand what states are putting out as the measure we're being measured against. So specific in New York, if the

measurement is to get to a certain percentage of dollars through a value-based contract, the thing that's chased then is the dollar rather than the quality outcome.

Now the quality outcome is built into the contracts themselves, and we hope that by partnerships with our providers and a shared goal to achieving whatever the incentive model is or to mitigate any risk that it may have on the down side, that it would coalesce around quality.

But I think it's really important to understand that as states are designing program designs and setting goals and working in partnership with their MCOs, they are looking for opportunities to make sure that we're all moving in the same direction and that there is a shared incentive to improve outcomes.

I think where there is a bit more flexibility in terms of state design, we see much more focus on improving specific quality measures. Again, I think to the comments made earlier, in every instance where we're participating in a value-based contract with a provider, it aligns to whatever the goals are of the state. So if the state has a specific goal or has a contractual requirement for us to improve maternal health, as an example, our value-based

contracts are structure in a way to support those endeavors.

And so I think it's really important as we all look at the maturation of value-based contracts in states and working with providers that we're really focused on understanding what is it we all want to achieve, so that it's not simply achieving a measure for the measure's sake but really looking at how are we collectively improving the outcomes for the members that are being served in Medicaid.

To the point around cost, it's almost impossible to look at total cost of care improvement, except over a long period of time, and I think there are several things that play into that. One of them was mentioned earlier, is membership churn and eligibility churn. Unfortunately, we see people coming in and out of Medicaid a lot, and it's really hard over a specific -- over a long period of time to say whether we're really moving the needle on cost.

We believe we will get there, especially as more and more providers align with us and look at taking on additional responsibility, not necessarily risk, but really looking at how do we share the goal of improving outcomes together, we'll see an improvement in cost of care. But

right now we are measuring more around how are we meeting both the states' expectations and how are we improving quality.

MS. ZETTLE: Thank you. And for my last question I'd like to turn to the issue of maternity, since that's certainly been a focus today. I'll start with Catherine and Tom. So Ohio and New York have both had created alternative payment models for maternity. Tom, in Ohio it is mandatory for providers to participate, versus in New York it's an option for MCOs to implement that.

Catherine, I don't know if you could start by talking about your experience in New York, and you did reference it earlier. If you could give a little bit more detail about United's decision to pursue a different approach to maternity care in New York.

MS. ANDERSON: From our experience nationally, in working in improving maternal outcomes, we felt it important to actually ask for an exception in New York, specifically around excluding NICUs, and for some people you might question why we're doing that. As we look at where the real opportunity is to work with our providers, we don't want to create a disincentive from a risk

standpoint of putting the potential of a costly NICU on a provider. We think that providers are likely, and our experience has shown, are likely to improve engagement with us and improve outcomes if we're focused on the low-to-moderate risk maternal episodes and focused on how do we improve engagement, how do we incentivize providers to get moms in to do prenatal care. All of that we know actually improves outcomes over time and actually decreases the high-risk pregnancies.

And so our focus has really been on carving out those high risk, focusing on the lower risk, getting providers to engage with the goal -- and again, our experience in Tennessee has shown that we can actually improve outcomes on those low-to-moderate risk moms and pregnancies, and that's really been the focus of why we asked for an exception in the State of New York.

MR. MATTINGLY: Yeah, and in Ohio obviously we have the existing episode that's showing some really good outcomes. And I agree with everything Catherine and I won't rehash that, because she said it so well.

Where we are starting to see the cracks form, and where we need to focus next, is with infant mortality and

some of the things that we're seeing there. You know, Columbus, Ohio, our capital, has one of the highest levels of infant mortality in the state. So how do we take all of that experience and all of that good work that our providers are doing, partnering with us, and they do partner with us really well, to start to impact the health crises that are out there.

What we're seeing are a lot of new services popping up around those episodes, so training programs for new moms and outreach to families so that they understand the car seat, so that they understand the stroller, so they understand how to handle a newborn, and involving the families in these.

So we're seeing some really cool innovations around that episode that are starting to reach those areas, but it really is what's the next step, given the success that we've had.

MS. ZETTLE: Bryan, would you like to talk about any initiatives you have in South Carolina?

DR. AMICK: Sure. So I think largely because of the sort of more directional, less prescriptive culture of many of the quality and incentives programs within our

managed care framework we've found that really the sweet spot in terms of targeted health conditions and quality improvement goals are those things where we see considerable variation amongst plans, but neither universal low nor high performance across the market.

The idea being that whenever we do see those universally low-performing outcomes that really does need a more prescriptive approach, and we handle those outside of our value-based withhold program, and have done that largely through what we've branded as South Carolina's Birth Outcomes Initiative, which has included participation from both Medicaid payers of all sorts, providers, commercial insurers, and have done a number of things in that space, including the elimination of coverage of elective C-section, mandatory coverage of all forms of contraception, including LARC insertion in hospital, and a little bit more recently turning toward a real focus in disparities and inequities in that particular clinical space.

But again, that seems to need a little bit more of sort of a state policy touch. There is a considerable public health component there. So it just didn't fit quite

right with the parameters and with the culture that we've created within our managed care quality program, which really targets improvement in those things where inter-plan variability is inconsistent. So we think there is really an opportunity, plan by plan, to actually impact those specific parameters.

MS. ZETTLE: Back over to you.

CHAIR BELLA: Thank you. Now we get to grill you with questions. Who would like to start? Darin.

COMMISSIONER GORDON: Thank you. It's a great panel. A lot of expertise up there.

I want to echo Bryan's comment. I do think we are very early on in all of this. Even though we've been talking about it for a while we are still learning much. There was a comment made earlier about, you know, there is still so much we don't know, but, you know, what I always said is we knew that fee-for-service wasn't driving improvements in value, so we have to try something different. So kudos to all of you for being a part of that.

You know, there's something, I think Catherine, you said, about these percentage targets and what that

causes you to focus on, like the higher spend and not necessarily -- you're not focusing on quality, you're not being more targeted, this and that. You know, I'd like you to elaborate on that, but I also want to hear from others, because as a recovering VBP addict, you know, I too threw out a high-level marker, and in hindsight, looking back, there were some areas for which it probably didn't make great sense to do value-based purchasing.

And I think, you know, looking at variability within the system in a particular area might be a better way to start to think about where you should think about VBP, versus here is some arbitrary target, because as you said, it sounded like you said it, it takes the focus somewhat off of quality at that point.

MS. ANDERSON: Yeah. So here's the reality of what happens when targets are set, with all good intention. We then focus on hitting that target by doing things like creating just shared savings models, where we are incentivizing, again, alignment to the quality which we think is right, and I want to say that that's not right. But I don't know that it materially moves the needle for creating better population health or improving the entire

program. We're simply then chasing, hitting whatever that threshold is, and then you find that the vast majority of providers are in incentive-only models that I don't know materially change performance or engagement over time.

And so what we're now focused on, again, we're certainly working with our states and trying to comply with those targets, but what we're seeing greater impact from are doing things like micro-incentives with providers, where we're saying, for instance, we'd like to identify people who have a social need, that's creating an emergency room visit in Hawaii, and saying to the ED, help us identify that need, and then link them to a community-based organization while they're in the ED and turn them back around. And let's incentivize for that at the immediate time that it's happening, to actually improve care.

And those little micro-incentives mean a ton to an emergency room, because they're able to hire more CHWs and others who can actually address the needs, but it doesn't necessarily align to -- maybe it doesn't align to a specific HEDIS measure that we're going to be able to track over time, but we know that it's actually improving the outcomes for individual members.

So I think that's where kind of we collectively, with states, need to identify different approaches, where we think we're actually going to see improvements in the entire program, rather than just trying to chase a number that may or may not improve outcomes.

COMMISSIONER GORDON: Yeah. Bryan?

DR. AMICK: Yeah. If I can just -- I mean, I certainly remember my first payment reform meeting as a slightly younger bureaucrat when I came back to office and drew a chart that said here's zero VBP, here's 100 percent VBP. We're going to start on this path, and our level of goodness and achievement is correlated to how close to 100 percent we've gotten. I mean, we have certainly evolved past that point now.

But there's still an honest question of what is the optimal level and optimum model of risk sharing down to the provider level that really is in the best interest of the patient, the Medicaid program, the managed care plan, the provider, and trying to sort of balance that out. I think there really is, and there certain remains questions of what the optimal levels are there.

I mean, some of this can be solved by making sure

that Medicaid agencies just don't create cliffs within these incentive programs that if you have an all-or-nothing program or if you hit this target you get sort of everything, and if you don't hit that target you get nothing is a pretty silly way to design an incentive. And there is, I think, a lot of nuance around that.

We've spent a lot of time making sure that we're not -- they were saying on the right side of the ROI, and one of the biggest sort of fixes that we've seen to try and accomplish that is making sure that you get some credit for partial work, and that, I think, has really helped solve some of those, either all-in or abandon kind of decisions that managed care plans have to make.

COMMISSIONER GORDON: Tom, did you have anything to add?

MR. MATTINGLY: Yeah. So it was certainly noted in the report that in Ohio it was, I hate say, made easy for us but made easy for us, right, because of the episodes, because of CPC, with the 50 percent threshold by 2020. We pretty well have that in hand.

What we're looking to now, and where I think we all need to go, is what does that percentage look like? Is

it is a percentage of providers in VBP or is it a percentage of outcomes from VBP, so that we are truly chasing the right thing.

COMMISSIONER GORDON: One other comment, if anyone wants to respond to this. It's kind of taking on what Chuck said earlier and kind of a new hit on it. Some of these interventions that are occurring through these arrangements don't come in on a traditional claim. You know, have you all found the magic answer to how you solve for a situation where we're promoting value-based purchasing, which creates a lot of provider creativity about how to, you know, solve problems, many of which may not be catchable in a claim. Therefore, there becomes this potential for, you know, the rates over time to not reward the right interventions. Has anyone come up with a magic answer there, or know of people that are moving in the right direction in regards to that?

MS. ANDERSON: I'm glad you brought that up because many of these things are not encounterable, and therefore we don't actually capture them on back side. And there is a risk of decreased rates over time, even though the dollars are actually going out the door in a different

model.

So I don't think that there is actually anyone who has solved for it. I think some states are better at identifying a certain percentage of admin costs that frankly goes into things that aren't admin. They really are innovation dollars, is probably a better way to think about that. And it's hard still to figure out how you represent that in an actuarial model.

But where we're seeing states that are really invested in this work, there is at least an understanding and sensitivity to the fact that you don't want to, over time, rip out dollars to achieve savings when, in reality, we're just actually covering them in a different bucket.

One of the things that we've seen a couple of states look at -- and again, I think how it's created, the details are really important -- but creating a reinvestment model so that as savings are achieved we're actually taking those savings, a percentage of those savings, and reinvesting them back in the community for targeted things like coordination with community-based organizations and social determinants, as an example.

Again, that's a little problematic, but at least

that happens after the rate development occurs, because it's not in the savings conversation. And we think that won't, over time, reduce our rates, but I do think it's something that we all have to be very mindful of, to make sure that we're investing in innovation.

CHAIR BELLA: Brian. Oh, not you, Bryan. Actually, never mind. You should all three be able to respond. My bad. I was jumping the gun. Please go ahead, Bryan and Tom.

DR. AMICK: That is a problem. I have no idea how we're going to solve it.

[Laughter.]

MR. MATTINGLY: And adding on to that, I think we're starting to see at least the foundation for how we solve it through the duals demonstrations, like here in Ohio, all of the others throughout the nation, because there are so many community outreaches, touches with those community-based providers, social determinants of health work that are built into those rates, I think that's kind of how we get to how we solve this.

CHAIR BELLA: This Brian now.

COMMISSIONER BURWELL: So my question follows up

well on what you just mentioned, Tom. I'd like you to talk a little bit about the challenges of developing value-based payment initiatives for different Medicaid populations, particularly the aged and disabled populations who account for the vast majority of expenditures, same duals, persons with disabilities, persons with very specialized types of disabilities, autism, whatever.

I understand a lot of these populations are not yet in managed care, but what has been your experience in kind of developing measures that are appropriate to outcomes for specific populations?

MR. MATTINGLY: Sure. It's a great question. It's extremely difficult to do so. It's very simple to whitewash and say these are your measures, but I'll go forward.

What we're seeing in Ohio is specialization through the health systems that's allowing us to look at those populations in a much more organized fashion.

One of the systems in Northeast Ohio has senior-specific EDs. So we can start to measure why are they going to that ED specifically versus other EDs and are they getting a better outcome from that ED, and can we

incentivize based on that?

We have a very large pediatric ACO in Central Ohio focusing on that population, and that one, in fact, being at risk, how does that function within the framework of everything that we have for a purely pediatric population?

Then as you move into some of the hybrid models, a duals population, it's providing the incentive for multiple outcomes, both a positive health outcome, but also many of them have a social outcome that they like to see moving out of an institution, being integrated into a community.

So it comes down to picking a measure that isn't encounterable sometimes, but we know is going to lead to a better health outcome overall.

MS. ANDERSON: I'd like to add to that, if I could.

So much, as I'm sure you're aware, the services that are provided to those complex populations actually are not traditional medical services. When we start to talk about HCBS benefits and other social supports and functional supports, we have to think about how we create

value, and we approach those providers in a different way, because many of them are ill-prepared to take on complex data analysis and certainly not raising their hands for downstream risk.

So I think this is where our thinking around micro incentives is really important, and I'll give you an example of a pilot that we're running around personal care attendants, where we're working with the agency to help educate personal care attendants to understand their role in early identification of decline and risk for emergency use, and that they are then communicating that directly to the care manager. And that by doing so as those individual personal care attendants improve outcomes, the incentive is actually coming to them. A portion of the incentive is coming to them as individual caregivers rather than just to the agency.

So I think that's an example of where we have to be really mindful of how all the pieces fit together and the types of providers' social, functional, physical, behavioral, all fit together, and how do you engage each of those types of providers in a way to actually improve outcomes?

DR. AMICK: Absolutely. I think because there's less development in this particular space, there's the need to -- if you think about the LAN framework, no one should be running to the fourth side of this equation until we figure out how to get through the 2C. Certainly, I think it makes sense to start with only upside risk to avoid unintended consequences in that particular space.

I think there's a broader question here that is to the degree to managed care's value comes from risk transfer, certainly other aspects as well, but risk transfer being one of the primary values of managed care itself, some of these populations having cost sort of patterns that may be suit best to be publicly insured to begin with.

So how do we get there even if managed care isn't the vehicle with which we do that? So not abandoning the effort to incentivize providers, to strive for better value and higher quality in a way that doesn't necessarily fit the box that we would maybe all call Medicaid managed care in its more traditional sense.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: Two questions, kind of

broad questions. One is sometimes success factors relate to services that are Medicaid carveouts, whether it's behavioral health or transportation, pharmacy, and so on.

I'm wondering whether you all have any comments around the extent to which value-based contracting might be changing managed care program design, so that some of those are carved in, and if not, how should we as a Commission think about driving value-based contracting if the hospital services are carved in and yet a lot of the predictors of use of hospital services might be outside of the reach of a health plan? It might be a behavioral health-related carveout, pharmacy-related carveout, transportation-related carveout.

So I want to just get at the program design piece related to carveouts and just get your thoughts.

DR. AMICK: I think that articulates very well the problem with the duals population as well where costs accruing to Medicare versus Medicaid. One may be potentially in the consequence of the other, so I think that is absolutely a broad difficult issue to kind of work through.

It is, I think, fair to say that if a Medicaid

program adopts a broad set of value-based payments, having as much of the benefit as rational included in that program, it is going to have to be one of the components of that program, almost as sort of a foundational design component. Otherwise, the inability to drive toward total cost of care will almost certainly create cross-incentives in a way that will ultimately not be optimal for the Medicaid program as a whole.

So I would certainly advocate that to the degree that value-based purchasing in managed care is desirable, the Medicaid benefit should be delivered through that managed care arrangement.

MS. ANDERSON: We would agree.

[Laughter.]

MS. ANDERSON: You're in agreement too?

MR. MATTINGLY: Oh, yeah.

MS. ANDERSON: I would say that we do know there are some instances where by funding design, there may need to be a certain carveout. Behavioral health is an example of that, and certain states are a portion of behavioral health, and certain states, just because of how it's funded.

I would say in those instances, if a state can't achieve a comprehensive model that it's really important to advocate that everybody is aligned in incentives, because you don't want behavioral health, as an example, to have very different incentives than physical health. That actually happens, and then you get a lot of finger-pointing as to which system is causing the problem or not, focused on improving care and quality.

So I think that, again, we think the ideal is comprehensive, but when that can't be achieved, the states really need to think about how do you create both a platform for having conversations and bringing everybody together, but making sure that there's no unintended consequences for how incentives are derived.

MR. MATTINGLY: Yeah. Just to tag on, I completely agree. I think the third component of that is the provider, and as I have discussions with providers about more robust programs, we have data that they don't at the managed care organization. We have the pharmacy data. We have behavioral health data. We have things that they don't have that we need to share with them if our expectation is that they be responsible for total cost of

care. So to the extent that it's sensible is the way to go.

VICE CHAIR MILLIGAN: The second question was we talked a little bit about the eligibility churn. I just want to ask about the change at a provider level in these arrangements of the risk composition over a little bit of time.

We've seen -- the Commission has talked about a lot of Medicaid eligibles are not on the rolls anymore. There's been a lot of redeterminations. I think, generally, sicker people have stayed. Healthier people have left. So total cost of care might be static even if things are successful because the per capita costs have gone up because of the acuity of member's panel to a given provider.

There are some other factors in which providers -- like it's kind of a Lake Wobegon kind of thing. Every provider thinks they have an above-average-risk panel.

Briefly, I know we're kind of short on time. How we should think about population mix changes over time as Medicaid eligibility changes and as people move in and out of the program or in and out of different provider

organizations.

MR. MATTINGLY: Yeah. I'll jump in. I think it's an ongoing conversation that we have to have, and I think that's how we approach the providers with it. A population mix is always going to change, but there are some guideposts that we can pinpoint to, and those vary within a geography, within a population, within an age group. But there are some fairly standard things that we can point to as those measures.

But then continuing that conversation -- because you're right. Everyone has the sickest patients. I know I do at CareSource.

[Laughter.]

MR. MATTINGLY: But we've got to get there. We've got to continue to have the conversation so that we're understanding what those changes are as the patient population ebbs and flows and as those disease states ebb and flow, so that we're always in front of what's coming next.

MS. ANDERSON: I think the other thing to think about, particularly as we think about the relationship with providers in this space, is figuring out how we can get to

a place where there's a collective appreciation for accountability. We have lots of conversations with providers who don't want to take the attribution of membership from us because maybe they can't figure out, to Commission Milligan's point earlier, about homeless population. They can't figure out how to find them, and so, therefore, they don't want those members attributed to them. They only want the ones that they can effect out improvements attributed to the practice. That clearly then creates a disconnect when we're looking at trying to improve comprehensive outcomes.

That requires an ongoing conversation, frankly, with providers to make sure that we're creating a model in which they can be successful and where they are rewarded for going out, for instance, and engaging people who may be homeless, and that may fall out of -- going back to New York, as an example, that may fall out of this prescribed design that the state created, and it's an unintended consequence.

So we would say that it's really important, both in terms of just understanding that these programs change as the economic conditions in states and across the country

changes. We need to be able to adjust for that, but we also need to make sure that there's some flexibility in how we engage our providers, so that we can actually encourage and reward active engagement, so that there isn't any unintentional cherry-picking of population.

DR. AMICK: Yeah. I think we've talked in several conversations, not as part of value-based purchasing, but the need for some sort of risk adjustment in the quality measurement space for a while now. Unfortunately, with all the sophistication we have for that from a financial standpoint, we still don't really have, as far as I know, any way to really incorporate risk adjustment into the measurement of quality of care. So I think that is in itself a broadly missing piece of the puzzle here.

I think another, we've made attempts to share our assessment of patient-level risk with the provider community, and every attempt at that has fallen on its face. I think it's a difference in terminology, a difference in language.

When I've tried to identify specific high-risk patients that are attributed to a clinician, that

information -- I don't think the provider community, at least not South Carolina, knows what to do with that yet.

So I think there's the need to bring those communities together and able to understand that a little bit better.

CHAIR BELLA: Martha, then Fred, then Kit, then Toby.

COMMISSIONER CARTER: To bring this way down to the ground sort of at a provider level, I was the CEO of a community health center, so had contracts with everybody because that's what health centers do. I think from the provide community, there's a lot of measure fatigue. So I really want to talk more about multi-payer alignment in measures.

Frankly, we would chase the measure that had the most bang for the buck, and that's not exactly what we wanted to be doing either.

Also, data sharing among payers, because we'd also be chasing a colonoscopy that got paid by somebody else, that somebody else needed to check the box.

So there's a lot of inefficiencies that get passed down to the practice and provider level. What

innovations are there at that level of measure alignment and data sharing among payers?

Sorry about that. It's maybe a hard question.

MS. ANDERSON: But it's a great question.

From a measure alignment perspective, I think we're seeing almost across the board a collective, whether stated or unstated, alignment to whatever the state is putting out as the measures that are important to the state. So we're seeing far fewer instances where we would have a different set of measures that we put in our agreement with the provider than another payer.

There are still some instances, unfortunately, where there might be -- we all agree on ten, but then we each have our own other two that we're trying to go after.

COMMISSIONER CARTER: Or different definitions?

MS. ANDERSON: Or different definitions. That's a really good point.

We are encouraging both at the state level as well as sort of associations and collaborations with other payers in our markets to say let's get together and at least agree on what the measures are so that we're not driving everybody batty.

But there's still work to do there, and I think it's important because states may change their measures year over year over year, and so I think we just have to make sure that we're really conscious of what that looks like.

The data piece is a really hard piece. Where there aren't highly effective HIEs, frankly, which should serve in this space, we don't necessarily have -- we don't have access to CareSource's data. They don't have access to ours. It does create pretty significant challenges.

I think there are emerging opportunities to extract from EMRs, to grab data that sits in the EMR, to be able to check the box, but again, that requires negotiation with every EMR vendor out there. And I can tell you that's tough.

Our first thought is let's work with the HIE. Let's make sure everybody is contributing to this, make sure they're highly functional.

Second is can we look at technology opportunities to extract, but again, that could be limited, then, to us. And not everyone would have access to that tool.

So I do think it's a huge problem, and

unfortunately, it's creating disincentives for providers.

MR. MATTINGLY: Yeah. For my part, I completely agree. To the data position, it's difficult and it's expensive. Often, you have to buy an instance of that system, and there are multiple systems. So we're holding that piece as well.

But it really does come down for me to aligning across product as well. If we can get ourselves in alignment with the state, the other plan is in alignment with us, then we have to align across our product so that as we go to a provider, as we go to a health system, we're not bringing a set of Medicare measures, a set of Medicaid measures, a set of commercial measures.

Yes, there are some that will fall out because they're valid measures in one of those programs, but indeed, here is our set of measures that align across the programs, so that we are chasing one ball.

DR. AMICK: It is an ongoing desire to be aligned with other payers, at least in our geographic market, that tends to lose its effect sort of across some population.

The payer with whom we need to be aligned for one population is different than the payer that's relevant to

the other population. So a pediatrician and an internist probably have a very different view in terms of -- if I choose to be aligned with Blue Cross, that's probably going to make the pediatrician happy. It might not work very well with a physician who also places into the Medicare space.

So I think sometimes we have -- there's a tradeoff between which payer we align with, and especially as we have a longer list of core quality measures from a CMS perspective, states certainly taking notice of those with the state scorecards, that creates a little bit of -- it doesn't create inflexibility, but it does create another north star that I have to look toward in terms of my ability to be flexible in adapting to what other payers in the state are doing.

CHAIR BELLA: Okay. We have five minutes left and lots of questions, which is great. We can run a little bit over, but I would ask Commissioners, if you want to hear from all three of the panelists then please feel free to state your question broadly. Otherwise, if it's targeted to a specific person, please just go ahead and address that specific person so that everybody doesn't feel

the need to respond.

Kit -- I'm sorry. Fred. Sorry. Fred.

COMMISSIONER CERISE: So just to pile on from Martha's comment about, from the provider perspective, I mean, if the states want to be serious about getting people to pay attention to these things, I think, Catherine, you made the point, aligning at the state level, and sort of getting that message out. There's give and take, Bryan, you know, with the tradeoffs that you have to deal with, but it seems like you have to be more prescriptive at the state level, just because it gets impossible for providers to pay attention to these things.

Let me ask, though, and I'll go to Catherine, just to simplify. You talked about social determinants and community health workers and sort of incentivizing that. Do you find, because I find, that when we get targeted like that -- and I think those are good things to look at -- that, you know, you chase that metric, but if it's not plugged to whatever that follow-up is, so if it's not that provider that's responsible, you find something, then you can get the next level of care, you know, whether that's at the provider level or the plan's responsibility. Can you

comment on how often you might see somebody chase a metric, like a primary care measure, and, you know, you chase it and you hit it hard, but then, the next step that you need, you have trouble delivering on?

I said Catherine, but Bryan, if you --

DR. AMICK: So absolutely. Some of this is thoughtful work by the state to make sure that we're doing these things well. So for example, diabetes is one of South Carolina's primary focuses right now. We heavily targeted A1c levels before we targeted A1c performance, sort of knowing that we sort of have to get there -- before we can incentive performance you have to draw the lab.

So I think there's some degree of just thoughtfulness from the state perspective. I would argue that any measure that's implemented by the state should not be sort of arbitrary. It should just be part of a sort of global effort by the state to address that aspect of care, and it should be communicated to the provider or community at large, and those things should not -- there should be a lifecycle of a quality measure in any of these spaces, where we say, where we sort of introduce -- we sort of bring any measure to market for one year of measurement,

absolutely no incentive, second year a bonus only, third year we actually start to incorporate a little bit of downside risk.

So I think a thoughtful process by which we're not just picking 12 HEDIS measures every 12 months and saying that we're going to see how we did on these, and with as much thoughtfulness, as much structure, as much anticipation as we can put into that process is the best that I can try and think through, aside from outright alignment, to kind of drive in that direction.

MS. ANDERSON: I don't want to break the rules.

CHAIR BELLA: Did you want to answer?

MS. ANDERSON: Yeah, really quickly. I think one of the things that we need to look at is that there is a comprehensive -- we need to look at more than just one instance of interaction. So in the example I used in micro-incentive in an ER in Hawaii, that it's not just that micro-incentive. Then we look at how do we incentivize, in this instance, FQHCs, to pick up those numbers when they go back out of the ED, and engage them proactively?

So I think one of the things we have to be really mindful of is that it's not just primary care doctors.

It's not just specialists. It's just FQHCs. We have to figure out what we're trying to achieve across the entire ecosystem, and then how do you engage each of the individual parts of that ecosystem in an incentive model that speaks to their responsibility and it aligns collectively.

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: I will try to limit my question. One kind of question and comment on this alignment of measures at the state level, which totally, from a policy standpoint, I have been on both sides. But I do want to push from Catherine and Tom, you know, part of what plans that I've seen, they like the difference in measures, because that's what drives the provider relationships, drives membership. And really that have always, you're fine with it, it doesn't create kind of what is the role for each Medicaid MCO overall, contracting under the same measures and requirements. So a response to that.

MS. ANDERSON: I think there is limited competitive advantage, frankly, on creating our own measures that we're chasing, as we learn more and we work

with our providers and we're trying to be really conscious of provider abrasion. Frankly, I think the greater value is aligning on the incentives and figuring out, again, there could be flexibility and innovation in how we pay for them, how we invest in their ability to invest in their infrastructure or bring in other resources so that they can take care of their patients. To me, that's where the competitive advantage is.

I think if we look at where we are at this point, there is not a competitive advantage in trying to figure out measures that are unique to United versus CareSource. I would rather have us all working on the same measures and then figure out how do we work with our providers in a different way, rather than competing on measures.

MR. MATTINGLY: Yeah, and I completely agree. As I've worked with providers over the years, the more disparate measures you put on them, the more difficult it becomes, and they start pointing the fingers at us. Well, United is doing this; why isn't CareSource doing this? CareSource is doing this; why isn't United?

So it creates a different conversation that results in either an ask for more money, a higher rate, or

an ask for a lower threshold, lower quality. Aligning them really makes all of the things line up.

COMMISSIONER DOUGLAS: The other question relates to value-based and telehealth and eConsult, in general. Anything you're doing on that front to really drive in terms of total cost of care, primary care, use of eConsult as a way to reduce but also improve quality and access?

MR. MATTINGLY: I would say we're very early with it. We're utilizing it, but starting to deploy it more throughout the State of Ohio. It's early yet so I don't really have a lot of outcomes.

COMMISSIONER DOUGLAS: Okay. Are you using value-based approaches?

MR. MATTINGLY: We are using it more with those that are using value-based approaches. There is not an incentive tied to, at this point.

MS. ANDERSON: Ours is really fee-based at this point in time. There are still some pretty significant limits, from a regulatory and programmatic perspective, in terms of reimbursement and how it works. Frankly, from state to state, we're at a point where it's really how do we encourage use through a more fee-based model rather than

tying it to value now. I think that's the next evolution.

CHAIR BELLA: Great. I'm going to violate my own new rule. I guess it's a rule. No, we're just going to go through a quick speed round to say, after you guys leave we're going to come back together and we're going to talk about what things are we interested in looking at as a Commission, going forward. And so this would be your chance to say, you know, you Commissioners could really make us more successful at this if you looked at these two things.

And so I would like for you each to tell us, if you were us or you were advising us, what could we be looking at and kind of opining on that would help move the ball in directions that you think would be positive for beneficiaries and for your plan and provider relationships?

I don't care who starts.

MR. MATTINGLY: I'll jump in. Very simple for me -- data integration. We have to be able to share data and share it meaningfully, so that we are all looking at the same things, so that when my grandmother or your sister or whoever walks in, they're looking at that whole picture. It's that simple for me.

MS. ANDERSON: Mine would be around ensuring funding, ongoing funding to drive innovation, so that we make sure that there is a desire to continue to innovate and work with providers and not have unintended consequences of pulling dollars out because we think there are savings, when, in fact, we need those dollars to get to integrated data or to make investments so that providers can be more successful.

DR. AMICK: I would say, from the same perspective, more flexibility -- creating those routes of flexibility in terms of how we think about the presence of value-based purchasing, both in terms of the rate-setting process but also in terms of specific regulatory requirements.

For example, the directed payments, 436.6 approach, that allows -- those mentioned in the report that allow states to pay in addition their cap rate. At this point, I believe CMS is still only approving those for one year at a time. So it's tough to approach these things on an annual basis, so I think as much flexibility as we can have in that space would be really helpful.

CHAIR BELLA: That's a great example. Thank you.

Well, I would like to thank the three of you again for joining us. We are going to take a short break. We will come back at 2:45. We will talk some more. We will take public comment at the end of our comments, and then we will move into our last session. So thank you very much.

[Applause.]

* [Recess.]

PART III: COMMISSION DISCUSSION AND NEXT STEPS

* CHAIR BELLA: We're going to go ahead and reconvene if folks can be making their way back to their seats, please.

Welcome back, you two. Amy, that was a great panel. Thank you.

I believe the purpose of our time together right now is to get our feedback on what we're interested in, where we'd like to go next.

So we had a little bit of this before the panel, but this is a great time for all of you to identify areas where you'd like to see a little bit more work or where we might think of doing some of that work in the next report cycle.

EXECUTIVE DIRECTOR SCHWARTZ: Can I just say

something?

CHAIR BELLA: Yes.

While Anne says something, so I don't have to pick on someone, let's get our list ready of who has comments.

EXECUTIVE DIRECTOR SCHWARTZ: To the question about the downside about publishing the report, I think there really isn't any, but we just wanted to clarify because we can always tell with you guys when we have contractor work that a question always comes up, "Are you going to publish it?"

Since we've already shared it with you, you know we have a certain confidence in it. There were certain comments made about the report itself, and I think there's a limited amount of tweaking we can do with the contractor, just because it was a firm fixed-price piece. If we want to do add-on work, that would have to come separately.

Also, then to Tricia's point, there's also additional writing that MACPAC staff can do, whether it's in an issue brief or just in the pages on our website to talk a little bit more, maybe a more 101 level around value-based payment. So that's also an option that's

available to us. So I just wanted to share that.

CHAIR BELLA: Okay. I'll start, and then maybe others will follow suit.

Just two comments. One is every time we talk about this, I still just find myself asking how do we know this is worth the effort, and there's a lot of states and others that are looking at what other people are doing and adopting that and trying to push that down. I think always asking ourselves what are we doing to collect information that helps us understand that this is worth the effort, and it may not be us collecting it.

The second thing -- and I'm not sure this is necessarily any sort of work, but it goes back to what Brian said. I get frustrated when we're always talking about the number of people that are in managed care products, and we don't talk about the dollars that are left outside of managed care products. Thinking about how much value-based stuff are we seeing for LTSS and for dual populations, I think, would be really important, because my guess is the number is really small. If a lot of what we're talking about seem to be barriers in more of a traditional TANF-based population and if we're having a

hard time getting providers to adopt there, then think about how hard it is going to be to get to those other population providers.

All right. No one has any other comments?

[No response.]

CHAIR BELLA: Any comments about multi-payer?

[No response.]

CHAIR BELLA: No? Kit. Thank you.

COMMISSIONER GORTON: So about multi-payer?

COMMISSIONER GORDON: He wants to talk about it.

COMMISSIONER GORTON: We're all being very compliant with the Chair today.

That's really, really, really hard. Among other things, each of all these provider contracts that we're talking about are confidential. They're all wrapped in a shroud of privacy, and one of the issues that you see is it's hard to talk about some of these add-on components.

You usually have to start with some sort of either withhold or some incentive. You're talking about upside. But that means you have to talk about what the base payment rates are. Plans are not interested -- first of all, you have different product mix, but I will say my

experience when I was at Tufts Health Plan was that we actually had to isolate commercial from Medicare Advantage from Medicaid from the exchange plans because one of the things that we saw was that providers were like, "Okay. Well, if you want me to do this in Medicaid, then this is what you got to pay me in commercial." It may have been a provider that I could live without in Medicaid, but the commercial plan can't live without them.

So you get those kind of tensions, and then when you add competitors to the room, if you go to the trade association -- one of the things we never talk about in the trade association is you never talk about contracting because it's against the law.

So the issues of collusion and price setting and who you have preferred relationships with, who you're paying what, the price transparency thing is real. The minute somebody finds out that the people across the street are getting 10 percent more than they are, then they want the 10 percent. The fact that you've done the math and you know that the people across the street, in fact, do have a sicker population or they have some special thing that you can't live without and the only way you can get them is to

give them a higher rate, but what you may be doing is you may be clamping down on volume. There are all those tradeoffs going on, and the more people who know about it, it becomes a level playing field.

I would be interested if Chuck has thoughts from given the Maryland experience with state price setting for the hospitals, whether that would make multi-payer easier, although I suspect the answer is not much.

CHAIR BELLA: Do you have a response, Chuck?

VICE CHAIR MILLIGAN: I think it makes multi-payer easier. It gives to the hospital rate-setting commission kind of the lead role more than the payers. It does create uniformity about what's measured and how it's measured.

Maybe this is a good time to make this comment. I think one of the challenges in Maryland and in other situations is it's hard to figure out who should get credit for a lot of good work that's happening because there are health homes and there's PCMHs and there's CMMI innovation grants and there's the hospital rate-setting waiver. If there's a dollar of savings, everybody wants to attribute it to their intervention, and I do think that that becomes

a challenge, exacerbated in Maryland because of how things are counted.

CHAIR BELLA: Sheldon, then Darin, then Toby.

COMMISSIONER RETCHIN: Well, I was just going to get back to --

What's the matter? I'll stand back.

COMMISSIONER BURWELL: [Speaking off microphone.]

COMMISSIONER RETCHIN: Yeah, thanks. That's enough of that.

[Laughter.]

COMMISSIONER RETCHIN: So it's just some comment on the multi-payer. I think if it's a box to check, it's doable, and that box to check, I think, would really be quality.

When you get to value and you get to costs, the populations are so radically different. Medicare is more an issue of utilization, given provider remuneration. Commercial is more an issue of price, and Medicaid is really -- I was actually pessimistic about VBP with Medicaid because 30 percent of providers don't even participate, and it's probably in the veneer, the small thin group of providers -- not facilities, but

practitioners -- who participate. I've always contended it's much, much lower than that. Take the volume of Medicaid patients. It's just very hard.

But I think across the board, unless it's generic sort of things like emphasis of primary care, I think the focus has to be on quality.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: I am a multi-payer. I mean, we had some success in multi-payer. I would say where I was always concerned and I think it will always be a factor when we talk about multi-payer is I was always looking over my shoulder to see whatever Medicare was going to come down with, because I said quite frequently to CMS, I'm just waiting for you to come in with a model that basically makes all of my years a pain and effort worthless, because whatever they come up with, it's going to override everything we did.

So while we did have some on the -- we had on the state employee, we had on Medicaid, and we had some on the commercial as well through the plans that were all participating, either Medicaid or state employee. You still have that dynamic, and again, it gets to critical

mass for the provider. So it doesn't have to be 100 percent, but it can't be 10 or 20 either. There's been some success there, but there's plenty of opportunity for sure.

Earlier, as you all were talking about the report, we also talked about not having much review or evidence on how some of these have worked just because of where they are in the process. I'd encourage you to look at Tennessee has released reviews of their efforts around VBP, and they were encouraging and promising.

I do think, to Brian's earlier point, when you look at this across the country and how states are doing, we are still very much in the early stages, and people are learning so, so very much. I think the only reason Tennessee was able to do that is because we were able to stick with a mode consistently for a period of time, whether it's right or there's ways to improve it, I'm sure. But at least directionally, it was very encouraging, which would to me indicate that this is a worthwhile pursuit.

CHAIR BELLA: Toby?

COMMISSIONER DOUGLAS: A couple. On the multi-payer, one thought, I was just digging deeper. It's back

around maternity care and thinking at our last meeting, one of the speakers was talking about California and the change in outcomes and improvement, and a lot of that was multi-payer. It was not really related to Medi-Cal, but the alignment across all payers on that driving it down.

I think it was Tom that brought up the issue of infrastructure and technology and data integration and the need for work on that front, and I'm just wondering if there's a way to tease that out more because this is an area that the MCOs can really drive the value-based payments. The state can really drive alignment, but there's always going to be this gap of how are we getting the systems, the providers to really invest in the infrastructure. And the payments aren't great enough to pay for that technology, and not necessarily we're looking for another HITECH Act funding. But what is the gap? If we truly want to drive the data collection and integration for value-based payment, we still have this problem of multiple systems that are not integrating, and what is it going to take? Who funds it? It's something we could tease out.

CHAIR BELLA: Brian?

COMMISSIONER BURWELL: I really don't know how to get at this, but I do think that there's potentially stuff we could do. There is a right way to do this and a wrong way to do this. I do think the issue of provider burden is legitimate. If you read the literature, I'm not an expert, but I've read enough where there is definitely a thread of people who have done a lot more work in this area that worry about creating a monster with all these performance measures all over the place and providers having to respond to all of them.

My own primary care doc quit her job and quit the profession because she said, "I didn't go to medical school to sit in front of a computer all day long." So I think it's a real thing.

I like Bryan's comment about how you got to start slow. You just start with a measure one year, and then you do bonus payments the second year, and then maybe you, you know -- it's an evolutionary process.

I don't know if we can get into this, but I do think it's a legitimate issue and kind of how value-based payment is rolling out an evolving. And it gets into the multi-payer thing, kind of aligning multi-players.

I was talking to Fred and I said, "How do you deal with this?" and he says, "Well, it really helps in Texas because it is standardized across the state." So even though there are multiple, lots of Medicaid plans, we all use the same measures.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: Thanks for the work on this.

To me, I'm more in a kind of monitoring, doing descriptive, keeping on top of it, personally not investing a lot in a lot of original research. I think there is a lot of work going on around data and how to do data capture and not chase charts and all of that burden. I could be convinced otherwise.

The one area where I do want to see us be more actively on top of what's going on is the rate-setting piece, and to me, it's embedded in the VBP discussion. But it's also embedded in a lot of the social determinates of how generally. If we believe the hypothesis that food security or housing or community health workers or other kinds of interventions that are really not resulting in a claim, avoid medical costs in hospitals, what is the state-

of-the-art, and where is it going in terms of making sure that the rates are adequate and not just built up based on the medical spend? Because if the medical spend goes down and you don't capture the interventions that achieve that outcome, you'll end up in a rate-setting death spiral.

So I do think it's helpful to kind of keep on top of that more actively because I think that there is a Medicaid-specific actuarial rate-setting element that is distinct from other payers.

But beyond that, I think I would suggest that we really just do more tracking, descriptive kind of work.

CHAIR BELLA: Yes. It feels like that's the direction of the Commission.

I would say we didn't state it again now, because I assume everybody assumed it had been stated enough earlier, but maternity care, obviously, and looking at bundles and episodes and everything that is going on and tying that to our other work, I think, is something that is of interest in addition to what Chuck has stated.

Sure.

COMMISSIONER CERISE: I think we've made a distinction around multi-payer alignment. The multi-payer

in terms of Medicare, commercial, Medicaid, I think, is very difficult. Within Medicaid in the state level, I think that it's worth pushing. I mean, I don't know, the state pushing, because I'm sitting here wondering what do we do next here as well. I agree with you guys, more descriptive stuff, because it just -- I'm just not sure where we make a huge impact in direction here.

But I would make that distinction on multi-payer. I think if we're going to look at that, I would try to focus on within the Medicaid plans at the state level.

COMMISSIONER DOUGLAS: But, Fred, I would say in areas where Medicaid has a really big proportion like maternity --

COMMISSIONER CERISE: Where you have over half the patients.

COMMISSIONER DOUGLAS: -- you can drive long-term care. You can drive that.

COMMISSIONER CERISE: I don't disagree.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: Sooner or later, the investment part is really important, not in the same way that Toby was referring to, but the part --

COMMISSIONER DOUGLAS: That was Darin.

COMMISSIONER GORDON: That Darin was referring. I hear them from the provider side, and I get that, but also, just from the agency side, I think we heard a little bit from Bryan. And he following up over the break was even talking about these things are hard and require some investments. You want to continue to see it grow and evolve and do it well. I think it's going to be challenging for Medicaid programs to do that, that more directed model in the absence of having some resource to stand that up. I think it's something that we just need to shine a light on.

CHAIR BELLA: I would like to invite anyone in the audience to make a public comment.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: No comments.

Rob and Amy, do you have any questions for us? DO you have what you need?

MS. ZETTLE: I think so, yeah. Thank you.

CHAIR BELLA: Okay. Great job. Thank you very much.

All right. We're in the home stretch. It's all yours to talk about TRICARE.

MEDICAID AND TRICARE: THIRD-PARTY LIABILITY COORDINATION

* MS. FORBES: Thank you. So this last session we're going to follow up on the presentation from last October, about coordination of third-party liability efforts between Medicaid and TRICARE. It has been a few months so I will go over a little bit of the background again, walk through findings from some of the additional research we did in response to your questions, and talk about some of the problems resulting from a lack of coordination between the programs, summarize some of the places where there are opportunities to improve coordination and TPL collections for Medicaid, and then I'll turn it back to you to discuss next steps.

Medicaid, of course, is designed to be the payer of last resort. If a Medicaid enrollee has other health insurance, that insurer is primarily responsible for providing coverage. Medicaid only pays for services and cost-sharing that are not covered by the primary insurer.

State Medicaid agencies have an affirmative

responsibility to take reasonable measures to identify which enrollees have other health insurance. They have to ask them at enrollment, and then periodically check with other databases. States also have to work with other insurers to coordinate benefits, especially when providers file claims with Medicaid and the state finds out later that the enrollee has other health insurance.

There are over 900 insurers in the country, but one organization that all states have to work with is TRICARE, the program that provides health benefits for active duty military members and their dependents. There are TRICARE members in all of the states. It is administered -- the main TRICARE program, the comprehensive health benefits program, is administered by two main carriers in the east and west. They are under contract to the Defense Health Agency. There are nearly 900,000 TRICARE members who also have Medicaid coverage, so this is an issue for all the state Medicaid programs.

Just to describe that relationship a little more, coordination between Medicaid and the TRICARE program, or rather its predecessor programs, began back in the 1980s. CMS executed a memorandum of understanding with the Defense

Health Agency, or the DHA, which is the agency that administers health benefits for active duty military and dependents. The MOU specifies, among other things, the terms of a data-sharing agreement where states can send data to the DHA once a year, and the DHA indicates to the states which Medicaid enrollees also have TRICARE coverage, so the states can then research and figure out if they need to coordinate benefits. That MOU and that process haven't changed much in the last 30 years.

I also want to note at this point that TRICARE operates -- it's a government health insurance program. While it's administered by commercial health insurers, because it operates through a government agency its policies are established by federal statute and federal rule. It's not governed by state insurance rules.

TRICARE policy for members who have TRICARE and Medicaid is that Medicaid is the payer of last resort, which is the federal policy on Medicaid. But when the TRICARE carriers are processing claims, including claims from members who have TRICARE and Medicaid, the carriers are following those TRICARE policies.

In 2017, CMS was doing its periodic, every-five-

year review of that memorandum of understanding, it determined that it could no longer certify the security of the data, which was part of the agreement. It was being asked to certify that the data-sharing between the states and the DHA was secure, and CMS decided it couldn't be in the middle of that anymore. So the annual data match between the states and the DHA has been discontinued since 2017.

Without a mechanism to conduct the data matches, state Medicaid programs can't identify the members who have primary coverage through TRICARE. This leads to Medicaid improperly paying some of those claims, which, in turn, shifts DoD health care costs to the states and HHS.

We talked to Medicaid TPL folks in a number of states and asked them, you know, the effects on them, how they work with other insurers on these issues. They said that they routinely conduct data matches to identify other health coverage or changes in other coverage that may not have been reported by enrollees, as a normal part of doing business.

For example, they conduct monthly or quarterly data matches with large insurers. They work with data

clearinghouses. Many insurers provide state Medicaid agencies with a large number of fields and a data extract to support automated data matching, more fields than the states get from the DHA match. The states themselves will do the match process and do the research.

To facilitate that insurer cooperation with these processes, states have developed standardized file layouts. They have contracted with national data clearinghouses. Some states will even pay insurers the costs of compiling and submitting that data because the ROI for an investment of getting those claims passed back to the insurers is obviously a positive return.

Part of the reason that insurers are willing to share this information with states on a monthly or quarterly basis is because all insurers are trying to avoid paying claims that are the responsibility of another payer. You know, no matter whose responsibility it is, everyone wants to get it done right the first time. The consensus seems to be, from everyone that we've talked to, that it's better for the secondary payer to cost avoid, to not pay a claim in the first place, if it's someone else's responsibility than it is to pay and chase, which is to pay

it and then coordinate benefits with the other payer to get reimbursement.

So another problem that happened when there were data matches going on every year is because that data match only happened once a year, the states found that a lot of the time they were paying claims for people they didn't know had TRICARE coverage, because people come on and off Medicaid at any time during the year. They could come on after an annual data match, the state could pay claims for months and months until the next annual data match, and then have to go back, do the research, and try to coordinate with the TRICARE carriers to get reimbursed, to do the pay and chase for all of those claims.

In addition, because DHA policy -- again, the TRICARE carriers follow DHA policy when processing claims. They treat Medicaid as the payer of last resort, but otherwise DHA policies -- they only accept claims for one year from date of service. Medicaid policy is to allow providers to file claims for a longer period of time, and Medicaid has longer to actually process and pay claims.

So some claims that are filed with Medicaid and paid properly end up being denied when sent to TRICARE

because they're past the TRICARE filing deadlines, either because they just have taken longer under the Medicaid rule or because by the time the match happens and the research happens and the coordination happens, it's been more than a year. So again, the result is that Medicaid ends up paying and being unable to get reimbursed for claims that are the responsibility of TRICARE.

The third problem has to do with the lack of coordination with Medicaid MCOs. When the DoD and CMS first began coordinating in the '80s, fewer than 3 percent of Medicaid beneficiaries were enrolled in managed care, so I don't think the issue of what to do with the Medicaid MCOs was probably even on their radar. Now over 68 percent of beneficiaries in Medicaid are enrolled in comprehensive managed care and over half of spending runs through MCOs, so it's obviously a much bigger part of the whole insurance side of Medicaid administration.

From the Medicaid perspective, MCOs are state contractors. They are delegated insurance functions, including TPL responsibilities by the state agency. However, as a matter of policy, DHA does not share data with Medicaid MCOs, whether or not they have been formally

delegated TPL responsibilities by their contracts with the state. TRICARE carriers only coordinate benefits and accept claims from state Medicaid agencies, and they require a current billing agreement with the state before they will do so.

So states can only coordinate benefits for a subset of Medicaid enrollees and payments that are still in fee-for-service. And because TRICARE carriers will not accept claims from Medicaid MCOs without a billing agreement, MCOs can't pay and chase any claims. Their only option is to cost avoid. Because DHA won't conduct data matches with the MCOs, MCOs have to rely on the state agency to give them information from that annual data match to know who to cost avoid for, so they are also in this issue of having to know which people have the eligibility for TRICARE, and so on.

So the end result is there is just an assumption that the capitation rates paid to MCOs are inaccurate, because they overestimate the cost of providing services, their services that are the responsibility of TRICARE that aren't identified and recovered, and they underestimate TPL recoveries.

These aren't new concerns. The OIG and the GAO were raising concerns about some of these things, the annual data match and the timely filing limit, before 2017, when the data match was still going on. CMS has tried to address some of these. They reached out to the DoD about TRICARE limitations and requirements. CMS updated its TPL manual for the states, provided additional guidance to the states about how to work with the TRICARE policies.

But we are still hearing about problems, particularly since the data match stopped in 2017. Just last fall, Tennessee said, in a letter to CMS, that states' ability to seek payments from other parties that may be legally responsible for the cost of care provided to Medicaid beneficiaries is currently inhibited by inconsistent and conflicting federal policies, and it inappropriately shifts health care costs that should be the responsibility of the federal government to states.

So there are a number of opportunities that could be taken to improve coordination of beneficiaries between Medicaid and TRICARE to ensure that claims costs aren't inappropriately shifted to states and HHS from DoD.

For example, state Medicaid agencies, CMS, DHA,

and the TRICARE carriers, could take steps to improve coordination and communication among agencies, such as having CMS play a more active role in facilitating state coordination of benefits activities at the interagency level. They could reinstate the data match, whether that's renegotiating a new data sharing agreement between CMS and DoD, developing a new, secure data transfer approach, initiating direct data transfer between the states and DHA, or some other approach.

They could improve the data match process by conducting more frequent matches, allowing states to do the matches using extracts from the DHA, or allowing the Medicaid MCOs to participate in the data match. They could extend the timely filing window beyond one year to align with Medicaid payment policies or with the three-year timely filing window that applies to other health insurers. They could allow coordination of benefits between TRICARE carriers and Medicaid MCOs. There are a lot of opportunities there.

It doesn't appear to us that any of these approaches require statutory authority. Some of these are just better communication and cooperation, and others, it

looks like the Defense Health Agency administrator has the flexibility to issue waivers on things like the timely filing limit, or could change policy in terms of doing things like signing billing agreements or negotiating a new data sharing agreement.

Which is not to say that the DHA doesn’t have its own concerns. Obviously, the security and privacy of the health data that they hold is a concern. Doing any of this is going to have administrative costs for them, and picking up their share of the claims costs is going to be a cost to them. So I don't mean to dismiss that, but this is also a responsibility of theirs.

Statutory changes could also be made, though, to better align federal policies and ensure that Medicaid remains the payer of last resort.

In terms of next steps, this is where I'd like to turn it back to you. We could write up a chapter and include it in our report, just to bring this to the attention of Congress. If you want to take action and make a recommendation, there could be a recommendation to the Secretary or to the Congress to restore cooperation, or you could make a recommendation for statutory change, something

like extending to TRICARE some of the requirements that are now applied to private sector insurers around things like the three-year timely filing limit or something like that, to ensure that Medicaid retains its position as the payer of last resort. So there is a range of things that you could recommend if you want to do that, or as I said, we could just write up what we have found and what the concerns are, and leave it at that.

But I'll turn it back to you. I am happy to try and answer any questions as well.

CHAIR BELLA: I have a question to start. How aware do you think this Administration is of this issue? And I'm asking because this Administration is all about transparency and using Medicaid dollars wisely and making sure that it's used appropriately. And in all of these cases, like this is where Medicaid is bearing something that it should not be. So how familiar of an issue is this, would you say? Do you have any sense?

MS. FORBES: I spoke to the TPL and the systems folks at CMS, and they are certain aware of it. As to whether it's a concern at higher levels in the agency, I don't know.

CHAIR BELLA: Martha.

COMMISSIONER CARTER: I just have a clarifying question. So on the surface it seems like extending the timely filing limit would make sense, but if CMS isn't willing to certify the data that seems like a pretty big hurdle. You know, is extending the filing limit going to help that problem? Am I mixing things up?

MS. FORBES: You're not. I mean, you're correct. there needs to be a mechanism for the data sharing to restart for the other changes to matter.

COMMISSIONER CARTER: So extending the filing limit could help, but that's not really the root issue. Isn't that right?

MS. FORBES: Yeah. Both things need to be -- well, data sharing has to be --

COMMISSIONER CARTER: Okay. Yeah. Certainly three months like -- doesn't work in this real world.

MS. FORBES: Yes.

COMMISSIONER CARTER: So yeah, extending the filing limit would help, but if there isn't that data sharing --

MS. FORBES: Correct.

COMMISSIONER CARTER: -- then that's not going to help as much as we would hope.

MS. FORBES: Correct.

CHAIR BELLA: Well, can I ask a question on that? I mean, we've had secure data sharing mechanisms already. I mean, they're sitting on a lot of data that they keep private, and they exchange with Medicare, for example. So what is it about this exchange that they don't feel comfortable that they can meet? Do you know?

MS. FORBES: The data sharing occurs between the DHA and the states, and not between the DHA, CHS, and the states. And so having an agreement, like a three-way agreement, is where the problem is, and what would have to be addressed.

CHAIR BELLA: I guess I'm just asking, do we know where CMS or the state feels like they're deficient? So is it a problem that the data use agreements just needs to be revamped? I mean, all I'm saying is states conduct secure exchange all the time, and so what is it about this that makes it not suitable? I understand it's CMS, and maybe CMS just doesn't feel comfortable attesting on behalf of all these states, but I have a hard time believing that

they can't meet the requirements.

MS. FORBES: I think you just nailed it.

CHAIR BELLA: Fred.

COMMISSIONER CERISE: These seem like just kind of operational things, that there's not an incentive on TRICARE's part to get right, why would you, but that it would make sense for us to point this out, whether that's a chapter or a recommendation or something. It would seem like, as you've sort of indicated, right now we think this is in the wrong bucket, and so we could very factually just point that out.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: Two things. One, I've never worked for a company that had a three-year timely filing limit, and I don't know where that number came from. Pretty standard. Twelve months is usually the sort of end of it. So people shouldn't have the impression that TRICARE is an outlier. That is a pretty standard timely filing limit. Yeah, a lot of times, it's three months.

For our contracted providers, in most of the plans that I've worked for, it's never more than 180 days and often just 90 days in order not to bounce the claim for

timely filing. So I'm not sure where that number came from, but it would not be my impression, anyway, that TRICARE is an outlier here.

In terms of COB and TPL, everybody else is doing the same thing too. If I'm primary for something and you don't get it to me by the time of the timely filing, then sorry. You should have baked that into the work flow. So I'm a little confused about that.

Then the second thing is more of a philosophical thing. Yes, if we want to be purist about it and we want to enforce in every instance that Medicaid is the payer of last resort, then we should spend a bunch of money to get this fixed and then push the costs over on to TRICARE where it will be more expensive, and that will maybe save the state some money and maybe not, because you're liable to end up with an administrative process on the part of the states that's going to eat up whatever little modest savings you might get.

900,000 people seems like a big number of people, but there's a lot of people in the country. I wonder if the flame is worth the candle really, and is it a big enough problem? GAO has flagged it. So it's not like it's

a secret.

I'm struggling with is this a big enough problem to chase after. Is it really material? I guess I'm not sure it is. Of all the things we want Congress to work on, do we really want them putting time and energy into changing a statute to force TRICARE to do what they appear to be unwilling to do?

CHAIR BELLA: Toby?

COMMISSIONER DOUGLAS: I definitely hear, Kit, your point on bang for the buck, but I do think it's our responsibility from a Commission, from program integrity, to raise, regardless of what the size is in this issue about what the ROI is. It's dollars that, in effect, overall, there's waste going on because of this interaction. So I think we need to flag it, and there are clear opportunities that are outlined that could be taken that, again, we flag, we raise, and this is an opportunity. It's our responsibility from a payment perspective of MACPAC to raise this overall inefficiency within the system.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: I'm going to align myself

with Fred, I think. I think we should point it out. I personally could lean toward recommendations around data sharing and timely filing, but if others aren't there, it's not an area I want to push.

I do want to comment. I do think the data transfer is something we should kind of point out the problems that are caused by lack of having that happen.

I just want to come back to your comment about the three years. I think that's right. I mean, my experience too, but I will tell you -- and I don't remember the details, Moira, about Medicare. But I know that a lot of times, states will retroactively identify an individual as being a dual eligible, and they'll change somebody from being Medicaid-only to a dual, because they might have obtained Medicare via SSDI or whatever.

At that point in time, providers can -- there is an exception to the Medicare timely filing based on when you know who the primary is, and so my recollection is it's one year from the date you learn who is primary. But whatever that is, it seems to me that those other kind of federal programs where Medicaid should -- properly is secondary, we should align the timely filing to permit.

Maybe it's based on when they become aware the Medicaid agency, the MCO, or the provider, but the clock shouldn't be running when nobody knows that there's a primary in a position to pay and it shouldn't be Medicaid.

I do think there's a program integrity piece, to Toby's point, and there's a state fiscal impact of this. If TRICARE isn't interested in playing ball or the administrating agencies aren't interested, there is still an impermissible cost shift to state budgets that I think is to me like within our ambit.

I lean toward minimally pointing out the problems caused by this issue, as I think you've done in a potential chapter, and I would go so far as to be willing to make some recommendations along those lines.

CHAIR BELLA: For each of us that says we would like to make recommendations, I'm going to push to say, is that to the Secretary or to Congress?

VICE CHAIR MILLIGAN: Personally, I think that if there is no statutory prohibition and yet nobody is playing ball, to me, it's to Congress because then you have to mandate that they play ball. If TRICARE has no incentive, they're aware of this issue, they're not taking action to

make sure that they, in fact, are primary when they ought to be primary, to me, that is a system failure that more conversations won't necessarily resolve.

CHAIR BELLA: Anne?

EXECUTIVE DIRECTOR SCHWARTZ: -- Congress doesn't have to act by changing the statute. I mean, Congress could send a letter. Congress could put report language in, say an extenders bill or appropriations bill. In terms of whether it is worth it to change the statute, if the suggestion that we have is not a statutory change, there are tools that Congress has at its disposal.

VICE CHAIR MILLIGAN: That's a really helpful clarification, Anne, but I think to me, what that means is that my personal comfort level is a recommendation to Congress with whatever vehicle is appropriate.

CHAIR BELLA: Sheldon?

COMMISSIONER RETCHIN: Maybe this was already mentioned or it's in the report and I missed it, but, Moira, do you -- so there are 900,000 beneficiaries who also have TRICARE as a primary payer source. It's about 1.5 percent of all our beneficiaries. But it's not all. Do we have any idea of the size of the data mismatch? Is

there any way to know how many are not? It's not 900,000. Do we know that number and what it costs per --

MS. FORBES: No. A couple of states -- I asked this question. Some of the states said -- I talked to a few states, and they said, "We used to collect $20 million from TRICARE, and now we don't because we don't have the match." So one state told me that. It's hard to extrapolate from that.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: I just wanted to go back to this question about Congress or to the administration. There are two different agencies involved here that's interfering with the data sharing, and CMS can't do it on their own. So it seems to me that any recommendations that we have, have to go higher up.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: So I'm not fundamentally opposed to doing this, but I did want to sort of raise the question and ask it out loud. If it's the sense of the Commission that we want to make a recommendation to Congress that they in some way, shape, or form make people play nicely together and do what they're supposed to do, I

don't have a problem with that.

For myself, I wonder about the materiality. $20 million, is that a lot of money?

COMMISSIONER RETCHIN: For one state.

COMMISSIONER GORTON: Well, but which state is it? Right? I mean, even in Rhode Island, $20 million is not such a huge amount of money.

Anyway, I just wanted to raise the materiality question, but I am going to be quiet. I certainly won't be pushing back hard if this is the sense of the Commission that that's where we want to go.

CHAIR BELLA: I would remember back to when we've talked to the health staffers. They encourage us to give them recommendations. I don't actually think we're burning a chip by doing this one, because it feels pretty straightforward. It's pretty straightforward. It seems pretty logical, which is probably why it won't happen.

[Laughter.]

CHAIR BELLA: So I don't know that there's a big downside to doing this one.

If we were to move in the direction where we want to publish a chapter, we want to include a recommendation,

I'd like to hear from folks. Kit said he's not going to die on the sword over that. Does anybody else have concerns about making an actual recommendation to Congress?

COMMISSIONER CARTER: Actually two recommendations, one, that there be a data-sharing agreement and, two, that the timely filing is extended to a year.

I was clear, Kit. I was saying that three months is way too short, and my experience, I certainly tried to negotiate longer time.

CHAIR BELLA: I think one course would be to not exempt TRICARE, right? That would be the statutory fix, or that doesn't -- just the data match?

MS. FORBES: The three years came from the DRA.

CHAIR BELLA: DRA.

MS. FORBES: Imposed a number of requirements on private -- on state-licensed insurers, including three-year timely filing. So one recommendation could be to take whatever was applied to state-licensed insurers and extend those to TRICARE.

CHAIR BELLA: I guess, Martha, I'm saying it might be possible that we hit it all in one, or we might

need a couple. I think if we give direction to take this feedback and come back to us with what you think the most straightforward recommendation is, we can do that.

VICE CHAIR MILLIGAN: Can I just make a friendly amendment?

CHAIR BELLA: Yes. Chuck is going to make a friendly amendment. So do a recommendation. We don't get half.

VICE CHAIR MILLIGAN: Right, exactly. Precisely. Now we're cracking.

So I think, Moira, between now and the April meeting, if you could look at what other benchmarks are for timely filing in this Medicare, where a payer, Medicaid becomes aware that there is a primary payer -- I think, on other words, the recommendation -- I think benchmarking into something makes sense. I think you've got some time to evaluate what potential benchmarks are, and the recommendation could be presented in a way that gives some options, like could be DRA, could be Medicare for duals, when Medicaid finds out or retro.

I just think I don't want to tie us to one benchmark when we've got time to look at other potential

benchmarks for a timely filing recommendation between now and what gets presented in April.

CHAIR BELLA: Thank you, Chuck.

Other comments or questions?

[No response.]

CHAIR BELLA: Moira, do you have what you need from us? Actually, stop.

I'm going to ask for public comment to see if anyone would like to make a comment on this.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: We are -- oh, no. We're one. One comment today. I was going to say we're O-for-O.

All right. Any other last comments or questions from the Commissioners?

[No response.]

CHAIR BELLA: Okay. Thank you. This concludes our meeting for today. We will see you back here at the public meeting at 9:00 a.m. tomorrow morning. Thank you.

* [Whereupon, at 3:40 p.m., the Public Session recessed, to reconvene at 9:00 a.m. on Friday, February 27, 2020.]

PUBLIC MEETING

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

Friday, February 28, 2020
9:00 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
CHARLES MILLIGAN, JD, MPH, Vice Chair
THOMAS BARKER, JD
TRICIA BROOKS, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
SHELDON RETCHIN, MD, MSPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:00 a.m.]

CHAIR BELLA: Good morning. We're going to go ahead and get started. Nothing better than it being Friday and starting off with dual eligibles. I mean, seriously, what could be better?

Welcome, Kirstin and Kristal. It's all yours.

HOW CHANGES IN THE MEDICARE ADVANTAGE MARKET ARE AFFECTING INTEGRATION OF CARE FOR DUALLY ELIGIBLE BENEFICIARIES: ANALYSIS AND COMMENTS ON PROPOSED RULE

* DR. VARDAMAN: Great. Good morning, Commissioners. Today I'm going to be bringing to you some results of work on the influence of the MA market on integrated care programs for dually eligible beneficiaries.

We've discussed some of this a number of times in the past, and we've been planning to bring you the results of two analyses for some time. Our timing turned out to be fortunate as CMS recently published a proposed rule for Medicare Advantage that contains several proposals relevant to this discussion, including one that would restrict the growth of D-SNP look-alike plans.

Today I'll provide some brief background and the results of data analyses and contracted interviews. Then I'll summarize several sections of the proposed rule that relate to D-SNPs and your previous discussions on the influence of the MA market on integrated care.

During the discussion you can reflect on the findings of the analytic work, sections of which we plan to incorporate into the June chapter on integrated care programs. Kirstin will be discussing more of what will be going into that chapter later this morning.

I would also welcome your feedback on CMS's proposals, as we anticipate you would be interested in commenting on this rule. Comments are due April 6th, so given the timing of the April meeting this is your opportunity to express what you would like in a comment letter.

First, as a reminder, dually eligible beneficiaries may choose among fee-for-service and multiple MA plan types to receive their Medicare benefits. Those MA plan types include three kinds of special needs plans: dual eligible special needs plans, institutional special needs plans, and chronic conditions special needs plans.

D-SNPs limit enrollment to dually eligible beneficiaries. They are required to have an approved model of care tailored to meet the needs of this population, and they have been found to be more likely than traditional MA plans to provide supplemental benefits such as dental and transportation. They are also required to have contracts with state Medicaid agencies, and as we've discussed previously, federal and state policy continues to push D-SNPs in the direction of greater integration with Medicaid.

For example, as we've discussed, D-SNPs can be aligned with managed long-term services and supports, or MLTSS programs. Some states require managed care organizations that offer MLTSS to offer companion D-SNPs and can even choose to only contract with those D-SNPs. Thus, since states have to sign contracts with D-SNPs in order for them to operate, states can limit the market in their state to support their integrated care efforts.

In comparison, D-SNP look-alike plans are traditional MA plans that are not subject to the additional requirements for D-SNPs but offer benefits targeted to dually eligible beneficiaries. They do not have formal relationships with Medicaid programs and thus do not

coordinate beneficiaries' Medicare and Medicaid benefits as is required of D-SNPs.

These plans largely enroll dually eligible beneficiaries, even though they are not technically permitted to limit enrollment to subgroups of Medicare beneficiaries. This has led to concern that they draw beneficiaries away from integrated care models. Look-alike plans were first identified in California, most notably in areas where the state’s offering Medicare and Medicaid plans through the Financial Alignment Initiatives.

Next, I'll walk through some results of our analysis of look-alike availability in 2019 and 2020.

We worked with Acumen, our data contractor, to update analyses published by our counterparts at MedPAC in their June 2019 report chapter, where they identified look-alikes in 2018 and 2019. We did this to see if growth in look-alike plans had continued into 2020. We ran the 2020 figures and also the 2019 numbers to display trends and to ensure our methodology was consistent with MedPAC's.

In the MA bid, plans project their total member months and how many of these months are projected to be from dually eligible beneficiaries. We converted those

member months to represent estimated full-year equivalent enrollees. We considered D-SNP look-alike plans to be those with enrollment that is over 50 percent dually eligible beneficiaries, and also repeated the analyses using 80 and 90 percent thresholds.

We found that -- and I will highlight some of the results here -- the number of traditional MA plans with enrollment of over 50 percent dually eligible beneficiaries increased from 94 in 2019 to 98 in 2020. The number of plans where enrollment is over 80 or 90 percent of beneficiaries that are dually eligible beneficiaries also increased over this time period.

When we look at the enrollment columns, projected enrollment in D-SNP look-alike plans grew substantially from 2019 to 2020. Total enrollment in these plans is projected to be about 271,000, nearly 25 percent higher than enrollment in such plans in 2019. This far exceeded the growth in enrollment in D-SNPs, which was about 14 percent.

The only plan type with enrollment growth exceeding D-SNP look-alike's plans was institutional special needs plans, which limit enrollment to

institutionalized beneficiaries. That's not depicted on this slide but I'll discuss them later in this presentation. And I would just like to note that when we chose higher thresholds, the enrollment declined somewhat from 2019 to 2020, but to be clear the 50 percent threshold is inclusive of those plans.

Looking at the state level, the number of states with look-alike plans, as we defined them, fell from 35 in 2019 to 28 in 2020, but again, the absolute number of plans actually rose. The state with the most look-alike plans was California, with 40, followed by 6 in Florida and Illinois. States with multiple D-SNP look-alike plans included Arizona and Virginia, where they could be competing with integrated care programs for enrollment.

A total of 14 plans were available in six states that do not have D-SNPs. So, for example, Illinois does not contract with D-SNPs and there were 6 there.

Multiple look-alike plans are also present in states that do not have integrated care programs but where D-SNPs are available. We do not know if managed care organizations may have first pursued a D-SNP there or if they chose to offer a D-SNP look-alike plan for other

reasons. The effect of look-alike plans in those states is unclear because they are not competing with the integrated care program for enrollment.

So to understand how changes in the MA market are affecting integrated care programs and dually eligible beneficiaries' care experiences, we contracted with RTI International and the Center for Health Care Strategies to conduct a literature review and stakeholder interviews. I would like to thank Molly Knowles and the rest of the RTI and CHCS team for their work. Their interviews included a broad range of stakeholder interviews, including federal and state officials, health plans, providers, and beneficiary advocates.

On the next few slides I'm going to describe some of the themes from their interviews. First, we were interested in understanding stakeholders' perspectives on the drivers of look-alike plan growth. Several stakeholders mentioned that the risk-adjusted payment for dually eligible members makes them attractive to MCOs, and particularly noted that look-alike plans received those payments but have fewer requirements to meet, compared to D-SNPs, which could make them more profitable.

Second, stakeholders mentioned that state policy decisions to limit D-SNP contracting, which we discussed earlier, is a factor in look-alike plan growth. Thus, the unintended consequence of restricting the D-SNP market to support aligning MLTSS and D-SNPs may have been incentivizing look-alike plan growth. In addition, some states do not contract with D-SNPs so look-alike plans allow MCOs to tailor a plan that meets the needs of this population in an unofficial way.

Another issue is that federal policy, such as those implementing the Bipartisan Budget Act of 2018, are putting more requirements on D-SNPs, which stakeholders said could be a continued catalyst for even more growth of look-alike plans.

Interviewees also discussed some of the factors affecting beneficiaries' decisions to enroll in a look-alike plan. For example, brokers for MA plans are often compensated for selling their products, but that is often prohibited in integrated care products like the Financial Alignment Initiative. So the incentives to enroll beneficiaries in the look-alike plans may put integrated products at a disadvantage.

Interviewees also identified examples of misleading marketing practices by some agents and brokers on behalf of look-alike plans. So, for example, one example provided was that look-alike plans might use marketing materials that indicate a relationship with the Medicaid program, which may lead a dually eligible beneficiary to assume there would be some coordination with their Medicaid benefits were they to enroll in that plan.

Beneficiary advocates also noted that there is some confusion among Medicare beneficiary enrollment counselors about what look-alike plans are and how to identify them, so they may not have the tools needed to help beneficiaries make informed choices about their plan choices.

In terms of consequences, interviewees' comments were pretty consistent with what we expected going into this work. They said that there was evidence that look-alikes are competing with integrated care plans, particularly in California, where there are as many dually eligible beneficiaries enrolled in look-alike plans as there are in integrated products.

There was also concern that beneficiaries

enrolled in look-alike plans are not getting the benefits the integrated care programs provide in terms of care coordination, although they also noted that beneficiaries with fewer needs may not be clear on the benefits of such coordination and may be attracted to look-alike plans for the supplemental benefits they offer, like dental or vision.

In addition to D-SNP look-alike plans, RTI and CHCS interviewed stakeholders about institutional special needs plans. These are a small but growing segment of Medicare Advantage, as our analysis showed, and many I-SNP enrollees are dually eligible.

Drivers of I-SNP growth cited by interviewees included increases in provider-owned I-SNPs and related financial factors motivating this trend. They noted that nursing homes may be frustrated with working with MA plans and so this gives them a way to have more control over their cash flow, and also that nursing homes are performing provider coalitions to implement new I-SNPs.

Stakeholders identified potential positive and negative effects of I-SNPs, but few had specific thoughts on the effects of I-SNPs on integrated care programs. For

example, one health plan industry representative said I-SNPs provide supplemental benefits that address specific needs of nursing home residents, but a beneficiary advocate was concerned that they might not encourage nursing home residents to return to the community.

Some industry representatives said that they were interested in working with states. The one state official said that they could see this as creating more work for states and that it might not align with their integrated care efforts, and so they were skeptical as to, you know, what states would be getting out of that arrangement.

In terms of supplemental benefits, Commissioners have expressed interest in understanding the new flexibilities given to MA plans and how that might affect integrated care programs. The evidence we've seen so far shows that uptake of expanded benefits has been slow, and stakeholders provided some perspectives on why this might be.

So, in particular, one interviewee said that plans might not be sure about the demand for these benefits and might not want to attract beneficiaries with higher needs and costs than anticipated. Another reason cited was

the difficulty engaging a fragmented provider community, and that plans need to get partners that will allow benefits to be offered across the plan coverage area.

Federal and state officials were uncertain of how expanded benefits would affect integrated care programs, but some said that these could address gaps in Medicaid coverage.

In terms of challenges brought about by the new flexibility, state officials noted that they have to develop ways to monitor, even among D-SNPs, coverage and use of benefits that overlap with the Medicaid program.

So as noted earlier, CMS issued a proposed rule that includes a number of policy changes affecting both D-SNPs and D-SNP look-alike plans. The Commission has an opportunity to make formal comments now, which can be informed by today's discussion. So in the next few slides we've outlined a few areas for potential comments.

First, in regards to look-alike plans, CMS is proposing to stop contracting with traditional MA plans where dually eligible beneficiaries comprise 80 percent or more of total enrollees. The agency's rationale is that look-alike plans hinder the meaningful implementation of

BBA 2018 requirements by allowing plans to circumvent these requirements.

To limit D-SNP look-alike plans, CMS proposes several actions. First, it will codify guidance prohibiting MCOs from marketing plans as if they were D-SNPs, including implying that the plan is for dually eligible beneficiaries, targeting marketing exclusively to dually eligible beneficiaries, or claiming a relationship with a state Medicaid agency where there is no contract in place.

Second, it would not enter into or renew an MA plan in which 80 percent or more of the projected enrollment are dually eligible beneficiaries or if the plan has actual enrollment at that threshold as of January of the current year, unless the plan has been active for less than one year and has 200 or fewer enrollees. The requirement would not apply in states where there are no D-SNPs or no other integrated care products that limit enrollment to dually eligible beneficiaries.

In your comment letter, MACPAC could voice support for this provision, which would build on prior comments that you all made in the 2018 comment letter,

where you urged CMS to monitor look-alikes and to consider action in this area. You could also comment on the threshold CMS has chosen or choose to talk about a need for continued monitoring to see how plans respond to this change if it is finalized.

In this rule, CMS also proposes changes to network adequacy requirements that would allow more MA plans and thus more D-SNPs to be offered in rural areas. Currently MA plans must ensure that 90 percent of beneficiaries have access to at least one provider or facility of certain specialties within published maximum time and distance standards.

CMS proposes to reduce the required percentage to 85 percent in certain counties with low population size and density and those designated as having extreme access considerations. There would also be credit given for the availability of telehealth for certain specialties. MACPAC could voice support for this provision and its possible effects of expanding D-SNP coverage.

The next area we wanted to highlight is a proposal to implement to BBA 2018 model of care requirements for C-SNPs, which CMS proposes to extend to

all SNP types, saying this is consistent with current regulations and guidance and avoids a burden of MCOs having to have different model of care standards where they offer multiple SNP types. While not specific to coordination with Medicaid benefits, MACPAC could discuss this proposal in that context in terms of how it might shrink the D-SNP models of care.

Finally, BBA 2018 allowed MA plans to provide additional supplemental benefits to chronically ill enrollees, referred to as SSBCI. This allows MA plans to waive requirements that all beneficiaries have access to the same benefits. The proposed rule includes detail on how CMS will implement these provisions.

Again, the Commission could discuss these proposals in the context of state integrated care efforts. We could foresee them making traditional MA plans more attractive to some dually eligibles, but they could also give D-SNPs more tools as well.

And with that I will end this presentation. We look forward to your comments on the analyses presented and your feedback on what to include in comments on the proposed rule. Thank you.

CHAIR BELLA: Thank you very much. The way I would like to structure this discussion this morning is to first ask if anybody has any technical questions about the analysis on the look-alikes or any questions, clarifications on the stakeholder interviews or those themes. Once we take care of the technical questions I'm going to ask if the Commission is in favor of commenting, and then we'll go through each of the potential areas that we could comment, and we will pick up your comments that way.

So any questions -- Tom, did you have your hand -- technical questions? Yeah, please go ahead.

COMMISSIONER BARKER: Thanks. Thanks, Kristal, for the presentation. I'm glad you mentioned supplemental benefits because that's actually something that had been in the back of my mind when you started the presentation, when I read the agenda.

I was just curious if you had more data on the types of supplemental benefits that D-SNPs and D-SNP look-alikes offer, and how they are similar to or different from supplemental benefits that other MA plans offer. Because as you point out in the slide, CMS' standards have

liberalized over the past couple of years, and then there was the SUPPORT Act, or I guess it was BBA 2018 that allowed SSBCI, supplemental benefits for the chronically ill.

DR. VARDAMAN: Well, we've seen some analyses that MedPAC produced last year, looking at D-SNPs and traditional MA plans and the supplemental benefits that they provide, and they found that D-SNPs were more likely than traditional MA plans to offer a variety of some of the more traditional supplemental benefits, like dental and transportation benefits.

In terms of some of the expanded flexibility, there has been fewer analyses out on that. We're actually in the process of doing some data runs that we're hoping will be able to include some of that information either in the June report or in some separate products, to look at particularly some of the newly expanded like preventive benefits and what they look like between D-SNPs, D-SNP look-alike plans, and other MA plans. So we hope to have that soon and be able to follow up with you on that.

COMMISSIONER BARKER: Great. Yeah, that's what I'd be interested in. Thank you.

CHAIR BELLA: Kit, then Toby.

COMMISSIONER GORTON: So in Slide 9, the one with the chart, in the briefing materials you gave us a state-by-state breakdown, and clearly there is something going on in California, and that needs to be addressed. And California is a big, important place but it's not the whole country. Sorry, Toby.

COMMISSIONER DOUGLAS: It's your fault.

[Laughter.]

CHAIR BELLA: It's your fault.

COMMISSIONER DOUGLAS: No, your fault.

COMMISSIONER GORTON: And I've been listening to this for years.

So my question is -- and it's around the CMS proposal to make 80 percent the threshold -- so my question is, do we have -- and you don't need to necessarily pull it out today, but is it available to us, the state-level data, so that we could say, okay, the 80 percent threshold solves the California, or addresses the California challenge and has minimal impact in the rest of the country? I mean, the numbers in the rest of the country are really pretty small, right?

COMMISSIONER DOUGLAS: And Florida.

COMMISSIONER GORTON: Florida too. Yes, thank you. So I'm sort of -- I think it would be useful, if we're going to comment, to be able to sort of double-click on this and say the major impacts of this, as our analysis shows, will be California and Florida. I don't know necessarily -- and we need to look at the states that don't have D-SNPs to see whether they would be negatively impacted, right? Because I'm not sure if the six in Illinois, if they're making a material contribution to that marketplace. I just would like us to have a little more granularity about what the impact of setting the threshold at 80 percent as opposed to 75 percent, or 60 or 50 or whatever.

So if we're going to support a number, I think we need to have done enough quantitative analysis ourselves to know what the impact of that threshold is.

CHAIR BELLA: So let me see if I understand what you're saying. First of all, is it correct that if there are no D-SNPs this doesn't apply?

DR. VARDAMAN: Correct. The proposal would only apply where there are D-SNPs available or a product that is

exclusive to dually eligible beneficiaries like MMPs.

CHAIR BELLA: Like MMPs. Okay. So in Illinois, it would be prohibited because the MMP is there?

DR. VARDAMAN: Correct.

CHAIR BELLA: Okay. So are you asking if for the state breakdown, we could look and see how many would be affected, how many would fall basically in the 50 to 80 percent threshold?

COMMISSIONER GORTON: Yes.

CHAIR BELLA: That's what you're looking for?

COMMISSIONER GORTON: Yes.

CHAIR BELLA: Do we have that information?

DR. VARDAMAN: We do. Because we identify plans based on these various thresholds, I could provide these figures for how many plans in each state meets the 80 and 90 percent thresholds. I think the patterns stay the same. The numbers of plans will drop in some states.

COMMISSIONER GORTON: Thank you.

CHAIR BELLA: Okay. Thank you.

Toby?

COMMISSIONER DOUGLAS: My question was exactly what Kit wants. I mean, if you could just at least for

today -- I mean, if you had it for California and Florida, I think it would be helpful just to know, if you're right on this, to understand how it plays out in those two areas, especially since --

CHAIR BELLA: Well, based on this chart, we'd be missing about 100,000 people if we didn't do -- if we put it at 50, we'd get 100,000 people more than at 80, is that right, if I'm looking at the 271 versus 182?

DR. VARDAMAN: Right.

CHAIR BELLA: Not exactly 100, but --

COMMISSIONER DOUGLAS: Yeah.

CHAIR BELLA: Okay.

COMMISSIONER DOUGLAS: Yeah. Just under. Is that the same?

CHAIR BELLA: Does anyone else have any questions on the analysis or the stakeholder interviews?

[No response.]

CHAIR BELLA: Okay. Let's talk about the -- what we want to comment. I'm going to suggest that it is an important opportunity for us to comment. We should be on the record and particularly -- we don't have to write a really long comment letter, but we have commented on look-

alikes, in particular, in the past, and it seems like it's an opportunity for us to appreciate that CMS is proposing to take action in this way, and then we can talk about the other areas.

First, does anyone have any concerns with commenting?

Let the record show lots of heads nodding no, so good, good.

Let's go through the potential areas that we could comment, and then we can get into a discussion about the issue generally or particularly what we might want to say in the comment.

So the first is on look-alikes. Would appreciate anyone's thoughts on look-alikes. We just had a bit of a discussion on where to draw the line, but do people have questions or comments on look-alikes generally?

Oh, I'm sorry, Darin.

COMMISSIONER GORDON: It works here too.

Just tagging on to what Kit and Toby were talking about, because I compared 80 and 90 percent, and I was thinking the other direction, 50 percent. But I'm glad that ultimately came out.

But I think the other thing we have to -- I mean, I think what they're trying to do here is only to address the existing D-SNPs. It's the growth in the D-SNP look-alikes that I think is the concern. So I just wanted to bring that out there. This isn't a static situation. The reason for the proposal is that we're starting to see that become more and more common, and it's seen as getting around some of the increased requirements for D-SNPs. So those are just general comments, and again, I'd like to see the 50 percent potentially going to a tighter threshold.

CHAIR BELLA: Yeah. I mean, my sense is it's hard for us to know whether 50 is best or 80 is best, and our comments could be along the lines of "We support this at an 80 percent threshold. We understand that this impact at a 50 percent threshold, you would pick up additional people." I mean, I think there's a way that we can do it where we don't necessarily have to put a stake in the ground that says 50, which might be where we end up, depending on the additional information that is provided.

Other thoughts on this issue?

[No response.]

CHAIR BELLA: Okay. We can always come back.

Next would be to talk about network adequacy.

Tricia, was that a hand raised? No, okay.

Comments on this provision? Do we want to include it in our comments, and if so, what would we like to say?

Darin?

COMMISSIONER GORDON: I think supporting it, I think, as we saw this being a problem for us in our state where it failed to recognize the NEMT benefit in Medicaid or telehealth in addressing some of the network challenges, but we also found situations where certain providers in certain areas knew that you had to have them in order to build out a whole part of our state. We were asked for -- our plans were asked for excessive rates, 300-plus percent of Medicare, in order to come into the network so you could build out your network, and that's obviously not helpful in promoting alignment and integration strategies.

So I'm supportive of -- I think it's a move in the right direction. Whether or not the percentage is right, I'm sure it's debatable, but directionally, I would support it.

CHAIR BELLA: Chuck and then Kit.

VICE CHAIR MILLIGAN: I want to align myself with what Darin said. I think it would be good to comment that directionally this is the right way to go.

I do think that in our comment, we could consider adding that we're going to be evaluating network standards for D-SNPs, and the extent to which network standards should align to the Medicaid of network standards, so that we may have further recommendations in the future around network adequacy and telehealth.

But I think for now, it would be good to signal that, signal directional support.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: So my recollection may be faulty, but I think another factor here, as I recall building a Medicare Advantage network, was that CMS requires you to build a network that is sufficient to serve the entire population, and if we look at the size of these plans, they're often in the single thousands.

To build a network that can support 100,000 Medicare Advantage lives when you know you're only going to enroll 3,000, it's a very expensive and daunting proposition, and I think we might -- and it's particularly

problematic in the rural areas.

If you're going to have 20 people in Wythe County, Virginia, then you don't need a huge -- first of all, a huge network doesn't exist in Wythe County, Virginia, but you don't need all of -- I mean, you need one or two of everything.

So I think the sizing of the network, if we can make a general comment that in addition to whatever the reduction in terms of the standards are, the sizing standard, that it would be easier for plans to build networks in rural areas if they were only building -- and more cost efficient if they were only building to the size of the anticipated membership.

CHAIR BELLA: Yes. I think that's kind of a purely Medicare Advantage thing, right? So it's easier for us to make recommendations on a D-SNP kind of thing. I mean, one of the things -- go ahead.

COMMISSIONER GORTON: But that's what I mean. That's a place where the Medicare Advantage rules being applied to the D-SNPs makes being a D-SNP harder.

CHAIR BELLA: Right.

I think the other thing is, in the demos, they

don't have to have network adequacy based on the whole Medicare Advantage population. They have to have it based on the duals in that area, which has helped, and that was applied to Minnesota as well as the capitated financial alignment one. So that's another kind of twist on that.

Other comments on network adequacy?

[No response.]

CHAIR BELLA: Okay. Care management requirements. Do you folks have comments on this? Does everyone understand what this is and the intent of this?

COMMISSIONER GORTON: I just wondered if this is a place -- and I'm thinking out loud, so this may be the world's stupidest idea. But part of the attraction for the look-alikes is the enhanced rates through risk adjustment, and I'm wondering if there isn't some way to tie availability of the enhanced rates to having a model of care which would -- I'm just asking the question. I don't know.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: So duals can be in regular MA plans that aren't look-alikes. I mean, they could be a Medicare Advantage plan that has 5 percent of its

membership as a dual eligible and 95 percent non-duals.

I would be nervous about going in a direction where the fact that there might be one dual eligible in an MA plan would wholly change the model of care requirements for MA, like standard MA products.

So I just wanted to caution about moving in a direction where having one dual eligible member converts everything into kind of a D-SNP or a SNP-type approach.

COMMISSIONER GORTON: Yeah. So that's not what I was suggesting. I was suggesting that if for that one dually eligible member, you wanted the enhanced rate, then you would need to figure out a way to provide that. I'm really thinking about really more the look-alikes.

If 50 percent of your members are duals and one of the observations we've made is that the look-alikes don't have to adhere to the model of care requirements, if in order to draw down the enhanced rates that come with these members, because Medicare sets rates on a person-by-person basis, in order to draw down those rates at some threshold, you needed to have a model of care that was consistent with part of what those rates are supposed to be paying for.

Again, just a thought. I don't want to belabor it today, but if people noodle on that, maybe that's another -- and that might be a conversation for a different day, but it just occurred to me as I was looking at it.

EXECUTIVE DIRECTOR SCHWARTZ: I was just going to say I feel like we like barely scratched the surface of that conversation, which is slightly different than this, and maybe it's better to take a deeper look at it before we get super enthusiastic about it.

COMMISSIONER GORTON: That's fair. I'm not super enthusiastic about it.

[Laughter.]

CHAIR BELLA: I think we can be keeping a parking-lot list. We know we're going to be doing work in this area in the next report cycle as well, and I would suggest we can include this and some of what we talk about.

Toby, then Brian.

COMMISSIONER DOUGLAS: Model of care. How are these new requirements? Are they similar to the financial alignment requirement? How are these new requirements, how far beyond what is already required under the demonstrations?

DR. VARDAMAN: I have to look into that a little bit. Just as a reminder, some of the requirements, including further defining requirements for interdisciplinary care teams, requiring face-to-face visits annually, either in person or through telehealth, and so some of those things may be the kinds of things that D-SNPs could be doing under their existing models of care, but this would codify these requirements.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: Just briefly, just educationally. Model of care, it's not necessarily aligned to the financial alignment stuff. It's really do health risk assessment, individualized plans of care assigned by the primary care provider member working with IDTs. I mean, it's a model of care.

Increasingly, just for people's awareness, as an element of the D-SNP state agreements, the MIPPA-type agreements, states are weighing in on models of care and elements they want to see included in D-SNPs. But, Toby, to your question, it's not -- it's similar in orientation, but it's its own sort of brain work.

COMMISSIONER DOUGLAS: So is this just making it

more prescriptive? Is that what the difference is or --

VICE CHAIR MILLIGAN: I'm going to turn it back to you, Kristal.

DR. VARDAMAN: Sure. Again, CMS is proposing to implement these requirements that were in BBA 2018 that were specific to C-SNPs but to extend them to all SNP types, so basically saying that it's already consistent with existing regulations and guidance because there are guidance and information on what's required for models of care, and that these would align them across SNP types.

CHAIR BELLA: We don't have to comment, or we can show general support for kind of consistency and whatever, but I'm not sure we know exactly what problem this solves. It may actually go in a different direction than where a state might be. I mean, we would want the ability for states to be able to align with some of these.

We don't have to feel compelled to comment. We can generally support these kinds of provisions, or we can just be silent.

Darin?

COMMISSIONER GORDON: Something you said, I had a question. When you say it could align with these, that

would be through the MIPPA agreements, right?

CHAIR BELLA: Sure. But maybe the state has -- yes. The more prescriptive things are, the harder sometimes it is for states to align because they may have a different view on how to do it.

COMMISSIONER GORDON: Right. I would say -- I thought you had said to allow states to allow this, and I thought that's what you were saying. I was like I think they already have the ability to do that, just to clarify.

CHAIR BELLA: Other thoughts on this?

Brian?

COMMISSIONER BURWELL: So in regard to the specific parts of the changes in the model of care, I wonder if it's worth commenting about D-SNPs that are a part of a fully integrated MLTSS program, so that there's a Medicaid participation and the D-SNP participation, and many of these requirements are within the Medicaid MLTSS contract. So I think we should just point out that there's a potential for overlap or lack of integration by imposing these additional requirements on D-SNPs.

I'm not sure what the answer is, but annual face-to-face visits and annual assessments and reassessments are

generally -- they require a requirement of MLTSS contractors on the Medicaid side.

CHAIR BELLA: So I'm going to suggest one of two paths. One is to say we're generally supportive of provisions that strengthen the model of care and kind of further integration and note that we want to take into account that it wouldn't have any negative impact on states' efforts to integrate or that we stay silent, because we really haven't done much work in this area. We haven't talked to any states. We don't really know exactly what problem we're trying to solve, and so we can be general, which is a fine position, or we can just stay silent.

Because I think, Brian, to go where you're going, I would feel more comfortable had we talked to some states and some plans to understand do they think this is a threat or do they welcome this kind of guidance, and I don't think we're informed enough to know that.

So my suggestion is we either generally support the overall concept or we don't need to include it in our comment letter.

What is the inclination of the group?

COMMISSIONER DOUGLAS: I like being positive and supporting but wanting to make sure it aligns with state efforts.

CHAIR BELLA: Does that work for everyone? Do you guys have enough on that subject to know where we want to go on that?

DR. VARDAMAN: Yes. Thanks.

CHAIR BELLA: Okay. Next is special supplemental benefits. Comments on this and what we might want to, as a Commission, explore further in our next round of work or what we might want to include in a comment letter?

Tom?

COMMISSIONER BARKER: On the comment letter, just given what Kristal said in response to my question, I'd maybe not want to say anything. I'd like to get more data because we might not have enough information to comment is my only thought. But I could be talked out of that view. That's my going-in thought?

VICE CHAIR MILLIGAN: Yeah, I agree, Tom, personally.

A couple things. One is I do think that there's a risk that -- Kristal, that you noted that -- some of

these benefits could pull people out of integrated products if they can get Medicaid LTSS-like benefits through the Medicare side.

On the other hand, I think that there are SSBCI, and I'll give you one example, Tom, where it can help augment an integrated program. For example, where there is managed Medicaid LTSS aligned to a D-SNP, some D-SNPs are using SSBCI authority to do things that are like pest control at home. That isn't a Medicaid LTSS-type service, but it enables somebody to stay at home with a functional deficit in which they need long-term services and supports. So that kind of pest control benefit as an SSBCI enables the Medicaid LTSS policy to be advanced, but it's not always the case.

So I agree with you that it's hard to weigh in on this because we don't have the full spectrum.

CHAIR BELLA: Other comments?

[No response.]

CHAIR BELLA: I mean, again, the comment could be this could be positive. It could also -- like we just don't know, and we want to keep an eye on it. I think you alluded to the fact, kind of note that this is out there,

and we want to keep an eye on how it's evolving.

Kit?

COMMISSIONER GORTON: Yes. I might take what you just said one step further. We know that the traditional MA plans use supplemental benefits to drive their membership in one direction or another. So you bring in Silver Sneakers because you want healthy seniors. So I think it would be worth noting that supplemental benefits have been used as selection tools in the past, and we would want to be vigilant in making sure that there were no untoward impacts on this population.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: I'm sorry. Initially, when CMS allowed SSBCI – so this is the first plan year, 2020 -- MA plans were prohibited from advertising or marketing them partly because it wasn't going to be available to all of the members. It was only people with chronic illness.

CMS later eased that and allowed plans to sell it, even though not all members get it. I do think that, not for comments -- I don't think we're there yet -- we can start weighing in on the implications of that in duals and D-SNP.

But the one other thing that I do want to just comment on, and this isn't something I think we should comment on, personally, but I just want to take the moment. There is a different approach to give people benefits that are kind of non-standard, which is VBID, value-based insurance design. And so one of the large national Medicare Advantage organizations, and not one I'm affiliated with but a different one, has a food benefit that is being offered through VBID, not through SSBCI or standard supplemental benefits.

So all today -- and I'm only mentioning that for context -- it was never intended initially to be used to market, and so that could be an issue we might want to weigh in on down the road.

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: And just a technical question, maybe for future. In the write-up it says that non D-SNP plans were still offered by a small fraction of the plans. So I just didn't -- based on what Kit was saying, is that true? I thought that these --

CHAIR BELLA: Where are you?

COMMISSIONER DOUGLAS: I know the audience

doesn't have -- page 11, it says, on key themes related to supplemental benefits.

DR. VARDAMAN: Right. So the analysis that is cited there is just in regard to some of the primarily health-related supplemental benefits in 2019. So it was the first year of data that they had and had found, you know, few plans were offering it at that time. And so that's something we wanted to continue to look at.

COMMISSIONER DOUGLAS: Okay. I feel like to understand the full MA versus D-SNP to understand is that really true, because I thought it started to proliferate more than that.

CHAIR BELLA: Brian.

COMMISSIONER BURWELL: I do think it's -- I mean, this is more for our more internal work than something that we might comment on to CMS, although I think we might want to mention it, in terms of our own work, in terms of how to promote more true integration in integrated care models, I think this is an important area, because we want to ensure that in integrated care models whatever extra benefits -- supplemental benefits are being provided by D-SNPs are well coordinated with MLTSS benefit packages. There is a

mention in the write-up about one state in which the state was coordinating the provision of non-medical transportation services, that the D-SNP would offer up to a certain number and then after that the MLTSS program would kick in and cover additional ones.

I think this is going to be -- those kinds of integration issues between the Medicaid benefit package and the D-SNP package are going to grow as the MA plans provide more supplemental benefits. I just think this is an area that we should monitor and do research on as we continue our work on integrated care.

CHAIR BELLA: Kit.

COMMISSIONER GORTON: And again for future work, not for the comment letter, I'd like to hear more about the I-SNPs and how they may potentially interact with MLTSS programs, and particularly how they might create a barrier to people moving to the community. It's already hard enough to get people out of institutional settings and into the community. And so if moving -- if that creates complexity or benefit loss by moving, then I think we should know more about that and we should shine a light on it.

We've made enormous progress over the course of the last generation getting people out of institutions. There's still a lot of work to be done, and I think we need not to be unintentionally creating barriers. And when Kristal was talking about particularly the provider-affiliated I-SNPs, I just think that's something that we should dig more deeply into and figure out what's going on there.

CHAIR BELLA: Okay. So I'm going to suggest on the supplemental benefits we have some loose language in there about keeping an eye on it, consistent with wanting to always be furthering integrated programs and keeping an eye on things that might unintentionally take away from that.

I agree. I was going to say, also, I-SNPs should go in our future bucket of work. We should understand particularly the driving forces and how they are or are not working with states, and kind of furthering those integrated efforts or not.

So I think you have what you need for the comment letter, right? Do you need anything else from us on this session?

DR. VARDAMAN: No.

CHAIR BELLA: Oh, Toby.

COMMISSIONER DOUGLAS: I was confused. So are we not talking about the 50 versus 80? Like where are landing on that? I wasn't clear on that.

CHAIR BELLA: Well, we don't have the data you asked for right now.

COMMISSIONER DOUGLAS: Yeah. So what are we --

CHAIR BELLA: And so our choices are to get those data and share them, as we draft the comment letter, or to comment that we're not experts on the threshold. At an 80 percent threshold we kind of land here and at a 50 percent threshold we land here. Perhaps with that new data saying an 80 percent threshold would work for 12 state, but taking it -- you know, it wouldn't pick up these states, something like that.

So we should choose if we want to put a stake in the ground on a number or if we want to just kind of lay out the facts.

COMMISSIONER DOUGLAS: I don't know the answer. What I would say, and I think they've got it, maybe, is that we -- the intent here, they have two steps, right?

One is to try to deter any new, and to really the ones that are egregious. And so the question to me, and maybe this is more of a statement rather than picking a -- is that they need to continue to ensure that there are up-front measures to safeguard against any new, unintended consequences.

And so it might be, for example, it could be that it's 80 percent now and any in the future that creep up above 50, that, you know, they have a different, but that this is something that is not a one-time fix, that this market is dynamic and unintended policy consequences that certain officials make might have impacts on that.

CHAIR BELLA: I'm going to trust these guys to kind of look at the data we have and give us a couple of options on how we might respond. In any case, 80 percent is like a starting point, and I'm sure CMS would view it like that too. If it doesn't hit their intended goals they could always change it as well.

Okay. Any other comments or questions on this body of work? How come you guys don't look more excited?

[No response.]

CHAIR BELLA: All right. We are now going to

move into our next session on duals and integrated care. The purpose of this session is to make sure everyone is comfortable with the three recommendations. This will now be the third time, at least, that we've discussed these. So I don't anticipate we need to spend a lot of time on these three.

The bulk of our discussion then can be talking about future work and coming back to the things that didn't rise to recommendation ready, but that we intend to signal that we're focused on in the next report cycle.

So anybody have any questions about what we're trying to get out of this session?

Okay. Kirstin.

IMPROVING INTEGRATION OF CARE FOR DUALLY ELIGIBLE BENEFICIARIES: DECISIONS ON RECOMMENDATIONS TO BE INCLUDED IN THE JUNE REPORT TO CONGRESS

* MS. BLOM: Thank you. So as Melanie said, in January we presented a bunch of options, as you will recall. Since then we took your feedback, we've refined that list down to take out things that you weren't interested in moving forward on, and to add a few things that were added in January.

You also expressed interest in moving forward on recommendations in a few areas, and so as Melanie said, we're going to talk about those today, but probably not spend a lot of time on them. Those will be included in the June report, to the extent that you guys want to move forward on them. And then we will go into the remaining policy options that we will be working on, probably speaking generally about in the chapter and then working on over the next report cycle.

We have talked with additional experts since our last meeting so that we could sort of refine the recommendations, and that is what you'll see in the language that we're going to show you today.

So our plan for today is to go over those draft recommendations, over specific language, then talk about the options and talk about next steps for the April meeting and for the June report.

So these are the three areas for recommendations that you all were interested in last time, at the January meeting. These include an exception to the special enrollment period for dually eligible beneficiaries who are enrolled in MMPs, and then two recommendations around

enhancing state capacity on Medicare and to provide additional resources to implement new models.

So starting with the exception to the special enrollment period, so just a quick background. As we talked about last time, certain Medicare Advantage enrollees qualify for special enrollment periods, which enable them to make coverage changes outside of the normal, the regular annual enrollment period that Medicare Advantage has. So duals are one of those groups, and prior to January of 2019, they could make changes every month.

As of 2019, CMS has changed the regulations to limit that ability to change to three times per year. That affects MA plans but it also affects MMPs, which is the reason why we are talking about it. All states that have MMPs opted out of this change, which they were able to do under the demonstration waiver. They did that because of concerns around limiting enrollment into MMPs. As you know, enrollment in MMPs has been an issue. Enrollment is much lower than was expected, and our understanding is that states felt like, no, we don't want to place any limits on when a person can enroll into an MMP.

Just for your information, the President's budget

for 2021 did include a related proposal to this one, which would actually further limit the applicability of the duals SEP. It would only allow the SEP to be applied in two events. One would be after auto-assignment into a Part D plan, and the second would be to enroll into an integrated product. So outside of that, duals would be treated the same as all other Medicare Advantage enrollees. And we are assuming that would affect MMPs as well, although the language of the President's budget isn't specific to that.

I am just mentioning that to you so that you are aware of it. That is not what we are -- that is not the approach we are taking. We are looking at recommending an exception to the current law special enrollment period, for MMPs only. That could be done through subregulatory guidance. What the President's budget would do would impact all duals, which would be outside the scope of what we're talking about.

This is the draft language for recommendation 1, around the special enrollment period. As I mentioned, federal officials told us this could be done through subregulatory guidance, so it would not require a statutory change. And we would love to get any feedback from you

guys on this language. I think I will go through all of them and then we can hear your thoughts at the end.

The second recommendation would be on enhancing state capacity on Medicare. We've heard from state officials on panels that have spoken to us about their limited knowledge of Medicare Advantage and how that might get in the way of setting up an integrated model. There are lots of things that states have authorities under existing law to do, for example, within their contracts with D-SNPs. But without the required expertise in Medicare Advantages states are limited in their ability to set up a contract that meets their needs.

Additional federal funding in the form of a higher FMAP or grant funding could support state efforts in this area. In talking with states we didn't hear strong preferences for either, for FMAP or grants. Some states, there have been grant programs -- there were grants associated with the financial alignment initiative and states spoke highly of that. Some states used FMAPs in other ways that were temporary. So we aren't making a specific call. It's up to you guys, but we feel like either of those would be appropriate.

This is the draft recommendation language we've developed for recommendation 2. This would require a statutory change, as Congress would have to make funding available.

And the third one is on enhancing state capacity to implement new models. So states are interested in establishing new integrated care programs. They might not have sufficient resources for the planning or the implementation or the up-front investments that go into setting these up. States obviously have many competing priorities and limited resources. Even trying to dedicate existing staff to something new like this could be really challenging.

CMS has made it pretty clear, in an April 2019 letter to state Medicaid directors, that they are open to new ideas from states, including models that are similar to Washington State's managed fee-for-service model, but also other models that could be state-specific, that could be new ideas. It was a fairly open-ended letter.

So we are making this recommendation with the idea that additional federal funding could support states to get them through that sort of -- to be a bridge to get

them through that early up-front investment that needs to occur before shared savings that would come from a managed fee-for-service model could be realized, or to get past their state legislatures.

This is the draft recommendation language for number 3, and again, in the same way as the second one, would require a statutory change because Congress would have to make funding available.

So we're going to move now to the policy options that remain. So, as I said, we've refined these after the January meeting, based on your feedback. We have kept the four buckets that we talked about in January, which were options that increase enrollment, options that make integrated products available to more people, options that promote greater integration in existing products, and then finally the big option, to establish a new program for duals.

So the two that we have, that we are focusing on in this next cycle around increasing enrollment are default enrollment into D-SNPs -- this is for Medicaid managed care enrollees who are becoming newly eligible for Medicare -- and then enrollment brokers. Brokers are a topic that

comes up a lot. We are planning to do some additional work in this area.

Just a quick note on default enrollment. We noted this in your materials that although this is an area that we know you guys are interested in highlighting, we wanted to -- our plan is to spend some time on this in the June chapter, but we haven't included it as a recommendation, both because states have existing authorities around this and CMS has put out a fair amount of technical assistance on this topic. But we are interested in your feedback on whether that's a good approach.

Making integrated products available to more beneficiaries has three areas of focus for us right now -- increasing state use of MIPPA authority, strengthening or doing something on MMPs, including things like maybe a frailty adjuster, maybe supplemental benefits, which are two things that were added at the last meeting. We could also think about, you know, providing authority to the Secretary to set up something that has the characteristics of an MMP, if we didn't want to look at permanent authority.

So this is an area we're just going to spend some time on, and MMPs are seen as a very highly integrated option, the highest perhaps, and so we want to spend some time thinking about what we can do in this area.

And then the third one is addressing differences in network adequacy standards between the two programs.

Just again, a quick note on MIPPA, similar to what I said about default enrollment on the last slide. This is also an area where there are existing authorities that states have and where CMS has put out a fair amount of guidance, so we are planning to talk about this in the June chapter but are not including it right now as a recommendation.

Promoting greater integration in existing products is something that Kristal actually talked about a fair amount in her presentation, particularly on the look-alikes piece of this, so I won't go into detail on this. The other two are limiting enrollment in D-SNPs to full-benefit duals, which is something that MedPAC has talked a fair amount about, and then having states only contract with D-SNPs whose parent organization also offers an MLTSS plan.

And then finally is this sort of larger bucket, which is a bit more of an unknown right now, but would be looking sort of generally into what establishing a new program might look like, what existing plans for this might be out there already, what it would look like for things like enrollment and financing. This is something we are planning to talk in a general way about in the chapter, but obviously are at the very early stages in this area.

This slide just summarizes the four buckets and then the options I've just discussed that fall within each of them, as kind of our plan for work going forward.

So for next steps, we'll take your feedback today on the recommendations that I talked about and then also the options going forward. We will be refining the language that we showed you today for a vote in April, assuming you want to move forward with that. And then also at the April meeting we will be bringing you two draft chapters on integrated care for duals. The first will be sort of a more descriptive chapter that will set up the context around the population and the models that are available, and then a second one -- and so flowing into the second one, which will be about the recommendations and the

options that we're focused on.

So with that I'll close and will be happy to take any feedback you guys have.

CHAIR BELLA: Thank you very much. Appreciate the comprehensiveness.

Let's start with the recommendations. Any questions on the recommendations?

Toby?

COMMISSIONER DOUGLAS: Just in kind of a -- can you talk a little bit -- and I can't remember from the last time. Why did we split Recommendations 2 and 3 into two separate recommendations? I can understand why in terms of just wanting to call out the differences. Is that the main reason of differences between fee-for-service and capitation?

I guess the comment, then, would be somewhere up front before the recommendations or somewhere mentioning why it's important, because it could be 1, just recommendation about state resources. Frankly, I don't know if a state is going to really have a fee-for-service.

It's a little strange to me, but I get the point of the value of calling out these unique things.

EXECUTIVE DIRECTOR SCHWARTZ: I think at one point, we did have them together, and someone suggested splitting them apart. But there's not a strong argument either way, and I think it's up to the will of the group.

COMMISSIONER DOUGLAS: I don't have a strong preference either. We probably need to explain why.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. There would be a separate rationale for each recommendation, but the second one appears, it's like the previous recommendation, you know, after blah-blah-blah, so -- I can't wait to see that in the transcript.

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: I mean, I guess the question is just like this: Does one apply to everyone and then the other one maybe apply to a fewer set of states?

MS. BLOM: Right. I mean, we could consider, especially on the third one too. We had talked about this originally in terms of non-capitated models, but it could be just sort of any new model. We could certainly combine them both, we -- you know, we don't feel strongly.

CHAIR BELLA: Martha?

COMMISSIONER CARTER: I had the same question.

It's not my area of expertise, but just reading it, I thought those seem like they're really similar in terms of state capacity, so why not combine them, but --

CHAIR BELLA: I think it's fine if we want to combine them. No. 3 runs the risk of making it look like we don't want to support states that do capitated models, which we want to support them doing managed fee-for-service and capitated and alternatives.

I think the thing has been that there has been feedback from states that are not managed care states, that they would like help doing a shared savings demonstration, where they're sharing in Medicare savings. So if we did keep No. 3, I think we might want to tweak it to be more, instead of it being non-capitated model, to be develop a shared savings model with Medicare or something, which I think would get us to the same place.

Do you have thoughts, Chuck?

[No response.]

CHAIR BELLA: Yeah, Fred.

COMMISSIONER CERISE: On both of those, the implications on the federal spending side, we talk about the extra spend, and then there's a comment made about the

spending -- or it could have an impact based on the integration that states do. Do we want to be stronger in terms of what we think will happen there?

It seems like we emphasize the federal spend, and you might want to say, "But we expect, obviously, savings from integration."

CHAIR BELLA: Yeah. We should do that.

So I'm going to ask that for April, you do two things. One, come with a combined recommendation, combine 2 and 3, and then also see if there's more of a distinction on 3 that would make it warranted to be its own thing. I think we can do that for April and pretty quickly make a choice between the two.

Is that okay with you?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

CHAIR BELLA: Okay. I have one request when we do the wording. If you could go to Recommendation 2. We talk about defraying state costs, and part of the problem is they are not spending it today. So we're not really defraying.

I'd like to say something more about allow states to invest in developing expertise to do blah-blah-blah,

because the other thing is I don't want Congress thinking that states are -- this is sort of supplanting state dollars that they already have. They don't have this money, and so that's why we have to get it to them.

All right. Any other comments on the recommendations?

VICE CHAIR MILLIGAN: Are we moving to other parts of the recommendation?

CHAIR BELLA: We are, yeah.

Are you guys comfortable coming back with a variation on that, or is that unnecessary?

MS. BLOM: No, that sounds good to us.

CHAIR BELLA: Okay. Now let's move to looking at our future work and/or if there's anything else we want to move into a recommendation category.

Chuck?

VICE CHAIR MILLIGAN: I have two comments, actually. One is -- if you could just go to Slide 14. I just wanted to use this as an illustration and mainly for the public or anybody who might read the transcript.

When we say something like "Our future work plan for next year might include other areas like limiting

enrollment to full-benefit duals or contracting only without D-SNPs that have an MLTSS," we're not trying to signal a recommendation that will, in fact, be made next year. I think it could read this way, like limited enrollment. It could read almost as a normative statement. I just want to say this is an area that we're going to be evaluating. We don't know quite what the form of any of this will take over the course of next year. I just want to use this slide to illustrate that point.

The comment I wanted to make is I do think personally that the MIPPA-related one, so Slide 13 actually, the first bullet, "increasing state use of MIPPA" -- I do think that it would be good to pull this in as a recommendation in April.

I do recognize, Kirstin, the point you made, which is states have this authority now. CMS has pushed out guidance. ICRC and others are pushing out guidance.

I do think, though, that if we make a recommendation as MACPAC, it lends a weight to this that I would like to lend a weight to.

So my own point of view is that this would be a good one to roll into an April-related recommendation.

EXECUTIVE DIRECTOR SCHWARTZ: Can I ask a question, Chuck? I'm trying to sort out in terms of the difference between a recommendation which is a direction for somebody to do something versus something that is not a recommendation but is in the text of the chapter. It could be in the executive summary. It can be in the initial part of the chapter. You know, appropriate ways to highlight it. I'm talking about the direction of the policy, and the reason I'm concerned here is we've had the discussion. And now today, Kristal shared the concerns that we hear from the stakeholders about how these actions, well-intended actions, because of the characteristics of the MA market, can have sort of an unintended consequence.

So my question really is, would you be satisfied if we had a strong statement that we would like to do this, but we recognize some of these countervailing market dynamics that would have to also be addressed? Because otherwise just saying states should exercise their MIPPA authorities, to me, is not a very strong recommendation.

VICE CHAIR MILLIGAN: To me, the wording of a recommendation wouldn't be as kind of benign as the way it's written on the slide right now, and so let me --

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. So can you go a little further with that?

VICE CHAIR MILLIGAN: Sure, sure. So let me just sort of frame it up. There could be an area where we talk about the rationale being there's been a lot of movement with how states, in fact, have used their MIPPA. We could give examples from some states that have driven integration. So, to me, the anchor is integration. It's not just using MIPPA for MIPPA's sake.

So I think we can, in the rationale, give some examples like using a single health risk assessment tool for both Medicaid and Medicare, as an example, or incorporating elements of the Medicaid LTSS into the D-SNP model of care, for example. So we can give some examples in the rationale, and then the recommendation could be states that -- and I don't want to do the wordsmithing here, but to me it would be states should utilize their MIPPA authority to drive integration. It would need to be stronger than that. It would need to be anchored around integration. I think a lot of it would be in the rationale and kind of capturing kind of the state-of-the-art in a lot of markets.

If that's still too soft because it's authority that exists now, so kind of why would we say it as if it's something that needs to change, I could be convinced. But I do think that it's stronger not just coming from a state Medicaid director letter or what ICRC pushes out. I think MACPAC as an entity carries authority too.

So that's my thought process, Anne.

EXECUTIVE DIRECTOR SCHWARTZ: I think we'll circle back with you on the words of this.

I fully understand where you're trying to go. My concern just is whether putting in a recommendation is the way to have that impact relative to other things we put in recommendations. That's all I'm concerned about, and we can float different things back and forth. And we can certainly talk about them as part of the chapter for April.

It's kind of hard to talk about. It's hard to go from the slides to the chapter with its fully fleshed-out rationale and how it has all the text.

VICE CHAIR MILLIGAN: Fair point.

CHAIR BELLA: Comments from others?

Sheldon?

COMMISSIONER RETCHIN: I wonder if on the network

adequacy issues and trying to draw that out and going back to, I guess, the relaxation of the network adequacy that we talked about a little bit earlier in rural areas and the text -- I guess there was mention of this is addressing shortages of specialties, right? Am I confusing things here, Kristal?

DR. VARDAMAN: Yes. So the proposed rule is to address certain specialties in particular. There's like a list of which specialties it applies to. I could provide all of that information.

COMMISSIONER RETCHIN: Yes. I guess just coming back to this later maybe when we get more granularity is the issue of, I guess, HPSAs or -- especially those with mental health workforce shortages. I'm not worried about cardiologists or orthopedists, but the mental health shortages in rural areas, the relaxation of those standards, especially with this population, I think, could be hazardous.

CHAIR BELLA: Brian?

COMMISSIONER BURWELL: I just want to be sure that when we discuss the recommendation about default enrollment in the D-SNPs in the June chapter -- I mean, I

see that recommendation as having two major components. One is streamlined enrollment. So if somebody is in a Medicaid managed care plan and is Medicaid-only and becomes a dual, that it can go into the aligned D-SNP of that plan through default enrollment.

The other is if someone is not in Medicaid managed care at all, but the state has an MLTSS program, a mandatory MLTSS program, that's aligned with the D-SNP. And there are several states that are like, you know, "You're now a dual. You have to enroll in this program," whether they could default into the aligned D-SNP, whether the state could require them to enroll in the aligned D-SNP at the time of their initial enrollment.

Do you see that difference?

MS. BLOM: In the second one, I thought you said there was no managed care.

COMMISSIONER BURWELL: There's no managed care prior to becoming a dual.

MS. BLOM: Okay.

COMMISSIONER BURWELL: I mean, the person was just --and as a result of becoming a dual, now has to be mandatorily -- so Pennsylvania is an example. Arizona is

an example.

MS. BLOM: So there's MLTSS and a D-SNP.

COMMISSIONER BURWELL: There's MLTSS with an aligned D-SNP.

MS. BLOM: Yeah. Okay.

COMMISSIONER BURWELL: So that when states have a mandatory MLTSS program, they can mandate enrollment also into the -- at least initially. I mean, there would be an opt-out.

MS. BLOM: Right, right.

COMMISSIONER BURWELL: But mandated enrollment into the aligned --

CHAIR BELLA: Can I try to restate what I think you're saying?

COMMISSIONER BURWELL: Okay.

CHAIR BELLA: Are you saying that with default enrollment, that works only when you're newly eligible, and you can go into the plan they already have a relationship with? You're talking about people who may already be in a Medicaid MCO, and a corresponding D-SNP is there. But because they're not newly eligible, they can't be default-enrolled, and so you want to be able to pull them. If they

have a relationship with a Medicaid MCO today and that Medicaid MCO starts offering a companion D-SNP, you want to be able to pull them over. Is that what you're saying?

COMMISSIONER BURWELL: I don't think so.

CHAIR BELLA: But what I just said, I would like us to look at, just for the record.

[Laughter.]

CHAIR BELLA: I can't follow what Brian is saying.

COMMISSIONER GORDON: I can --

CHAIR BELLA: Okay.

VICE CHAIR MILLIGAN: So more on Washington, D.C., I want to just make up an example. Let's say that there are Medicaid MCOs in Washington, D.C., and one procurement, Medicaid MCOs. There's a separate procurement, Medicaid LTSS MCOs. You're in a regular MCO, and then you become a dual. You may not be default-enrolled, because the program you're in, it's just like Healthy Moms and Kids. It's TANF, SSI.

COMMISSIONER BURWELL: Right.

VICE CHAIR MILLIGAN: There are states in which the MLTSS procurement in a given region, it's separate from

the Medicaid MCO procurement in the same region, and then a person in the regular MCO, not the MLTSS one, becomes a dual. That's the issue that we're confronted with. It's like what happens to that person, right?

Am I tracking correctly, Brian? Maybe not.

COMMISSIONER BURWELL: I'm saying they're two different entities. I'll just use the example of Pennsylvania. So there are three MCOs in Pennsylvania in the MLTSS program, some of which participate in the under-65 program. When they become a dual, they have to enroll in the duals program, and they can pick one of three plans. That's mandatory.

All the plans also have an aligned D-SNP. I just want us to consider a policy option where the state could say, "You're default-enrolled into the aligned D-SNP as well when you enroll in the MLTSS program."

CHAIR BELLA: Yeah. That's like passive enrollment.

COMMISSIONER BURWELL: Yeah, passive enrollment.

CHAIR BELLA: Yeah. That's what passive enrollment is.

COMMISSIONER BURWELL: I think there's a

difference between passive enrollment and streamlined enrollment. Right.

CHAIR BELLA: I think it is a similar theme, which is to say if there is a relationship on the Medicaid side and that entity purchased states on the D-SNP side, do we have tools to allow them to be aligned? Does that make sense?

So, in Pennsylvania's case, if it's Plan A and I'm in Plan and I was in Plan A before and there was the D-SNP and I'm not just now becoming a dual, but I want the state to be able to pull me over into that D-SNP as well, just like they would if I was turning 65 and pulling me over.

MS. BLOM: We can look into that.

Just to clarify, this one right now is not on our list of recommendations. It's in our --

COMMISSIONER BURWELL: Right.

MS. BLOM: Okay.

COMMISSIONER BURWELL: But just in how we present this as a policy option that we're considering.

CHAIR BELLA: Any other comments?

[No response.]

CHAIR BELLA: Okay. What I heard is that good to go on the recommendations. You're going to come back with a potential hybrid -- or combining of 2 and 3, and we will take a crack at a MIPPA-type recommendation and see if it could have enough teeth to have something that the Commission is comfortable with. If not, we'll focus our efforts on that in the chapter and in the rationale.

And I'm hearing support for the additional things that are on Slide 16 to be the work that we focus on in the upcoming report cycle.

I'm going to now ask if there's any public comment.

Thank you, Camille.

PUBLIC COMMENT

* MS. DOBSON: You're welcome. Good morning, Camille Dobson, deputy executive director at ADvancing States. We represent the aging and disability directors who deliver LTSS in the state.

So I had a couple of questions and wanted to support some of the Commission's recommendations.

Can I clarify on Draft Recommendation 1? And maybe I'm confused. I don't know if anybody else is, so

I'll take the stupid question. That the recommendation is that you can enroll monthly, but you want to limit disenrollment to quarterly?

[No response.]

MS. DOBSON: Okay. That's what I thought you were saying, but I wanted to just clarify that that was the case. Okay. Then yes.

CHAIR BELLA: We should probably make sure that's clear. The disenrollment stays the way it is.

MS. DOBSON: Yeah.

CHAIR BELLA: What we're changing is the ability to enroll.

MS. DOBSON: To enroll, right. I thought that was the distinction.

The second, on Draft Recommendation 2 and 3, obviously, we fully support. It's a huge barrier to states moving forward.

I would argue that the separation of the recommendations are important, and here is why. To me, the state capacity on Medicare is sort of fundamental across the board. For states to do anything on integration, to even start using their MIPPA contract, they need that

information.

Secondly, if states want to move further on the integration to actually build a program, to me, that's separate and apart. That's actually even more intensive. Technical assistance, as you said, you know, building infrastructure, identifying an accountable entity that you can actually capitate, that's slightly a different skill set and actually a higher-level skill set, and sort of just understanding Medicare basically, which I think you'd need to have to even, for example, start drawing in Medicare data.

So I defer to the Commission's decision, but to me, there is slightly different emphasis, and I think you might need like sort of technical assistance money on the second, on the Recommendation 3 sort of basic infrastructure-building money on one -- on Recommendation 2.

Then the third thing, I think, I wanted to say was about the policy option that Brian was getting to. To me, there are a lot of acute care plans, programs in the country who exclude duals completely. So they're not in managed care at all, actually, until they turn 25, and I

think what I was thinking Brian was saying is that, right, they're not in managed care at all today. In a state like Missouri, for example, who excludes all their duals, right, they just say we don't know why they shouldn't -- they're -- you know, it's acute care, Medicare, like they're out. But when they turn 65, they actually are able to -- they could be enrolled in a mandatory program, and should they, in fact, do that?

Maybe I'm missing the state. Maybe I'm missing the issue that you're trying to get at, but to me, when they -- when a state has a program, I guess it doesn't really matter. Never mind.

[Laughter.]

MS. DOBSON: Now, see, I talked myself -- I've been sitting here talking myself into this spiral of figuring out exactly what it is this is trying to actually get, and I get the MLTSS in Pennsylvania where they're in an acute care MCO and there's MLTSS. But let's say they're not in managed care at all for their acute, and then they become -- there's an MLTSS program available when they hit a certain age. I just want to make sure that that's available too.

COMMISSIONER BURWELL: Yes.

MS. DOBSON: Yes?

COMMISSIONER BURWELL: That's my recommendation.

MS. DOBSON: That's what I thought. Okay. I would support that. Any opportunity to get individuals when they have an integrated product to get them into an integrated product should be supported.

I think that's it. Thank you.

CHAIR BELLA: Thank you.

Other comments from the public?

[No response.]

CHAIR BELLA: Any last comments from Commissioners?

[No response.]

CHAIR BELLA: Kirstin and Kristal, any other clarification you need from us?

MS. BLOM: No, thank you. We're good.

CHAIR BELLA: Okay. Thank you very much.

We are going to take a break. What time do we want to be back? Fifteen or 10 minutes? So we make sure we can get to the last session, let's take a break for 10 minutes. So if you can come back at 10:35, we'll get

started. Thank you.

* [Recess.]

CHAIR BELLA: Okay. If everyone can make their way to their seats we will get started again.

Welcome, Martha. You are going to engage us in a discussion in anticipation of a rule that may come out. Yes? It's all yours.

FORTHCOMING RULE ON PROGRAM INTEGRITY AND ELIGIBILITY DETERMINATION PROCESSES

* MS. HEBERLEIN: Thank you. So today we will be discussing a forthcoming rule on program integrity and the eligibility determination process. I will begin the session with a brief refresher of the existing rules as well as what we know regarding their implementation, before discussion of areas for potential changes and comments.

So there is currently a proposed rule that would strengthen the integrity of the Medicaid eligibility determination process, including verification, changes in circumstances, and redetermination, that is under review at the Office of Management and Budget. Additional details of what is in the rule are not yet available, but the Administration's proposed budget for fiscal year 2021

indicates that the proposed rule will allows states the option to conduct more frequent eligibility determinations, among other changes.

The rule is scheduled for release in April of 2020, but that date could shift.

So historically, Medicaid enrollment and renewal processes relied on in-person applications and paper documentation to verify eligibility. States had considerable flexibility in designing and administering many aspects of the process, leading to variation across states and populations. Following the enactment of CHIP, a number of states focused their efforts on enrolling and retaining eligible children in both Medicaid and CHIP, and state experiences and research from that time found that these efforts to simplify the enrollment and renewal process were successful in encouraging enrollment of eligible children, reducing the loss of coverage, and promoting continuous coverage.

The ACA sought to build on these successful experiences and modeled many of the changes to the enrollment and renewal processes on measures that had been established for children.

So current law takes a fairly uniform approach to application enrollment and renewal, although states still have some flexibility. So, for example, states have flexibility in how they conduct eligibility verifications in terms of what data they tap.

While there are a number of other pieces to the process, I'm going to focus on the three areas that were highlighted for inclusion in the proposed rule, including verification, changes in circumstances, and redetermination. So states must verify citizenship, immigration status, and financial eligibility and should rely on electronic data sources to the greatest extent possible. For those eligible on the basis of modified adjusted gross income, or MAGI, states renew eligibility once every 12 months, and for those whose eligibility is based on something other than MAGI, states can redetermine eligibility more frequently.

To renew coverage for all beneficiaries, states must first attempt to confirm ongoing eligibility based on information available from a beneficiary's account or other available data sources prior to asking for information from the individual.

States must also establish procedures under which enrollees can report changes that may affect their eligibility. Beneficiaries are responsible for reporting such changes and must be able to do so through any of the modes, including paper, phone, online, and in person, that are required for the application. In addition, a state must promptly redetermine eligibility when it receives information about a change in circumstances that may affect a beneficiary's eligibility.

These rules were intended to reduce effort for both enrollees and program administrators with the goal of increasing the share of eligible individuals that enroll and retain coverage, decreasing errors associated with administering the complex eligibility rules, and determining eligibility more efficiently.

So the federal government and the states have less than four years to establish the rules and implement in the infrastructure needed to comply with the new requirements, and as you may remember, the initial implementation period was a bit challenging. As time has passed it appears that many of those initial difficulties have subsided, although some states are still experiencing

problems in certain areas.

So work done for MACPAC examining implementation of the ACA in six states showed that states were balancing the need for accurate eligibility determinations with the desire to make enrollment as streamlined as possible for beneficiaries. The systems' connections with electronic data sources facilitated real-time eligibility determinations, more efficient application processing, and auto-renewal. Most respondents remarked that the efficiencies gained through the data interfaces reduced the administrative costs as well as fluctuations on and off the Medicaid program.

In addition, some respondents felt that the states' rules-based processes have helped to reduce inaccurate determinations. Although even with a robust rules engine and the electronic use of data, verifying income remained one of the biggest challenges that they faced, as some beneficiaries, particularly those with unstable incomes, were required to provide additional documentation at application and renewal.

We also know that states are still addressing implementation issues. For example, systems issues may

have played a role in the declining enrollment in some states in recent years. In the fall of 2019, MACPAC spoke to a number of state officials who mentioned that the enrollment changes were due in part to restarting the renewal process, as some individuals were found no longer to be eligible and others did not respond to renewal requests.

Other states mentioned confusion regarding the interpretation of certain rules or difficulty in implementing some of the changes, and some states had to reprocess cases in order to come in compliance with the regulations.

There have also been concerns about the accuracy of determinations, although audit results suggest that the errors are primarily the result of inadequate verification and record-keeping, rather than incorrect determinations.

In December, you will remember that we presented a review of the payment error rate measurement findings, or PERM, from the first eligibility reviews conducted after implementation of the ACA. The PERM results showed that most eligibility errors in the one-third of states sampled were due to insufficient information to determine

eligibility, primarily related to income or resources. A smaller number of Medicaid eligibility errors were due to noncompliance with redetermination requirements or because the beneficiary was ineligible for the program or service provided.

The results of the PERM audits are consistent with some audits by the U.S. Department of Health and Human Services Office of the Inspector General. These audits found a lack of documentation inhibited the ability to assess the accuracy of eligibility determinations as well as cases for which verifications were not completed.

A more recent review by the U.S. Government Accountability Office examined 47 state and federal audits, and identified a number of accuracy issues. In some cases, these issues resulted in errors of eligibility determinations and in other instances they did not.

So as noted, the proposed rule remains under review and will likely come out in April. Given that many of the current requirements are described in regulation, the rule could be narrow or broad in terms of the changes it makes. However, based on prior guidance and comments from CMS, as well as the focus of past Commissioner

discussions, I will highlight some possible areas for changes and comments you guys can make.

So beginning with verification requirements, while the general requirement to use electronic data sources is in statute, the proposed rule could provide additional parameters regarding the use of data, such as specifying which data sources states must use. The Commission could support the use of electronic data to the maximum extent possible when verifying eligibility. Based on our work, looking at implementation of the ACA, states viewed these data sources as facilitating eligibility and enrollment processes. In addition, it has been shown that documentation requirements can be a barrier for individuals applying for renewing coverage. The Commission could also comment that states may need technical assistance or guidance as audit results suggested some states still have work to do in terms of following the existing requirements.

The PERM findings also noted that many eligibility errors were due to insufficient information to determine eligibility. Currently, states must include in the applicant's record facts to support their determination decision, but the regulation provides little detail, and no

formal guidance has been released describing what supporting documentation should include. So the Commission could comment in support of retaining documentation to leave a paper trail so that audits can be conducted.

In terms of routine data checks, states currently have the flexibility to determine which data sources they use and how frequently they check them, and the vast majority of states have established some sort of periodic data check. However, there are no explicit regulations describing how frequently states can conduct data checks and how much time individuals need to be given to respond to a request for additional information.

So the Commission could comment on whether or not states should be required to conduct routine data checks, whether additional parameters should be established around their use, or whether such practices should be prohibited. On the one hand, more frequent data checks may lead to the discovery of information that affects an individual's eligibility, helping to ensure that they remain eligible during their enrollment period. On the other hand, periodically checking data sources may result in more frequent churning, as many low-income individuals

experience fluctuations in income.

Minimizing frequent coverage changes, which have the potential to negatively affect health, costs, and administrative burdens, was the rationale for the Commission's 2013 recommendation for an option of 12-month continuous eligibility for adults.

The PERM audit findings also noted that redeterminations were not conducted in 8 percent of sampled Medicaid cases and 13 percent of sampled CHIP cases. When states launched new eligibility systems in response to changes in the ACA, the technical issues were common, and a number of states delayed processing renewals, as we talked about in our September meeting. Although states now appear to be processing renewals in a timely basis, the Commission could comment in support of the existing requirement to conduct renewals on an annual basis.

Based on the President's budget, CMS seems poised to offer states the option of requiring more frequent renewals than every 12 months. Data from prior to the implementation of the ACA suggests that more frequent renewals can led to declines in enrollment. While some individuals may re-enroll within a few months, churning can

interrupt their coverage and this could be a burden to payers, providers, and plans. So the Commission could comment on whether or not more frequent renewals should be allowed. The Commission has discussed barriers to enrollment and renewals on a number of occasions, and as previously mentioned the issue of churning led the Commission to recommend a state option for 12-month continuous eligibility in 2013.

In terms of supporting individual success, it may be the case that additional requirements may be placed on individuals under the proposed rule. For example, if more frequent renewals are allowed, beneficiaries will need to respond to notices and possibly submit additional documentation to verify eligibility more often. Yet communication with beneficiaries remains a challenge. The Commission could comment that individuals applying for and renewing coverage under different rules should understand their obligations and have the time and means to fulfill them. So you could require the specification of a 30-day response period, for example, or that they be able to submit information online.

The final area for potential comment could be to

continue with implementation. Implementation was challenging for both the federal government and states, and for some states implementation has taken longer as they are still working on resolving issues in terms of compliance with the existing rules and fixing systems to process applications and renewals in a timely manner. The Commission could comment that states need additional time and guidance to implement the rules as currently designed. Commissioners have noted that there is now more consistency and rigor behind the rules than there was in the past, and given the complexity of the program the rules can be difficult to implement. Commissioners have also noted that there may still be ways to improvement implementation of the current processes.

So with that I will turn it over to you to discuss the rule that is not yet a rule and see where we want to comment.

CHAIR BELLA: Thank you, Martha. Tricia.

COMMISSIONER BROOKS: Okay. Well, I know we're trying to get out of here in a little bit of time but I could talk about this for a very, very long time.

I am extremely concerned, particularly about any

mandates that CMS might put on states, rather than offering additional flexibility. But that said, I think states currently do have significant flexibility in how they manage their enrollment processes.

As Martha mentioned -- and, Martha, you did a great job with that summary -- you know, there -- and I remember Toby saying, at some point, this was like the decline in enrollment was a correction, you know, that to some regards, you know, the delay of renewals and system issues certainly had confounded the problem, right?

But that blame doesn't just fall on states. It definitely falls on CMS. For example, the PERM audits are based on what is in a state's verification plan. So states have to file a verification plan that tells the federal government which data sources they're using, how frequently they're using those, if they're applying optional reasonable compatibility standards.

Those are not required to be approved by CMS, but they do have to be filed. But because there is no approval process for them, many of those plans have never been updated since they were originally filed in 2013, and as systems were brought up, states found that they really

needed to do things differently than they had put in their original verification plan.

So some of the errors that we see in PERM could be that the states changed their process but the PERM rules required them to look at what was in that plan and they highlight the discrepancy.

So I think, Martha clearly identifies that of those high-eligibility error rates, they only were able to absolutely determine that 3 percent of Medicaid were incorrect and 11 percent in CHIP. And I made this comment previously, that those in CHIP were not necessarily because they weren't eligible at all, it was because they were eligible for Medicaid but in the wrong category.

So lots of issues there. CMS has changed its interpretation on certain aspects of verification over time, without any of that being documented in writing. How you apply reasonable compatibility is one of those areas. How you and when you have to verify zero income is another one of those areas. We've seen that.

So it seems to me that before we start loading on more frequent, stricter verifications, that we need to spend the time to continue to perfect the systems so that

they are working, because if we put more requirements on top of what's already there it's only going to make the problem worse in certain states.

If CMS comes out with a rule that imposes mandates, there are conservative political forces that will be pushing state legislators to adopt changes that Medicaid staff wouldn't even want to do, because you hear the passion when we bring in these panels from staff. So I think that we need to be careful of the ramifications of even suggesting that we tighten things up, because there will be political forces making sure that those happen.

There are some positive things that could be done with the rule. For example, if a state does a periodic review, they are not required to give beneficiaries 30 days, as they are at renewal. That's a problem that doesn't align very well, so that could be something positive that could come out of the rule.

There should also be more guidance on providing better consumer information and engaging them digitally. So we have eight states that have not yet implemented online accounts, and online accounts are a great way because, as we know, the younger populations coming up are

addicted to their smart devices, and if we have an online account, where we can easily go in and update our address, it resolves a lot of problems.

But it's tremendous variability across the states in terms of how advanced -- I mean, in terms of consumer use of digital products. So you range from a low of 3 percent of online applications in Alabama to 100 percent in Oklahoma, both, you know, relatively conservative states. So a lot more can be done to encourage states to have online counts and to increase the use of those digital communications, because that would be a really important way to get people to respond.

We know, from years of research, that probably a good estimate is around a third of individuals fall off at a review or at renewal for failure to respond. States give them one opportunity, one piece of mail. And we'll have more. I think some folks know I'm a co-author with the Kaiser Family Foundation folks on an annual eligibility study, and we're going to have more data when we publish this year, March 31st, on things like how many follow-ups do states do, which only do one, which give you 10 days to respond. How many states are doing anything proactive to

update mailing addresses? These are all positive steps that states can take.

But I think churn is just extremely problematic. We've worked for more than two decades, particularly in children's coverage, to identify the aspects of verification that lead to churn. Many of those were things that were picked up in the Affordable Care Act as requirements for states, and we need to just keep moving ahead on that, because continuous eligibility is important, not just for people who have extensive ongoing health care needs but it's really important for children.

And I've talked about this before. If we don't get a handle on keeping kids in coverage, continuously, getting the health care they need, so that they don't fill up the pipeline as adults with multiple chronic conditions, we are not going to bend the cost curve in this country.

So I think that's probably enough at this point, but my closing comment is that -- and Martha brought this up in terms of the impact on providers or plans. We cannot adequately measure the quality of health care that kids get or anybody if we don't have continuous eligibility. Those children with periodic gaps in coverage are not included.

They don't get swept into the quality measurement. We're spending billions of dollars on managed care plans. We can't hold them accountable for delivery of quality and improvement in quality if we can't adequately measure it.

So I hope we can come out with some strong -- well, comments back on this particular rule that really just say we need to keep working to refine and make the systems we've got more precise so that they work better, and we can come back and revisit that after we have another couple of rounds of PERM and see what happens from there.

CHAIR BELLA: Thank you.

Toby?

COMMISSIONER DOUGLAS: The final comments of Tricia, I definitely agree kind of the overall theme should be around refining and improving on the systems that we have today and really focusing first on program integrity and ensuring those who are eligible should be on the program and that the value that we really need to build off of, the use of automation. I think there's a lot of tools now with automation that give states significant flexibility on data checks and ability to engage with their beneficiaries in ways to validate and ensure eligibility,

and that the idea of increasing -- that we also want value, and I think we need to add in about administrative burdens on states and any types of what we move to automation is reduce the administrative burden on states as well as costs and renewals will only increase those types of administrative burdens that we really do not want states to bear.

So program integrity, ensuring those who are eligible stay eligible, and automation are important themes to just hit on, and it's too early to be making significant changes that only increase administrative costs within the system and don't seem to be solving a problem that we have.

COMMISSIONER GORTON: So I agree with Tricia that the quality piece of it is important.

The standard metrics assume you have a year of data, and pretty typically, if you don't have a year of data, you get excluded from the metric. So it creates blind spots, which I think is problematic from an operational point of view.

Getting somebody into a health plan and model of care, it doesn't happen overnight, and so our experience, for example, in the financial alignment initiative is you

could take 90 days just to sort of engage a member and get him in, right? So six months really -- if you had to do that for one six-month period and then you lost three months and now you have another, if it's more than 90 days -- is that right? -- then it's a new thing, right? So then you have to do it again. So there's administrative burden to the churn as well.

Then the last piece is there's financial impact to the plans. The rates are set, assuming that you have somebody for a year, and we know that there's lots and lots of research that when you get somebody into a new managed environment, it takes you about six months to get all of the pent-up demand that they have taken care of.

So what you essentially do if you cut eligibility to a six-month period of time is you -- there's not the other six months where they're better. So, essentially, you artificially inflate the risk of the population, and you make that population more expensive again.

Now, for us in Massachusetts, it was a big problem in the financial alignment initiative because people would come on. They'd say with us for 120 or 180 days, and they'd be gone. So it was just at the point

where you got their costs coming down. They were under management. Things were okay, and then they're gone.

So I think from those three perspectives, the data suggests that it is not in the interest of either individual beneficiaries or the programs, either in terms of efficiency or in terms of quality, to have shorter periods of eligibility, which is why I think the Commission in the past has recommended 12-month continuous eligibility.

We made the argument yesterday about maternity care, right? A pregnant woman who comes in, finding out that she's pregnant at six or eight weeks doesn't get 12 months.

So that would be where I would want to encourage us to comment, and I agree with all the stuff Toby said. I won't repeat it.

COMMISSIONER DOUGLAS: I just want to make sure we're not going through -- I don't agree with proposing 12-month continuous eligibility, because the whole purpose here is the data, the ability to do the data checks, if data checks show someone is ineligible and they can reach out midyear, they can then engage and disenroll.

What I think we need to be careful -- that's where the problem -- there is no problem of going to six months right now, because the data systems, if a state is using and doing the flexibility to have, it can engage with beneficiaries and check their eligibility. And if they have a significant change, they engage them, and they will work on it.

Going to saying we believe in -- then opens up the question of, okay, then you need six months to be able to check. I think the purpose -- my feeling is we're not solving a problem right now. The systems need time to work out, and states need to be able to fully take advantage of the data systems to be in check and see if there are individuals.

Maybe at some point, it makes sense to go to 12-month continuous. I get it from a plan, and I totally agree. But I think we're better off staying away from that, and more it's that we need the systems to continue to work the way they were envisioned to be.

CHAIR BELLA: So, Toby, I think the 12-month reference was back in 2013 that MACPAC recommended 12 months as an option. So we've already --

COMMISSIONER DOUGLAS: [Speaking off microphone.]

EXECUTIVE DIRECTOR SCHWARTZ: No. It was -- it was to --

CHAIR BELLA: It was in response.

EXECUTIVE DIRECTOR SCHWARTZ: -- in response to the ACA. Create a statutory option for children enrolled in CHIP and adults who were enrolled in Medicaid.

CHAIR BELLA: Yeah. It's always been an option. It's not been required.

COMMISSIONER DOUGLAS: Yeah.

CHAIR BELLA: Other comments?

[No response.]

CHAIR BELLA: All right. I have a couple of thoughts, and just kind of, Martha, pulling together themes, I mean, I think these are the things that seem consistent from where the Commission has been.

One is administrative simplicity is something we talk about. Two is program integrity. Three is sort of transparency. Like it may not fit as well here, but partly what we're trying to do is understand what's working and what's not working and what problem we're trying to solve. Fourth would be allowing beneficiaries to be successful. I

think that is an important theme that we also addressed in the work requirements discussion, and, Toby, you hit on that too, which just to me ties to if you're eligible, let's make sure that you stay eligible and you get the services that you need.

And if it seems appropriate if we wanted to reference prior work on optional 12-month, we incorporate that into the letter as well.

Excuse me? What, Tricia?

COMMISSIONER BROOKS: You already have the option for 12-month.

CHAIR BELLA: Right.

COMMISSIONER BROOKS: I mean, I see Toby's point. You're saying don't put that recommendation in, but I think it's fair to say we have -- you know, MACPAC previously has suggested this, and it just demonstrates the importance of continuous eligibility to churn, and you make stricter, more frequent reviews, and you are going to have churn. It goes against the concept.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: Yeah. What I was hearing Toby -- and you correct me if I'm wrong -- was saying that

pushing for a requirement, a 12-month continuous enrollment, we shouldn't be going there. I agree with that. I think it should be allowed to be a state option. I don't agree with going and saying that we should be commenting that that should be a requirement.

COMMISSIONER GORTON: No. And I didn't mean to be suggesting that.

CHAIR BELLA: No, no one is suggesting mandatory 12-month continuous eligibility, just to be clear, for this purpose. The other --

Leanna?

COMMISSIONER GEORGE: I just want to comment briefly. Most of the routine data checks, I understand how, especially in farming communities, like where I'm from, you might go six months without hardly getting a paycheck because you work 80 hours a week during season when you're harvesting and stuff like that.

One thing, that we don't really want to take these children off, because this month, dad made a lot more money than he makes the rest of the year, but because a data check happened this month, we're going to kick him off. I mean, I don't know what kind of constraints we have

the ability to do, but, you know, I like the idea of routine data checks. But I think we need to be -- fashion it, to a certain degree, where, okay, if two data checks in a row or three, however, if it's quarterly or what have you, we'll put you above the annual income limits. Then they need to start looking at the change of eligibility. But just because you have a period because you're either working holiday hours or you're working like in the farm community, and that is variation -- or construction. There's a lot of communities with these lower incomes that -- or work facilities that have the variations from month to month to month, so --

CHAIR BELLA: Yeah. I think that -- there were two more points I wanted to make sure and hit. One is minimize churn, and second is recognize income fluctuations and how that ties in.

I do think, Martha, you also heard support for maximizing use of electronic data elements.

So let me ask you, Martha -- actually, let's go to public comment first. Is there anyone in the audience who would like to comment?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. Martha, with what's been discussed and the themes we've talked about, do you have enough information about these various areas, or would you like more precision in one or all of them?

MS. HEBERLEIN: I think without something specific to comment on, I don't know that you can be more precise. So this is really helpful to get sort of the general themes, and then when the rule comes out, we'll see if we can have another public discussion or just draft a letter based on the discussion today.

CHAIR BELLA: Okay. We have plenty of time if anyone wants to opine on anything related to this, please.

[Laughter.]

CHAIR BELLA: Anne, any comments?

[No response.]

CHAIR BELLA: Okay. Martha, thank you very much. We'll look forward to seeing what happens on this one.

And with that, anybody? Toby, you look perched to say something. No?

All right. Well, this concludes our February meeting. I had to think if it was February or March.

We'll see you all in April. Thank you very much.

* [Whereupon, at 11:06 a.m., the Public Session was adjourned.]