PUBLIC MEETING

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

Thursday, January 23, 2020
9:31 a.m.

COMMISSIONERS PRESENT:

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TRICIA BROOKS, MBA
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MARTHA CARTER, DHSc, MBA, APRN, CNM
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P R O C E E D I N G S

[9:31 a.m.]

CHAIR BELLA: All right. We're going to go ahead and get started, if everyone can take their seats, please.

Good morning. Welcome to the January meeting of MACPAC. We have quite a full agenda the next couple of days and with a lot of focus on maternity, and we're going to start this morning hearing from Erin and Tamara about access to treatment for pregnant women with substance use disorder and infants with neonatal abstinence syndrome. So I'll go ahead and turn it over to the two of you. Thank you.

MEDICAID'S ROLE IN MATERNITY CARE: FOCUS ON PREGNANT WOMEN WITH SUBSTANCE USE DISORDER AND INFANTS WITH NEONATAL ABSTINENCE SYNDROME

PART I: SETTING THE CONTEXT

* MS. McMULLEN: Thank you. So we've structured this morning's session into three different sessions. First, we will present findings from two complementary data sets which have allowed us to estimate the prevalence of substance use disorder among pregnant women as well as the

rates at which these women seek treatment. We'll also be talking about the availability of specialty substance use treatment programs for pregnant women with a substance use disorder. And we'll briefly summarize national findings related to neonatal abstinence syndrome and provide you with an update of federal initiatives in this area.

During the second session you're going to hearing from an expert panel on these topics. After a break, you'll have additional time to reflect on this morning's presentation as well as what you heard from the panel and offer thoughts on MACPAC's ongoing work in this area. Based on your feedback, this information could be incorporated into a chapter on maternal health or it could be a separate stand-alone chapter.

So for the first data analysis, we contracted with the State Health Access Data Assistance Center, or SHADAC, at the University of Minnesota to analyze the National Survey on Drug Use and Health, which is a federal survey conducted annually in all 50 states and the District of Columbia. It's sponsored by the Substance Abuse and Mental Health Services Administration. It provides information on self-reported tobacco, alcohol, and drug

use, mental health, and other health-related issues in the U.S.

Our goal for this analysis was to estimate the prevalence of substance use disorder among pregnant women and the rate at which pregnant women with a substance use disorder seek treatment.

Due to issues with sample size, we had to combine data from 2015 to 2018. In addition, we were unable to further analyze the data to ascertain additional demographic information, state-level estimates, or information about the settings in which pregnant women sought treatment.

Similarly, we were unable to identify treatment rates based on specific substance use disorders such as alcohol use disorder or opioid use disorder.

Select findings from that analysis are presented here on this slide. As you can see, Medicaid beneficiaries who were pregnant were more likely to abuse or have a substance use dependency in the previous year than pregnant women with other forms of coverage.

Pregnant Medicaid beneficiaries were also more likely to report ever using methamphetamines. However,

pregnant Medicaid beneficiaries were less likely to report alcohol use in the previous year than pregnant women with other forms of coverage.

Using the same data set, we estimated rates at which pregnant women with a substance use disorder sought treatment. Pregnant Medicaid beneficiaries with a substance use disorder are more likely to have ever received treatment for their substance use than pregnant women with other forms of coverage. Treatment services, however, remain substantially underutilized.

From 2015 to 2018, only one in five pregnant Medicaid beneficiaries with a substance use disorder received alcohol or drug treatment in a health care setting in the previous year, and health care settings include an outpatient drug or alcohol rehabilitation facility, an inpatient hospital overnight, an outpatient mental health center, an emergency room, or in a private doctor's office.

So the next three slides summarize findings from MACPAC's analysis of the National Survey of Substance Abuse Treatment Services, or N-SSATS, which describes the availability of specialty substance use treatment programs in the United States.

In 2018, less than one-quarter of specialty programs in the U.S. offered programming for pregnant or postpartum women. For pregnant and postpartum women with a substance use disorder, access to providers that offer medication-assisted treatment for opioid use disorder is also limited. Only 8 percent of specialty substance use treatment facilities offered both programming for pregnant or postpartum women and at least one of the three medications that are FDA approved to treat opioid use disorder.

Pregnant and postpartum women with a SUD may need additional support, including child care, when seeking treatment. However, only 6 percent of substance use treatment facilities in the U.S. provide child care for patients and accept Medicaid. That rate also varies greatly by state. Moreover, only 2 percent of facilities provide residential beds for their clients' children and accept Medicaid.

In 2018, just 15 percent of specialty substance use treatment programs offered outpatient treatment, programming for pregnant or postpartum women, and reported accepting Medicaid. However, providers offering

programming for pregnant or postpartum women and more intensive substance use treatment such as partial hospitalization or residential treatment are less common.

The percentage of substance use treatment facilities with special programming for pregnant and postpartum women that also accept Medicaid varies greatly by state. This ranges from 4 percent in the District of Columbia to 40 percent in Delaware.

With that, I'll hand it over to Tamara.

* MS. HUSON: Thank you, Erin.

Neonatal abstinence syndrome, or NAS, is a drug withdrawal syndrome that some infants born to women using opioids or other substances may experience following birth. Medicaid has the highest incidence of NAS births among all payers, at a rate of 12.8 per 1,000 newborn hospitalizations in 2016, as seen on the graph. This is more than a four-fold increase since 2004.

Rates of NAS and the number of NAS births paid for by state Medicaid programs varies. In 2017, as seen on the map on this slide, this ranged from three babies born with NAS per 1,000 hospital births in Nebraska to 88.3 babies born with NAS per 1,000 hospital births in West

Virginia.

Medicaid is the primary payer of NAS-related births, covering 83 percent of these births in 2016. The costs for treating an infant with NAS is substantially higher. For example, between 2011 and 2014, the mean hospital cost for an infant with NAS covered by Medicaid was $19,340 compared to $3,700 for infants without NAS. Total Medicaid costs associated with NAS were estimated at $462 million in 2014. One of our panelists in the next session will discuss neonatal abstinence syndrome in greater detail, including the standard of care and barriers to treatment.

In February of last year, the Center for Medicare & Medicaid Innovation announced two new models of care. I will spend more time discussing the first model, which specifically addresses opioid use disorders among pregnant women and infants with neonatal abstinence syndrome. The Maternal Opioid Misuse Model, or MOM model, provides funding to state Medicaid agencies to target pregnant and postpartum women with an OUD and their infants. The goals of the model are to improve access to services, quality of care, and coordination of care, as well as increase service

delivery capacity and infrastructure, all while creating sustainable coverage and payment strategies.

The MOM model requires that pregnant and postpartum women with OUD receive a comprehensive set of services. Awardees have the flexibility to define a particular set of services within the model that meets the following five components: comprehensive care management, care coordination, health promotion, individual and family support, and referral to community and social services.

This past December, cooperative agreements totaling approximately $50 million were made to ten states for a five-year period of performance. Awardees will use the funds to transition into a new model of care for pregnant women with an OUD and then fully implement their plan. Our panelists in the next session, from Maine, West Virginia, and Tennessee, are all MOM model grantees and will share more about their state programs with you shortly.

The second model is the Integrated Care for Kids, or InCK, model. The InCK model targets all Medicaid and CHIP beneficiaries from birth to age 21. The model's goals are to improve child health, reduce avoidable inpatient

stays and out-of-home placements, reduce fragmentation and service delivery, and create alternative payment models. While not specific to beneficiaries with substance use disorders, the InCK model aims to serve the needs of the whole child by bringing together medical, behavioral, and community-based services.

The SUPPORT Act included several provisions of importance to the Medicaid program. With regard to infants with neonatal abstinence syndrome, Section 1007 of the SUPPORT Act established a new state plan option to make inpatient or outpatient services available at residential pediatric recovery centers. In addition, Section 1012 of the SUPPORT Act creates a new limited exception to the Institutions for Mental Diseases, or IMD, exclusion for certain pregnant and postpartum women who are eligible for Medicaid on the basis of their pregnancy. This exception allows states to claim federal financial participation for non-IMD services delivered to women during pregnancy and up to 60 days postpartum for patients in an IMD for the treatment of an SUD. States are expected to be in compliance by October 1st of this year.

That concludes our overview of access to

treatment for pregnant women with a substance use disorder and infants with neonatal abstinence syndrome. So, with that, I will turn it back over to the Commission for questions. Thank you.

CHAIR BELLA: Thank you very much. Martha.

COMMISSIONER CARTER: Thank you for that great overview. I had a question. The HRSA-supported community health centers have been incentivized to provide outpatient or office-based medication-assisted treatment over the past several years, and I wondered if your slides reflect those data and other sort of private physician offices, private practitioners that have just incorporated MAT into their services. Was that included here, or were you just looking at specialty services?

MS. McMULLEN: So I'll answer the second part of your question first. Regarding availability of office-based opioid use treatment, we did include some information in your background paper that accompanied this, but it's not reflected in the slides today.

Regarding the facilities, the facility data that we reported, it's self-reported by the facilities to SAMHSA. So every year it's a census survey that goes out

to any specialty substance use treatment program. So if you fall within kind of that catchment, then you would be reported in the survey. I'm not sure whether or not it would capture any HRSA-supported facilities.

COMMISSIONER CARTER: The health centers don't report to SAMHSA. As far as I know, they report to HRSA. So that would be a good piece of information to include because the health centers, like I said, really ramped up their MAT services with support from HRSA just to address this issue.

CHAIR BELLA: Darin.

COMMISSIONER GORDON: This is helpful context setting. On Slide 9, one of the things that I'm just curious about and I just don't know if there's any research out there, but I'd just be curious if you have any level of comfort with the fidelity of diagnosing NAS. The reason I say that is when we first started identifying it as a major problem several years ago, we were not able to identify that NAS was the cause for a sudden uptick in the NICU, because they weren't coding it as such. And as we found as years went on, a great deal of education was needed in working with some of our large medical centers and academic

medical centers and talking with other hospitals to make sure that people understood when a NAS diagnosis was appropriate and how to do so.

So I'm just curious as I looked at that map. It's like if others are not seeing or experiencing large volumes, whether or not, you know, there's just this natural evolution that happens when you start to see it and then, you know, there's broader education to all the other hospitals about what's really going on so as to have more accurate diagnosing occurring. I'm just curious if you all have run across anything in that regard.

MS. McMULLEN: So I think our three panelists can definitely talk about this a bit more, but I think in the research that we have done, we did come across some materials in different states where there was clearly a state-led initiative to do more correct coding around NAS. I'll let our panelists maybe talk about that a little bit more.

CHAIR BELLA: Other questions? Stacey.

COMMISSIONER LAMPKIN: Yeah, thanks. I had a question about the SUPPORT Act, encouragement for the use of residential pediatric recovery centers. Is that

something -- I don't know much about that kind of provider. Is that something that is available in most areas? Or are those just very rarely available? How real is that option? I guess is my question.

MS. McMULLEN: Sure. We have not -- we've been kind of monitoring to see if states are putting in SPAs to do this type of care, and we haven't really come across anything at this point. Prior to the SUPPORT Act -- and you'll hear about this in a little bit from our panelists -- West Virginia put together a state plan option for non-hospital-based treatment for these populations.

Based on the work that we've done looking at the N-SSATS data, there aren't any survey questions of the facilities that ask if they're providing, you know, care for both mom and infant. There's just this one question that asks if they have a special program for pregnant or postpartum women. So that's all we have. There isn't any kind of additional information about what types of care infants are receiving in non-hospital-based settings.

I think the N-SSATS data is kind of the best that we have right now in terms of what's available at the specialty substance use provider level.

CHAIR BELLA: Peter and then Kit.

COMMISSIONER SZILAGYI: Thanks for the overview. Actually I have a very similar question. On Slide 6, where you talk about the percentage of the treatment providers that offer outpatient treatment, I had the flip question, which is the percentage of patients, and so I guess that data is not available?

MS. McMULLEN: So we presented some figures from the National Survey of Drug Use and Health in here, and we were hoping that we would be able to put some estimates around what settings pregnant women with a substance use disorder were getting treatment. Unfortunately, when we ran that information, the sample size wasn't big enough for us to report reliable estimates to you. That's why on Slide 4 we just have received alcohol or drug treatment in a health care setting. That was as granular as we could get.

CHAIR BELLA: Kit.

COMMISSIONER GORTON: So on that same topic, Slide 7 and the percentage of treatment facilities, I just want to observe that this is a specific case of a general phenomenon, which is that substance use treatment

facilities are rarely equipped to take care of patients with any other comorbidity. If you have somebody with mobility impairment, if you have somebody with diabetes, if you have somebody with significant heart disease, you can't get them into these places. They get pushed aside in that the facilities will say they do not have the expertise to take care of it. So the issue is dreadfully important for pregnant women and their children, but it's part of a much bigger issue, which is the siloed way that we deliver substance abuse care. And this lack of residential settings for people with other complications, if people have serious mental health, those kind of things, then getting them into a substance treatment program that will take care of their other comorbidity concomitantly with the substance use is enormously difficult. And I think it's worth stating the general case as we focus on this specific problem.

CHAIR BELLA: Tricia.

COMMISSIONER BROOKS: Thanks for this, guys. Great data, although we don't love what it actually tells us.

Has any more work been done to more closely

examine the states that have the high percentages -- this is on Slide 7 -- of facilities that do have specialized programming for pregnant women? So you've got four states in the 30 to 40 percent range. I'm just curious what we can learn about best practices potentially in those states, and how did they, you know, increase the facilities that are doing that programming?

MS. McMULLEN: So we haven't looked at that specifically for this project, but in the work that we did previously on oversight of IMDs and behavioral health facilities we looked at state licensure requirements for facilities. And one of the things we did find was that some states do have additional requirements for facilities that want to serve pregnant women. So it’s something, I think, that we could maybe do some digging into.

Other states use, instead of using the licensure structure, they might use contracting mechanisms through their single-state substance use authority to put additional requirements on providers. Similarly, you know, state Medicaid programs might do that as well. So it's something we could maybe do a little bit more digging into in those states where we're seeing a higher percentage of

providers that are able -- that have special programs for that population.

CHAIR BELLA: I'm just curious if, especially since the next panelists are all grantees for the MOM model, can you tell us how many states were interested, and like a little bit of context on presumably the MOM model is trying to bring these numbers up. And kind of just help us understand a little bit about the demand, to the extent that you're aware, and anything else that would be helpful for us as these folks are coming in, so that we can think about, is this something we want to see more states adopting, and the other model, yeah, sure.

MS. McMULLEN: We don't have information on how many states apply to the MOM or the InCK model, but that's something we could follow up on and try to get for you all.

MS. RUMLEY: Hi. I'm from the MOM model. We had 11 states apply.

CHAIR BELLA: Sure. Thank you. We have a representative of the MOM model in the audience who said there were 11 states that applied. Thank you very much. We would welcome -- if there's any other background you want to share with the Commission, you're welcome to go to

the microphone and share that. Not to put you on the spot, but if you'd like to.

MS. RUMLEY: [Off microphone.]

CHAIR BELLA: Just so we can keep this on the record, do you mind stating your name?

MS. RUMLEY: Hi. I'm Laura Rumley. I'm with the Center for Medicaid and Medicare Innovation. I'm a project officer on the MOM model. I'm actually Olivia Alford's project officer. We awarded, I believe, 11 states, 10 states -- I'm sorry, 10 states in January, and we are just getting started with states exploring what Medicaid authorities are going to use to implement and pay for this integrated type of care and the menu of services that the MOM model requires. I don't have much to add beyond what the women have discussed here today, but if you have any specific questions after the panel discussion, I'd be happy to try to answer them or to get back to you. Thanks.

CHAIR BELLA: Thank you for letting us put you on the spot and for being here today. We may take you up on that, terms of having questions.

All right. Any additional questions or discussion from Commission members? Martha.

COMMISSIONER CARTER: Back to Kit's question about facility care for people with comorbidities, I think that gets into the IMD exclusion pretty deeply, and I think we need to think about that question in the IMD context as well.

CHAIR BELLA: Any other comments or questions before we move into the panel? Fred.

COMMISSIONER CERISE: Just a clarifying question. Just the divergence of the rate between Medicaid and private insurance. The private staying so flat -- is there any other coding issues or things that are captured differentially in Medicaid than among other payers? Because you would think even the private one would go up some over time, you know, with the increase in opioid use. No?

MS. McMULLEN: In terms of different coding that's occurring, I don't know if I can speak to that at all, but perhaps maybe our panel can talk about what kind of -- some of the research that one of our panelists could talk about, some of the research that they've found.

You know, Medicaid is the primary payer of most births, and it's 88 percent for -- 83 percent for births

related to NAS. I think there's a lot of -- I think Darin raised some questions earlier about just what's going on with reporting, and are we underreporting or over-reporting. I think it probably depends on what state you're in. You know, I think Tamara and I are kind of scouring for as much research as we can find on this topic, to try to get at some of those questions.

CHAIR BELLA: Chuck.

VICE CHAIR MILLIGAN: Yeah, just on this topic. I do think, Erin, that private insurance is largely self-insured employers, and their reimbursement of the plans that do kind of the administration of that isn't going to be as -- they're not going to require the coding for revenue purposes the way that a lot of states might for federal grants, for federal reporting. So I do think it may be worth looking whether some of the private insurance or other payers are underreported, because they're -- how the providers and the MCOs get paid isn't quite as reliant on coding accuracy for their internal reimbursement purposes.

So I just -- I think that might be worth just keeping in mind.

CHAIR BELLA: Okay. Well, you have teed us up well. Just to remind everyone, we will have a panel now for about an hour and 15 minutes. We'll take a short break to let the panelists kind of ease out of the spotlight, and then we'll have a discussion amongst ourselves, and we will take public comment at the end of that, so somewhere between 11:30 and 12.

So it's -- Erin, are you going to introduce the panelists? All right. Then we'll move into that part of the session. Thank you very much.

Good morning, and welcome. Thank you for being here.

PART II: PANEL DISCUSSION

MS. McMULLEN: All right. So I'm going to do a quick introduction, and then I'll turn it over to our panelists. First, we're going to hear from Dr. Stephen Patrick. Dr. Patrick is Director of the Vanderbilt Center for Child Health Policy and Assistant Professor of Pediatrics and Health Policy at the Vanderbilt School of Medicine. He is also an attending neonatologist at the Children's Hospital at Vanderbilt, an adjunct physician policy researcher at the RAND Corporation, and a guest

researcher at the Centers for Disease Control and Prevention.

His NIDA-funded research focuses on improving outcomes for opioid-exposed infants and women with an opioid-use disorder, as well as evaluating state and federal drug control policies. He is board-certified in both pediatrics and neonatal-perinatal medicine. Dr. Patrick received his medical degree from the Florida State University College of Medicine, and a master's in public health from Harvard University.

Our second panelist is Dr. James Becker. Dr. Becker is Vice Dean for Government Affairs, Health Care Policy, and External Affairs at the Joan C. Edwards School of Medicine at Marshall University. He also serves as Medical Director for the West Virginia Medicaid program, where he is heavily involved in the state's Section 1115 substance use disorder waiver, its Medicaid health home, and the development of a HRSA-funded patient-centered medical home.

Dr. Becker is a Certified Diplomat of the American Board of Family Medicine and board-certified in addiction medicine under the American Board of Preventive

Medicine. He received his medical degree from the Marshall University School of Medicine.

And our third panelist is Ms. Olivia Alford. Ms. Alford is Director of the Value-Based Purchasing Unit in the Office of MaineCare Services, where she oversees multiple programs for Maine's Medicaid program, including three health homes, the accountable communities programs, and the state's primary care and case management program. She has also been involved in recent Maine delivery system reforms, including the state's Section 1115 substance use disorder waiver submission, refinement of the state's opioid health home, and applications for various federal funding opportunities.

Ms. Alford holds a master of public health with a focus on health management and policy from the University of Michigan School of Public Health.

Each of our panelists will give a brief presentation and then we're planning to use the majority of the time allotted for today's session for conversation between you and the panelists. Following this session, you'll have additional time to reflect on your findings from Tamara's and my presentation that we gave earlier, as

well as what you hear from our panelists.

And with that I will hand it over to Dr. Patrick.

* DR. PATRICK: Well, it's an honor to be here today to talk about some of our work on this issue.

You know, as a practicing neonatologist, I was trained to take care of babies with birth defects, who were born far too early, and a few years ago we started seeing a different kind of infant, and these were infants having opioid withdrawal. And they really stand out in the neonatal ICU, which is more common to have ventilators than it is to have a crying baby. I typically describe babies that have opioid withdrawal as a colicky baby times five. They're more irritable, have decreased muscle tone, and they really stand out.

But over time the context of those infants became more apparent, and so today I'm going to talk a little bit about some of that broader context as we move forward.

First, more pregnant women have opioid use disorder in the United States. These are data from the Centers for Disease Control and Prevention. On the Y axis is cases of pregnant women delivering with opioid use disorder, and on the X axis is year. And you can see a

pretty steady rise over the last decade, pretty similar to the work that was just presented earlier.

But it's not a simple story. So first off, trauma is common, and this is of women in treatment. About three-quarters report sexual abuse, similar amount of emotional abuse, and about half physical abuse. Adverse child experiences are also something to consider. Adults, for example, with greater than five ACEs are 8 times more likely than those with zero to have substance use disorder, 10 times more likely to inject drugs.

And then from some of our work published in JAMA earlier this year, looking at 580 U.S. counties, trying to get a context of what's happening in communities, we found that higher rates of mental health shortage areas were associated, when accounting for other factors, with higher rates of neonatal abstinence syndrome; and long-term unemployment, as a 10-year moving average of unemployment, in the county was also associated with a higher rate.

To put some points on that, about a 2-percentage point increase in long-term unemployment in remote rural communities was associated with a 34 percent higher rate of neonatal abstinence syndrome.

Still, getting into treatment is difficult, and I'm going to present just a little bit about this to highlight that issue. First, as we're talking about buprenorphine and methadone, the two medications that are recommended for treatment for opioid use disorder, when I describe why this is important you can think about the pregnant woman and the fetus going through periods of intoxication withdrawal when someone is using heroin, for example.

Medications for opioid use disorder stabilize that. We know that use of those medications in pregnancy decreases the woman's risk of overdose death, relapse, hepatitis C, and HIV. And for the infant, that infant is more likely to go to term and have higher birth weight, but it does come with some risk of drug withdrawal.

What's important about this is that babies born very pre-term -- let's take about a 24-weeker or a 25-weeker -- they don't develop signs of drug withdrawal. They are too immature. So what we're trading is that very high-risk, pre-term infant for a bigger infant who can have drug withdrawal, and that's a good tradeoff.

Still, women face barriers to treatment, and I'm

going to present some pilot data here. This is from around 120 treatment facilities. This is pilot data for a NIDA-funded randomized field experiment that is just finishing up. But still, within these pilot data where we asked both outpatient waiver providers in four states as well as OTPs would they take insurance, we found insurance acceptance varied substantially by states and by payer, and that there was a high proportion of cash-only providers.

When we dug into whether or not they would accept pregnant patients, OTPs, about 90 percent, agreed to take pregnant women, and about half of the outpatient docs would agree to take pregnant women. And importantly, as already pointed out by this group, OTPs are far more rare, and a lot of the expansion we've seen in treatment recently has been among outpatient waivered docs.

So when we take this together, access to these medications has challenges -- cash pay, we also see scope of practice issues, including in my home state, in Tennessee, even though the Comprehensive Addiction and Recovery Act allows PAs, NPs, and midwives to prescribe these medications, states like Tennessee strictly forbid it. Pregnancy also appears to be a barrier, as well as the

difference between OTPs and waivered positions.

So why is it? Why is it so hard? I think digging into this, we don't really know. We don't have the data. Is it reimbursement? Are there training issues? Fewer than 2 percent of OBs, for example, are waivered to prescribe buprenorphine. And again, comprehensive care issues programs are rare.

So as was presented already by the group earlier, and this is from some of our work, the rates of neonatal abstinence syndrome have grown substantially across the United States. Again, here on the Y axis is rate per 1,000 hospital births in the U.S.

Nationally, we've seen a substantial increase, seven-fold the diagnoses of neonatal abstinence syndrome. To put that another way, it's about one infant born every 15 minutes on average in the U.S. having opioid withdrawal; and that's accounting for about half a billion dollars, as was highlighted earlier, in cost, just for the birth hospitalization.

If we look at the effect on Medicaid, mean costs for an infant with NAS is about five times as great as an uncomplicated term birth. For an 11-year period in one of

our studies, there was a $2 billion in excess costs to Medicaid financed deliveries for NAS. We point this out as an important piece, because one of the things that's already highlighted are some of the inefficiencies that we see in the system reacting to the problem in the neonatal ICU as opposed to improving access to treatment and thinking about some of the connections for both mom and baby downstream.

The hospital care is changing and was already highlight too. There are multiple challenges. First, there are no gold standards for caring for infants with neonatal abstinence syndrome. In the coming months, the American Academy of Pediatrics will revise their policy statement on this. That's not out yet. But still, even in that context, most of the tools we use to diagnose this syndrome were developed in the 1970s, haven't been validated, were in a different population that includes term infants only heroin exposed, and there's no real agreement on how to use this tool in various settings.

Treatment protocols are also not standardized. There is a lot of variation in state surveillance definitions, and as was pointed out earlier, some issues

with coding too. We know that if you have a diagnosis of NAS, that the positive predictive value of actually having clinical NAS is high, but the sensitivity appears to be pretty darn low.

Still, even in this context we see shifting models of care. The traditional model of care, as practiced in most parts of the U.S. is to separate mom and baby, place the baby in an ICU, create a system of care that's completely separate from the mom. Breastfeeding, for example, is oftentimes not allowed. There's a real focus on the correct medicine -- do we test morphine or methadone -- as opposed to the correct care process, and care is oftentimes not standardized.

Newer models, including what we're doing at Vanderbilt, are changing that. Keeping the dyad intact outside of the ICU -- these infants are not critically ill. Treatment inclusive of the mother. Breastfeeding, there's evidence to suggest that women, when they breastfeed, if they're in recovery, that decreases NAS severity and duration of stay. Focusing on the care process. We know from now multiple studies, even though there isn't a gold standard protocol, if we just do the same thing every time

that improves outcomes. We've seen this from large national perinatal collaboratives and state perinatal collaboratives as well.

Thinking about transitions to home, and I think this is, again, understanding kind of some of the silos that exist throughout the continuum, first, beginning with optimal care in the hospital. Some of the things we just discussed, including assessing other risks like hepatitis C.

So as we think about sending an infant home, this is, I think, where some of the silos become more apparent too. Are we really connecting to things that we know that work, including home visitation? Have we engaged with the child welfare system, as was mentioned earlier? Are infants actually getting referral to IDEA Part C or early intervention? Do we have systems of care in place to make sure they're getting more frequent pediatrician follow-up? Are we coordinating with maternal treatment as well?

One of the things that I think is worth mentioning is the child welfare system. As was highlighted earlier, we've seen about 10,000 more infants are in the foster care system today than were in 2011, and there is a

lot of variation from state to state. West Virginia, for example, 4 percent of infants are in the foster care system.

Plans of Safe Care being rolled out by states across the country right now, and this is the result of multiple modifications of the Child Abuse Prevention and Treatment Act. The idea is to keep the infant safe but also to focus on connecting mom to treatments, beginning prenatally. The SUPPORT Act actually highlights the role of Medicaid in addition to other state programs increasing those Plans of Safe Care.

Next, the Family First Prevention Services Act allows states to use Title V-E funds for prevention, including connection to treatments. Notably, ACF regulations suggest that Title V-E be a payer of last resort.

The last thing I wanted to mention was just our MOM model, that we're sort of working through conceptualizing, again, as we're now 23 days into this. Beginning to try to break down many of the silos that we're talking about, providing both evidence-based case throughout, and connection to many public resources like

care coordination, peer support, and I'm happy to talk more about this.

I know that was a pretty fast squeezing in things into 10 minutes, so thanks for the time.

* DR. BECKER: Thank you.

Good morning. I'm Jim Becker. I'm here really at the request of Cynthia Bean, our Commissioner. She's tied up on child welfare issues right now in West Virginia, and the legislature is in session. And so things are pretty busy.

I'm happy to be here. I could talk about 10 different topics, but I've made a decision to talk about three that seem to impact pretty directly the things that this group is concerned about today.

I want to compliment you on the materials you put out. I get those summaries from you, the reports to the Congress, and I'm really impressed with what you do. And you should feel good about the work that you do. I get those, and then I have to fight to keep those in my office because staff want to take them away and read them. And then I can't find them when I need data out of them, so my compliments to you and your work.

EXECUTIVE DIRECTOR SCHWARTZ: Send us more names of your staff who want them, and we'll send them their own copies.

DR. BECKER: Okay. I'll do that. Thank you for the offer.

So I'm going to talk about three things. The first thing I'm going to talk about is our 1115 waiver for substance use disorder, and I'm going to do a very high level of that. And I'll share a little bit of the impact and outcome with you. We don't have a lot of formal evaluation data available yet, but I'm going to cover that.

The second thing I'll talk about is the CMS SPA that we just got approved for the neonatal abstinence syndrome children to be in a community care setting, and so we'll talk about that. It's known in West Virginia as Lily's Place.

Then the third thing I will do is talk about what we think we will wind up doing with our MOM's grant, which is early in development, so we'll get to that.

So our 1115 waiver was something that we had been hoping for, for a long time. We recognized for many years that there are a lot of gaps in the care of people

struggling with substance use disorder, and you can do this and this. But you can't connect it to this, and so closing the gap and actually creating more of a comprehensive network of care was what we were hoping for. And so that's how our 1115 waiver was written.

We were one of the first five states to get an 1115 waiver for this purpose, and I feel very good about how it's going. It hasn't been easy, and it's required quite a busy team scurrying around in a relationship with public health that's sometimes been challenging. But the program is working extremely well, and I think if there was anything I could say about it, it is closing the gaps.

Here's some examples. We were approved for this waiver in October of 2017, and we began January of 2018 with the first phase of the rollout. In that first phase of the rollout, one of the things we did was find a way to cover SBIRT screening. We had never been able to do that really, and under the waiver, we're doing it now. We're very successful with that.

I would offer the opinion that we get a lot of the SBIR, and then we struggle when we get to the treatment part and getting people into treatment.

But we also took the OTPs, the methadone programs in our state, and we pulled them into the services, because they had always been alone. And we had no way of seeing their data, and to us, it was very important that we understand which of our patients were in methadone programs. So by offering to pay for it and putting it in a bundled model, we were able to set up a really good system to take care of about 1,800 people.

In total, our methadone clinics in West Virginia take care of about 8,000 or 8,500 patients, but 1,800 of those folks are enrolled with Medicaid. And we take care of that payment.

The other thing we did in Phase One was talk about getting naloxone out there, and that's been very successful. I think it's been successful nationwide, but we've done a good job of getting that out into the field. And we have the data to show that it saves lives in the field, and we have the data to show that it reduces the number of people who are intubated, either in the field or in the emergency room. And that translated into medical savings.

Phase Two began in July of 2018 when we added on

our residential adult services and our withdrawal management and very importantly the peer recovery support specialist coverage. It's really been successful in our program. Having peer supports available to interact with patients can be a way that you keep those patients engaged.

We have training programs in the state, a credentialing program, and we have a target of getting 400 peer recovery support specialists out there. Right now, we have about 200, maybe 210.

Now, we were doing pretty well, and then we decided that we wanted to move this out of the carveout situation and put it in managed care. So right now, we're in a little bump working with managed care, but managed care is taking it on. And they've come to the table and learned all the things we thought ought to be done, and so we're tracking that. And it's part of the evidence that we're collecting about the effectiveness of these programs. The entire waiver can be found in Chapter 504 of our policy manual.

Let me change gears just slightly and get back to the topic of neonatal abstinence syndrome. I'll tell you that 10 years ago, one of the congressmen in West Virginia

came to my office and said, "Can you tell me how many children in West Virginia Medicaid has who have neonatal abstinence syndrome?" and I said, "I'm sure I can." And he left.

I got in the code books, and I began looking at codes for hospitalizations and put the list together, and I gave those to the data gurus. And the data gurus got back to me and said three. I said, "What? It can't be three." Our ICU at my hospital or NICU at our hospital had 17 babies who were probably NAS babies at that time, and so we realized there was a serious problem with identifying them through the coding system, as you heard Dr. Patrick say. This is really a challenge.

So the incidence of NAS in West Virginia is quite high, and it's quite high particularly in Cabell County, which is where I practice, but also in Raleigh and in Berkley County. We are a state that does not have abundant medical services, and because we're so rural, there are a lot of challenges to get patients into care, anyway.

The cost of that care is quite high when an infant has NAS, and some people have estimated the average cost at 36- or $37,000 as opposed to about $6,000 for a

normal live birth. And the length of stay is dramatically long with the average at 16.4, but probably quite a bit longer than that with some of the patterns that we're seeing these days in terms of drug use by the mothers.

And neonatal abstinence infants do represent a large portion of the Medicaid population that's in care, so very important for us.

We did a number of different things to try to address this issue of neonatal abstinence syndrome. Obviously, we put in placed the CDC guidelines to try to reduce exposure to prescription drugs, but most importantly of all, I think, the West Virginia Perinatal Partnership led us in an effort to try to identify those children more effectively and then to identify where they would get care and how they would get follow-up, because there are many developmental challenges that need to also be tracked and, obviously, safe home situations and things like that.

If you haven't read the paper, you probably haven't heard that West Virginia has an absolutely awful foster care situation right now, with about 7,700 children in the foster care situation and 22,000 children who are in some other type of safe surveillance because of substance

use disorder in families.

Other things we tried to do with the NAS effort were to put in place comprehensive harm reduction programs. There's a broad range, and we've done some drug summits and educational efforts.

Let me mention Lily's Place here. Lily's Place is a facility in Huntington, West Virginia, that's been in the process of developing for at least five years, and West Virginia worked with CMS and created a state plan amendment that makes it possible for that to be recognized as its own model for care, for residential care for these infants during the time that they are withdrawing. And they do very good comprehensive care. They engage the patient and the parents in all of the various therapies that are necessary, and everybody seems pretty happy with the performance. Unfortunately, there are only 12 beds in that unit, and we probably need centers like that all across the state.

Out of our awareness of the challenge of NAS, we've put together a subcabinet working group, and it really is a good group from Public Health and Children's Services and DHHR and others, and that working group is

trying to do some other things, including make NAS a reportable condition. So there's a discussion about reporting risk of NAS and then the concern about protecting privacy for families and avoiding patients, families getting drawn into the child protective service system. So we're trying to not make this in any way punitive but simply a way that we can offer services to people at risk.

We have a lot of services across the state. At one time, we only had four drug-free moms and babies programs available. Our goal with the new MOM's grant is to increase those numbers to 16, and so we're working hard on that. These programs have really demonstrated their value.

So, finally, the MOM's grant, we are very excited about that MOM's grant. Obviously, we'll build on the drug-free moms and babies program. We'll be particularly looking at moving the care from the normal six weeks postpartum out to a full year of postpartum care and then transition into well-woman care as it goes.

At that point, I'm going to stop. Thank you.

* MS. ALFORD: Good morning.

There's no slides for me. I'm just going to have

a few remarks here.

Again, I'm more on the delivery system payment reform side of things, so I also will be speaking to some of the work that Maine has been doing to address these issues from really very much a policy and implementation standpoint.

I do also want to acknowledge and thank you so much for having us here today. We use your resources as they come out, again, across the office, and we find them very valuable and sharing more of a national perspective in helping us really do things faster and more efficiently at the state level, so we do appreciate that.

For the Maine Medicaid program, I think it is important to note a few things about our program. We are one of the few remaining non-Medicaid managed care states in the country. We just recently expanded Medicaid. After the full expansion, we expect to be serving about 313,000 people and covering approximately 23 percent of our population. So we're a relatively small program, but as far as this topic is concerned, another one of the states that's been extremely hard hit, our rates of neonatal abstinence syndrome statewide are about five times the

national average. So our 2018 data had us at 28.3 births per 1,000 live births having NAS, although I agree that there are some data concerns regarding those numbers that we can talk about.

Another way to look at it is that we have about 900 substance-exposed infant reports to Child Protective Services annually.

Also, I know that we have talked mostly about opioid use disorder, but in Maine, we still have very troubling trends around alcohol use during pregnancy. In some of our counties, one in five women are still smoking during pregnancy. So there's other substances that remain very important to us and the rising risk of methamphetamines as well. So I will talk briefly about the need to always maintain a broader perspective on the full range of substances being used during pregnancy.

In addition to those figures, Maine is a highly rural state. We're the most rural state east of the Mississippi. We have significant issues with workforce and with access to care. We have just two NICUs in our state. We have two Level 2 nurseries, and then we have a total of 26 birthing hospitals, although a few have closed in recent

years. And more are facing financial struggles to maintain those service lines in rural hospitals, so other areas that play into our concerns around this issue and making sure that women are treated appropriately according to their level of risk, as close to home as possible, but in a place that is well equipped to serve their needs.

So I'd just like to touch on three themes regarding this topic today and how we're addressing them through mostly delivery system reform, using different Medicaid authorities, and pursuit of additional federal funding.

First, just briefly, we haven't touched on the enormous impact of stigma in pregnant women seeking care. It's still a huge concern. While we have a number of women who have a diagnosis who are in treatment, I think there's so much that we don't know about who isn't in treatment, who isn't seeking care, and the reality of how our child protective system works. It really does need to work. It really pushes us to think about how we can bring Child Protective Services and Medicaid closer together, so that that reality does not negatively impact women entering treatment.

For our MOM award, which I'll talk a lot about through this, one of the major things is focusing No Wrong Door Approach to treatment using what we have in the state called the CradleME line, which is a specialized referral system for birthing families, where they can call in and be connected to resources. And we're hoping to really do a lot of outreach and promotion of that line to spread the message about positive messaging around getting into treatment during the pregnancy for substance use disorder.

So really in my wheelhouse, it's talking about how Medicaid specifically can use alternative payment models and incentives to support the integration of care.

Like in many other states, we have the services, but we also know that women, say a well-connected, well-served women, women in treatment are seeing so many different providers and have so many different people involved in their lives during this time frame. You have their MAT prescriber, perhaps, their substance use counselor, their OB, their child protective worker. When they go into the hospital, there's new staff there. They have public health nursing. The list goes on and on.

Really, what I think that leads us to is thinking

about how we can align incentives across those programs to work towards a shared policy goal.

Our maternal opioid misuse model seeks to establish more of an integrated system of care that brings together these services and supports.

We are looking to, again, push some of the work towards the prenatal period that could best be initiated at that point in time to set women up for success, including establishing plans of safe care with providers and natural supports, so that that is not something that's initiated in the hospital setting, thinking about bringing prenatal providers in on early contraceptive counseling and then during labor and delivery having hospitals who are well equipped to offer the option of postpartum long-acting reversible contraceptive during that short window of opportunity.

So one of the things, just to be more specific about how MaineCare, our program, hopes to implement the MOM model is that we actually have an opioid health home program that's been up and running for over two years.

Similar to the conversation that took place before, our opioid health home program is really for people

with opioid use disorder who are receiving medication-assisted treatment through a team-based approach to care. It includes peer supports, nurse care managers, MAT prescribers. It's a bundled payment for the counseling, the prescribing, the urine drug screening, and then the care coordination and health promotion services.

But similar to what you were talking about, the first adopters of that model were the substance use treatment specialty providers, less so around primary care, and certainly not maternity care providers were not becoming opioid health homes in our program.

So we've been pushing more towards making sure substance use treatment providers are addressing other kind of conditions and just the importance of primary care and screening in general, but for the MOM model, we're hoping to essentially create a maternity opioid health home, where, again, individuals with opioid use disorder can receive a bundled payment, team-based approach to care, but one that caters to the specialized needs of pregnant women. So that's how we plan to roll out and sustain the MOM model and meet the program goals.

So I want to close just briefly with a few

challenges that remain for us. We just recently applied for 1115 waiver for the IMD exclusion for substance use disorder, and while the impact on increasing residential beds is clear, we also took the opportunity to propose four pilot programs that look at the full continuum of treatment and recovery for families.

So you have a pregnant woman -- and we're talking about that today, and we're talking about even maybe the first year of life through the MOM initiative in treating the women and the infants and setting them up for success, but those are parents now. And the thing about Medicaid funding, as you all know, and certain programs and initiatives, they are very condition-specific or eligibility category-specific. And we often forget about the longer-term or holistic family approach to care.

So our four pilot programs are really focused on parents with substance use disorder and those who are at risk of child protective involvement or who already have that.

Very, very briefly, the four pilot programs that we have requested approval to implement, not yet approved by any means, are to provide parenting supports, parenting

interventions, skills-based supports for parents to make sure that they can maintain and develop healthy attachments, maintain independent community living.

And then two more that I'm going to speak to in a little more detail, one being that there's a role for recovery residences in this continuum of recovery supports for pregnant women and parents with substance use disorder, and recovery residences are not residences that Medicaid would support directly, but we're proposing to have a value-based payment approach to allow them to provide Medicaid-covered services, such as enhanced case management and funding essentially to address social determinants of health through these certified recovery residences to help ensure that families can reside in a recovery residence and then establish themselves successfully independently in the community, and we have some programs in Maine that are doing this well, and we think that we should see if we can prove that with a value-based payment approach to see what their outcomes are on cost and quality.

And, last, there are eligibility gaps in Medicaid programs that cause trouble for this population, including the period of child protective involvement, where even

temporary removal of the child can cause individuals to lose coverage, again, because we classify people in these categories, and we propose to close that gap by allowing folks to maintain coverage during the child protective process so that at least treatment and support can continue to give the best chance for that family to remain intact.

So I would like to say that while we are hopeful there's an 1115 waiver, I think it's important as a non-managed care state to really emphasize how important these 1115 waivers are for us to be able to pilot and test new initiatives, and they need to be manageable for us to do it at the state level as far as workload and rigor, while also meeting the expectations of the federal government.

One thing that I also want to just say is an opportunity that I appreciate so much is when CMS does put out guidance regarding specific SPAs and other state programs that have been successful in getting coverage for certain of these kind of gray areas of coverage that have led to us being able to do these things more efficiently at the state level.

Thank you.

CHAIR BELLA: Thank you all very much. I have a

feeling you're about to get bombarded with questions and comments, so, Martha, would you like to kick it off?

COMMISSIONER CARTER: Thank you so much. This was a really meaty presentation, and you all are on the cutting edge. You know, you really are out there developing programs that need to be developed and are doing a great job with it. I really appreciate it.

So my question is a rather broad one. If we could wave a magic wand, what would help you more? Is there anything this Commission could recommend? Or what would help you more to go out there and do what you see needs to be done?

DR. PATRICK: So I think one of the issues is that in many cases we know the right things to do; they're just not happening, and a lot of that has to do with siloing. The issue is that no one group owns this issue, and so you see, as has already been mentioned, addiction care is really separate from prenatal care, is really separate from the child welfare service, is really separate from the mental health block grant, is really separate from Title V.

In my mind, some really focused realignment of

where those incentives are placed. We spend a lot of money in my units -- right? -- where I think that's some of the most inefficient ways to do that. If we could realign incentives to incentivize, perhaps enhance reimbursement for providers to provide treatment and then really coordinate some of those post-discharge services. We really have no idea how many eligible infants are getting things like early intervention services. There are so many gaps along the way.

Most infants, for example, that are exposed to hepatitis C, which has increased because of the opioid crisis, are also not getting tested. Those gaps just become more apparent throughout. So I think it comes to -- it has to do with breaking down silos and reimagining where those incentives are.

DR. BECKER: I agree with what Stephen is saying there, and I'll take it even further. I think what would be very helpful to us is to get more endorsement of the role of primary care in the management of patients with substance use disorder. What I saw happen in this world is that a lot of people chose that as an area of special care that they thought they could do, and then they didn't do

the comprehensive care piece. And so they offered MAT service, but they weren't even comfortable with the testing for hepatitis. And so patients got very, very narrow care, and we really do need to move into a world where primary care, pediatrics, internal medicine, family medicine, OB/GYNs are really the people who are able to do this, because this is no different than any other condition. It really needs to be managed in a comprehensive way.

And then, because there's a role for the behavioral health that's pretty important, I think endorsing collaborative care models where mental health services are co-located with the primary care would be just a tremendous step forward in dealing with the problem. If we don't do that, we'll go broke. If we don't do that, we won't be effective, because we won't target the comorbidities, because people will float from program to program, and they never build a comprehensive relationship. This has got to be seen as a problem that spans the life, you know? So that would be what I would dream of, Martha.

MS. ALFORD: Yeah, I would agree with those two recommendations. I think the issue of how much effort is needed to -- and it's happening in our states, I'm assuming

all of our states, to bring together public health, your child protective system, your single state authority on substance use, and the Medicaid program is enormous. And we all have the risk of doing duplicative work and needing to meet separate requirements that are quite similar. And we can align incentives at the state level, and I think Medicaid plays a really important role in that, and you can lead that work at the Medicaid program in this space. It's not even so much about multi-payer alignment. It's about the Medicaid program taking that leadership. But without some of the endorsements around the coordinated care and the expectations of providers to implement evidence-based care, even as far as national organizations putting out joint statements on -- you know, the American Academy of Pediatrics is coming out with something new. Those are so helpful, I think, to push the envelope forward so that we can take evidence-based care into our models and then promote them among providers, provide the incentive for them to provide that evidence-based care.

I have to say that the additional federal funding around initiatives like MOM where we also received $2 million through the SUPPORT Act Section 1003 funding to

increase our substance use provider capacity, which I didn't speak about, but those additional funds help the Medicaid program pay for things that are not -- they're not Medicaid-covered services, but they're necessary to implement these models. They're infrastructure-building activities; they're coordination and collaboration funds; and they're very important for us to actually move the needle on new models of care.

CHAIR BELLA: Peter and then Kisha.

COMMISSIONER SZILAGYI: Thank you for your great presentations and for highlighting this really, really important problem.

Just as kind of a brief context, as a pediatrician, we're trying to change the conversation around substance abuse and moms with substance abuse or dads with substance abuse. As Dr. Patrick pointed out, most of these people have had adverse childhood experiences or trauma. We're trying to change the conversation from, "What's wrong with you?" to, "What happened to you and how can we help?"

So my question for you -- and, actually, my overall question was really exactly the same as Martha's.

Two questions. If you could just summarize at a high level, what is the evidence base for these integrated care models on the impact on moms and children, just sort of at a very high level? How effective are they?

Second, what's the real gap in your states between if you implemented these MOMs models -- and I know you're not doing InCK or, you know, other states are doing InCK. What's the gap between what you're planning on implementing and what your state really needs? And what policy changes might help bridge that gap?

DR. PATRICK: Well, I think the evidence base is weak, honestly, with some of the integrated care piece, and the other folks can comment on that. The one thing that's not weak is medications. We have overwhelming evidence that medications for opioid use disorder save lives, to quote the National Academy's report, and there are still multiple barriers to them, including prior authorization, dosing. I think that is one issue by itself. That's where the best evidence is in terms of mom treatment. The question around coordination, peer support, at least the last time -- the literature's just not as overwhelming. Other folks may have other thoughts on the literature

there.

For newborn care, it really has to do with standardization; it has to do with things like there's emerging evidence -- there's recent meta-analyses on rooming-in, for example, with moms. There's data around breastfeeding. Some of the looking at models of care that really integrate DCS, or child welfare, excuse me, with early intervention services, they don't exist as far as I know.

And the second part of your question?

COMMISSIONER SZILAGYI: The gap in your states between --

DR. PATRICK: Sorry for that. Honestly, I think it's scale and scope. Even as I talk to folks in my own state, there is so much good work that's happening. The problem is that the "n" is so much lower than what is actually needed, and so I think we're going to, you know, hopefully work on building a model that will begin to integrate some of the things we've been talking about. It's really what we've envisioned. But is the scope and scale even in this model, is it enough to really bend the curve?

My sort of bias at this is that this really takes a massive investment that breaks down the silos, Ryan White-like in terms of investment that builds the infrastructure that is enduring.

One of the things I think the opioid crisis has shown us are the silos and the breakdowns in maternal and child health that I hope we begin to identify and fix with things moving forward. But I think it's scale and scope in my mind.

DR. BECKER: I do think that there is some evidence of the effectiveness of these heavily integrated programs. In West Virginia, the first four drug-free moms and babies programs have reported out on outcomes for those infants and the number of infants who are delivered with no evidence of effect from mom's previous history of exposing her fetus to opiates or to other medications. That data is still floating around out there and really not in a form that's published or perhaps it's not even publishable yet should be published. I think that instinct tells us that if we'd put more services into this and we're more sensitive to those issues that you mentioned, like the ACEs and trauma, that we have to get better outcome. You know,

we're convinced that that will work.

In the county that I practice in, Marshall University put together a program called "Project Hope for Women and Children," and it's a residential facility for women, pregnant and postpartum, and their children. And it gives them comprehensive services for both the mom and the children. This is only an 18-bed unit -- or 18-unit facility, but we have great hope that it will help, and we've graduated several classes out of that facility who have gone on to what we hope is a much better and much safer life.

So I think we have all kinds of gaps to close and all kinds of things that have to be connected, but, you know, we'll just keep doing the best we can with it.

MS. ALFORD: Yeah, as far the integrated care model question, I'm part of -- I'm not going to get the official name right, but it's a PCORI study that's taking place in northern New England looking at whether integrated maternity and substance use care models are superior from a PCORI perspective to referral-based systems. And in Maine, we -- so that's not -- that will be ongoing. I think it is not clear whether the integrated births may be a more

referral-based coordinated system of disparate providers is more efficient.

We have chosen to go with the integrated care model though allowing for referral-based systems supported through things like telehealth, so you're getting as close to an integrated experience as is feasible. We want to our program -- our MOM model will be statewide, and in some areas, when you're traveling an hour and a half for maternity care and an hour and a half in the other direction for substance use treatment, you know, we're not going to get to an integrated care model in the traditional sense. But we think that there's ways to work around that. So I'm looking forward to the results of that, you know, more evaluation of that PCORI study.

But I think the MOM model will have some great information that comes out of it. The measures that they're looking at include some important indicators like patient activation, continuity of treatment through this period, and will hopefully be able to classify some trends that you're seeing across the country in some shifts that Dr. Patrick talked about regarding changes in hospitals' approach to treating infants with NAS. In our world we

call it "Eat, Sleep, Console" as the model. And I think taking into consideration that there will be evidence to support essentially those changes in the way hospitals approach this care, there is evidence to support postpartum long-acting reversible contraceptives. There's evidence to support components of these models, and it's just whether you need to have the whole package together or we should just, you know, at least try to implement what we can.

DR. BECKER: Could I add one other comment to that? I do think there is strong evidence for the effectiveness of a care coordination model, and they don't all look alike, but that element is in all of these that we're talking about, and ours will have a heavy care coordination component. Hard to describe sometimes, but very effective, and we've got some very rigorous evaluation of the impact of care coordination that we could share.

CHAIR BELLA: Kisha, then Chuck, then Fred, then Darin.

COMMISSIONER DAVIS: Thank you. I really appreciate the information that you've brought and, you know, really being leaders in this area.

I have a comment and then a question. One is

just highlighting the difficulties for, you know, a new mom who's trying to combat the system. You know, I'm a family physician and an MAT provider, and I had a patient, she was pregnant, so I'm providing her suboxone, and she's also seeing maternal fetal medicine and she's also seeing her regular OB and she's also seeing the endocrinologist and she's also seeing her therapist and trying to hold down a part-time job. And at least we're in an area that's not rural and she doesn't have to drive an hour to get to each of these places. But, you know, the complexity of that and the more that that can be integrated and of ease to take off the stress of just being pregnant is really significant.

But my question is around families. You know, a lot of these moms, you know, their infant that may be born with NAS is not the only child that they have at home, and so what you all are doing in terms of looking at families, keeping families together, helping that mom support other children that might still be in the household while she's going through her treatment.

DR. PATRICK: I can speak to what we're doing at Vanderbilt. We have a clinic for pregnant women with

opioid use disorder that includes comprehensive care and addiction treatment. And about two years ago, we launched a model for infants that we call "Team Hope." We've had about 300 opioid-exposed infants greater than 35 weeks in the last two years. And the way we've worked to create and engage families, both prenatally and then in the hospitals, to keep moms and babies together, we've been able with the support of some foundations, written through our MOM model, too, to have a child life specialist engaging families and siblings and beginning to integrate things a bit better.

It's a starting point. It's not perfect. And the question of how do we engage fathers I think is important and even the role of fathers, because sometimes there are high rates of domestic violence in some populations, too, that we have to be mindful of. But how we begin to engage the entire family holistically has been part of our approach, but it's still a work in progress.

DR. BECKER: I think that is really a major challenge. We have multiple clinics that are trying to address those particular issues, and at the university where I practice, we really make every effort to integrate the services as much as possible and to have a coordinator

on every case.

The other important component of that I think is to track the development, and particularly educational development, of the children. And so we have a special clinic that's run through pediatrics that is tracking those children for meeting their, you know -- I'm blocking on the word -- "milestones". Milestones. And so we follow them pretty closely, and I think we share our data actually over to the Vanderbilt database.

MS. ALFORD: Yeah, this is a tough one. I mentioned quickly that both through our 1115 waiver and also through our state plan and also through Family First Preventive Services Act funding and also through maternal block grant funding, there are activities around interventions that are intended to support parents in establishing healthy connections, essentially looking after the development of their child in a way that supports -- or avoids essentially ACEs for the child. And there's a number of evidence-based interventions, and they're classified in different ways for all these different programs -- another way where alignment could help. So we're looking to cover some of those evidence-based

programs to support parents so that when the time comes at delivery and they're being assessed with their plan of safe care of what they're going to do to maintain a safe environment for their child, that those can be taken into consideration.

So it's really a collaborative effort across a lot of different funding sources to make sure that we can support folks. And it's not just with Medicaid-covered services, I think, because home visiting services that are in the home, public health nursing, whatever it's called in your state, is really critical because Medicaid isn't necessarily going to go into that space. You know, that's a space that's covered through the maternal block grants essentially, and it's a great service that we just need to coordinate better with.

And I think just in general we as a state have a lot of work to do with our EPSDT services and making sure that families know their rights and beneficiaries know their rights and providers know how to access that additional level of support for families and children that need them.

VICE CHAIR MILLIGAN: I want to thank you. You

guys have great presentations, great response to our questions.

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

In your presentation, Olivia, you talked about eligibility categories and some of the ways those can box in some of the program delivery. If a woman qualifies by virtue of pregnancy, the only requirement is delivering pregnancy-related services. It's not full Medicaid benefits, and so a lot of co-morbid conditions, arguably, are not part of the standard Medicaid benefit package that woman receives. Is that something you're addressing in your 1115, and do you have thoughts about that generally?

MS. ALFORD: Well, in Maine, it's a full benefit that the pregnant women receive by virtue of that eligibility category. That's the facts, but is that always translated into making sure that women know they can access all those services? I think that's sometimes a different question.

I think what we find is that, for example, we have existing targeted case management services for pregnant women with substance use disorder, but then as

soon as they give birth, that service went away.

The opioid health home program, I think, is an appropriate avenue at least for individuals with opioid use disorder, where it provides a more continuous eligibility option that we as a state can establish and provide more robust supports around for people with opioid use disorder. Pregnancy doesn't qualify you for a health home service, but your chronic condition does. And that will maintain you in that service for a longer period of time.

VICE CHAIR MILLIGAN: Thank you.

The second question is for everybody. One of the things that you haven't really discussed -- and the Commission, we've discussed it in different meetings over time -- is some of the implications of Part 2 and confidentiality of treatment for substance use disorder and how that can impact breaking down some of the siloes all of you have referenced in this presentation.

We've heard in the past from certain substance use disorder advocates and providers that that confidentiality matters because outside of the medical system, the stigma is very strong. It can jeopardize custody. It can jeopardize subsidized housing. It can

jeopardize employment, et cetera, and yet if treating providers who are primary care, other programs, if there isn't a lot of the data sharing across the treatment team for a pregnant mom, it can create some of the issues that you've raised.

I wanted to ask each of you if you have a point of view around Part 2 and the confidentiality implications in addressing this health crisis.

MS. ALFORD: Yeah. We definitely see Part 2 as a barrier to care coordination. It remains a constant question among providers who are trying to do this work, and what I'm looking forward to with the MOM model is their specific technical assistance being offered around the consent forms that will be useful for what are often going to be integrated care models, because that is an area where I think if we can get a good agreed-upon way to do that, we have mechanisms. And we use mechanisms in our value-based purchasing programs to share data across providers through a secure online portal, claims data and reports and all sorts of things that I think will be incredibly valuable, but in general, my general feeling is there's still plenty of work to be done around Part 2.

VICE CHAIR MILLIGAN: If I can just interrupt before the other speakers, I think it might be useful if there are materials coming out of the MOM grants or around consent forms, best practices with data sharing, I think that might be something worth us tracking.

DR. BECKER: I would offer that I think we crossed the bridge on Part 2 when we did our health home in 2014 for bipolar disorder and risk of viral hepatitis, because the sharing of information was so important to the success of that program and there was so much anxiety about it as we got into it, that I think the discussion about how to handle that played out pretty well there.

I think that we have not really perceived it as a major problem in the current setting of addressing substance use disorder in pregnancy or neonatal abstinence syndrome.

In part, that's a tribute to the fact that the systems are well integrated and that information shares easily within those systems, and patients get a lot of care concentrated in one setting.

So I don't see it as big a problem today as I did four or five years ago.

DR. PATRICK: I think the comments that have been made were spot on.

Functionally and day-to-day, we are at one institution and sharing is not that hard. That said, as we begin to think through what a plan of safe care looks like, how we communicate to DCS, all of those issues are fraught with potential landmines.

So I think the sort of balance of sharing information -- I don't have the right answer because I think they're both true. I think your points about stigma, about how different groups respond is true. I also think that it's a challenge to care coordination if we can't. The only time that NAS becomes a dangerous diagnosis is if I don't know there's been an opioid-exposed infant. The infant goes home and has withdrawal at home. So information sharing is critical. Being careful about it, I think, is also critical.

CHAIR BELLA: Fred?

COMMISSIONER CERISE: I have more of a comment, but if you feel like you can add to it, I'd like to hear your thoughts on it.

Just sitting here listening, when you say 83

percent of these cases are in the Medicaid program, it really does speak to the importance of Medicaid and this Commission and others trying to sort out what is the right approach, and as Dr. Patrick said, it begs for something like a Ryan White scale of this is how you've got to fix it from prenatal to hospital-based to post. And it sounds like we're still really early in trying to figure out what works, but there's this mix of issues that you've identified, and I'm curious.

We're going to be looking to you to say, "Okay. What are those things right now that you know that would make an impact?" Ms. Alford, you said things like immediate postpartum contraceptives. I know right now, that's still a confusing issue for places, what Medicaid covers. Do you cover it as an inpatient? Do you cover it as an outpatient? So you may put those services off, and then you lose a lot of women.

I would be interested in knowing, as we look at this, what are those immediate things that we think we could make an impact with and then what are those things that you're working on, the integrated care model, the work that you're doing there, which sounds like that ought to be

a big part of the solution. What's the experience there? I'd be interested in like Lily's Place.

When you take women out of that environment in the prenatal setting and provide residential services, how does that translate into the incidence of neonatal abstinence syndrome? Is there not only a clinical benefit but an ROI afterwards?

Things like the rooming-in as opposed to putting babies in the NICU, it seems like that could inform Medicaid policy pretty quickly because that's an expensive NICU service and if there's a better clinical model.

So just looking at what are those things we should be paying attention and pushing right now because we feel like we've got good evidence, and then as we look at the demonstrations, we're just going to be depending on you guys to give us the model there because it is such a critical issue.

And it's one of those issues where Medicaid, a lot of health care and everything. You got a third in this system, a third in this system. This is concentrated in Medicaid. So Medicaid has a real interest in figuring out the right approach.

MS. ALFORD: Well, I will just say, as I mentioned the long-acting reversible contraceptives, that's an example where CMS did an excellent job. I thought they put out an informational bulletin in 2017 that was extremely clear on what some reimbursement strategies are, payment strategies are to make sure that that is not disincentivized from a payment perspective for hospitals, and so we adopted that policy years ago based on that guidance being so clear to us, although we then didn't do a great job communicating it. So that's part of what the MOM model will do, is let's communicate what we did two years ago and make sure hospitals understand it, but that was an example for me where I felt like the federal guidance was so specific and so clear that it was very useful.

DR. PATRICK: So I would just say too that one of the challenges, I think you're spot on in that 80, 90 percent in some states are covered by Medicaid.

I think the issue is that if you do one piece of this, there can be unintended consequences, and this is why I think a comprehensive approach of stepping back and how the pieces step together. For example, like plans of safe care in the child welfare space, functionally, in some

states, all that did was identify more substance-exposed infants without actually functionally creating a plan of safe care. It just was a mechanism to get more reporting to child welfare in already stretched systems. It's well intentioned, but if we don't put the pieces together -- so I think Medicaid's role is putting this together from pregnancy to one year in a comprehensive way.

And as Ms. Alford reported out earlier, the thing is this transcends opioids too. Alcohol used is far more common. It is the number one preventable cause of developmental delay in kids.

The opioid crisis at some point will begin to get better. We have to build systems of care that will ensure, and I think the urgency, at least in my speech right now, my actual pressured speech right now, is the fact that people are dying. We have pilot programs. We have grants from Congress. It really needs something big and holistic. Otherwise, I fear that we're going to continue picking off little pieces of this, without making a big impact.

CHAIR BELLA: Martha, were you on this point? You jumped kind of quickly. So if you want to hit this?

COMMISSIONER CARTER: [Speaking off microphone.]

CHAIR BELLA: Okay. Then Darin, then Tom, then Martha.

COMMISSIONER GORDON: Thank you for the panelists. This has been great, and this is an issue I've been working on for probably over 10 years, much of that time as the Medicaid Director in Tennessee, where we started to see this epidemic evolve right before our very eyes and then since even, sitting on a board of a company trying to address this issue.

As is evidenced by everything you said, it's one of the more complicated issues that I've dealt with in my over-25 years of Medicaid, and I think partially because some of the items Dr. Patrick had on the slide about its community, it's ACEs, it's all these factors, and so a singular approach is complicated. I think it's a multifaceted approach that is definitely necessary.

I have two questions, one for you, Dr. Patrick, and it's good to see you.

In our deck, I was so busy trying to find the slide that was up there that didn't get into our electronic version, where you were talking about scope of practice. So I missed some of what you were saying there. Is there

some evidence out there that by expanding scope of practice to other clinicians that it has led to better outcomes, or is that evidence still being built? Could you elaborate on that, please?

DR. PATRICK: Yeah. There was a paper in Health Affairs last month that looked at how the CARA provision enhanced expansion and particularly in rural communities. We don't have outcomes. What we do have is treatment capacity at this point.

The CARA provision, in particular, really enhanced access or at least providers in rural communities, and states that have more -- you can look at their map in the article. States that have more restrictive scope of practice or specific provisions like Tennessee, you can see a very big difference in terms of diminished treatment capacity.

In terms of outcomes, not that I'm aware of, it's just 2016 has been CARA model.

COMMISSIONER GORDON: Although access is an early indicator to some improvement and outcomes, so that's helpful. Thanks for pointing to that.

My other question is broader, and some of you

actually hinted toward it in some of your comments. I'd like your thoughts on the provision, typically coverage for pregnant moms 60 days postpartum, in some cases slightly longer, although you're seeing some states, including Tennessee, recognizing that that can complicate treatment in these situations.

But I'd like to get your thoughts, all the committee members, on whether or not your states are taking steps in that direction or if there's research or just general reaction to some interest to moving eligibility out more broadly for the mother.

DR. BECKER: So we believe it is wise, and we've made a decision to move it out to a year and then transition those patients at that point into well-woman care. So we're basically just opening that up.

We saw that as a major problem for women, particularly who had substance use disorder issues. We don't like the interruption of the care. We want things to be continuous, and so we've gone in that direction.

DR. PATRICK: I would just highlight there is evidence to suggest. We know, as was pointed out earlier, that pregnancy is a stressful time. It's a time where

relapse occurs. We know that when people lose coverage, they lose access to treatment, including medications for opioid use disorder.

In states like Tennessee, a third of the maternal mortality rates are associated with substance use. As we dig into that, a lot of this may be driven from that. It's too early to put those directly together, but as you mentioned, Tennessee is currently considering extending coverage out to a year.

I think it's critically important for the dyad. Addiction is a chronic relapsing medical condition, and having access to at least medications is really critically important, particularly as the families go through many of the stressors that have already been highlighted.

MS. ALFORD: Yeah. For Maine, extending 12 months postpartum is something that's being considered through legislation, just as we speak, probably.

Up to this point, Medicaid has taken a more piecemeal approach. So I'll be interested to see. I think it's more of a question about cost at this point for us with all that's going on, but certainly would support the models that we're trying to implement.

COMMISSIONER GORDON: Thank you.

CHAIR BELLA: Tom?

COMMISSIONER BARKER: Thanks. Thanks for the presentations. They were very helpful.

Dr. Patrick, I wanted to focus on something in your slides and Slide 6 where you talk about shifting models of care, and it just for me raised the question. And I'll ask this of all of you. Does the current benefit design of the Medicaid program in any way hinder the ability of states to treat opioid addiction?

To me, the obvious example is the IMD exclusion, but CMS has dealt with that, and Congress dealt with that in the SUPPORT Act. But are there other provisions of Medicaid that hinder the ability of a state or a provider to treat opioid addiction in the Medicaid population?

DR. PATRICK: So I'll speak directly towards the care models for newborn care that we discussed.

I do hear from some providers. AAP recommends that all opioid-exposed infants be observed for three to seven days to see if they develop signs of withdrawals, and from some providers, from that I hear, that can be a barrier in terms of getting reimbursement for that period

of time in bundled care payment.

For example, in our hospital, we've had, again, 300 opioid-exposed infants. We've diagnosed 25 percent with withdrawal, and in part, that's because we're doing a better job of getting to them early and providing the resources that keep them from escalating.

In terms of newborn care specifically, that's one of those pieces. It was already mentioned, some of the issues around LARCs and how states have dealt with that, including Tennessee, but I think it remains to be a challenge.

I do wonder more broadly about treatment access and are there ways to enhance reimbursement or reallocate resources to incentivize providers, particularly family medicines, obstetricians providing opioid agonist treatment.

DR. BECKER: I would say to your question, I don't believe there are great barriers anymore in the Medicaid system in which I work. I do believe that there was a problem when we had prior authorization requirement on access to suboxone or buprenorphine products. We dropped that.

I do believe that there was a problem when we required providers to enroll in order to prescribe buprenorphine, and that was on top of having to obtain their DATA 2000 waiver. That's gone.

I do think that there was a barrier at some time regarding oversight of counseling services, and in order to get paid for a certain counseling service, you had to have another higher-level behavioral health specialist available to supervise. So things like that, I think we dealt with those years ago, probably.

Right now, I can't think of an immediate barrier in getting treatment in the Medicaid system at all.

We've actually enrolled -- in West Virginia, we have 430 enrolled MAT providers, and we track all of their prescribing. They get feedback on their performance, and they can sort of see what their average daily dose is and things like that and recidivism. So I do think sharing more data with the providers of these services will be helpful to improving quality, but as far as barriers, I'd say we don't really have any that I'm aware of.

MS. ALFORD: I would agree. I think that at the statutory level I don't think there remain major barriers.

Another one I would mention that was alleviated was just the ability to use some of the more alternative workforce, like peer recovery coaches or -- and I'm forgetting the exact reference -- but the clarification that certain services can be ordered by a physician and delivered by someone else to support, I believe it is rehabilitative services or something, in 2013.

So I think a lot of it remains up to states in looking at their own administration of their programs and conflicts with scope of practice laws, licensing, those types of intersections still remain very receptive at the state level but I don't think federally, I have a big issue.

DR. PATRICK: Can I do a quick follow-up? I think the question is, who is not at the table, in my mind, in part because I get emails from folks in the community where clearly the birth was paid for by Medicaid but they can't find access to a treatment provider because no one is taking insurance. And I think the question is, that, to me, is one of the bigger barriers. We have treatment networks, and states are building to improve and enhance those with additional services, but if, in your community,

people only take cash, that itself is a barrier.

CHAIR BELLA: Can I just ask a clarifying question, particular from the two state folks? It's lovely if it's the case that there's nothing blocking kind of the coverage and treatment of this. I have a hard time believing that. So just -- can I just ask, there's nothing eligibility wise or that you have to do by a waiver today that would be easier for you to do sort of in a non-waiver way? Can we just ask that question one more time, because we hear that there are eligibility issues, whether it's related to the narrowness in what a woman is able to get, the length of time a woman is able to get it, and/or I applaud CMS as well for offering states a lot of waiver opportunities, but states also get frustrated with having to do things via waiver, and sort of the impermanency of that and the resource demands of that.

So can you just – we, can we just double-check if there's anything else that you might want to share with us? Not that I'm leading the audience --

MS. ALFORD: No, no.

CHAIR BELLA: -- but I'm having a hard time with that.

MS. ALFORD: Thank you. Yeah, I guess I was thinking more on the what's an allowable coverage service perspective. So I will say, as I mentioned in my comments, we are a small agency. We are not managed care. So for us to implement 1115 waivers, it's not something we can take lightly from a workload perspective and a cost perspective of what's required. I think you might be talking about this later today as far as the rigor of evaluations and other requirements of reporting aligned with the 1115 waivers. And they really are a tool that we need to have in our toolkits to be able to do things on a sub-state basis, to waive certain provisions around comparability and, as I said, statewide-ness.

So while we don't -- in Maine, we only have one active 1115 waiver that we've had for, you know, 18 years or so, and it's one of the few that's been approved for a 10-year duration instead of a shorter duration, so, I mean, those allowances -- it's an avenue that we know we need to have access to. We don't have a ton of experience for good reason with pursuing them.

But as we get further into this, I think we're going to see how manageable they are for a state of our

size to do them. But they do provide a really important way for us to truly test innovation, and also to do things that are more innovative, such as the recovery residence and value-based purchasing kind of bundled payment to recovery residences that I talked about, that's modeled after North Carolina's 1115 waiver.

So it seems like each state is treated very differently in the approval process for those, and they can take years to approve. So I'm hopeful that we have a positive experience this coming year with ours.

DR. BECKER: So I've reexamined my optimism.

[Laughter.]

DR. BECKER: I will give you these. Location is an issue in the state, and so it is a barrier. If you're in one of the nine counties that has no MAT provider of any kind, then that is a barrier and it's a barrier for everybody.

And so that we try to work on by adopting some telehealth standards, and I would say that when you get into the world of telehealth and telemedicine, that is still a barrier. Even though we've tried hard to write clear standards to allow the services to flow that way, it

really doesn't, or you get denied payment because it's not the right connection.

So I would say to the issue of location, that's something we have to address. Telehealth/telemedicine clarifications would be very helpful in that regard. And then the other thing that is right now a bump in the road, and I hope it's not a permanent bump, is this conversion over to managed care taking care of the SUD population. They don't handle this real smoothly yet. They started in July. And so while I think their ownership of the treatment services is necessary, I think we're going to have a little rough time with it, and hopefully it's a temporary barrier.

MS. ALFORD: Thank you so much for mentioning the telehealth. I had in my notes to mention the Ryan Haight Act -- I'm not sure how you pronounce it. There's a pending exemption that's supposed to be issued from the federal government, I think through the SUPPORT Act, that was supposed to clarify and provide more leniency for MAT prescribing via telehealth, that I think was due last fall, and I don't believe that's come out yet. And at the state level we've gone so far, but that federal law is a

remaining barrier. So I can follow up with the specific citation but I believe it's past due.

CHAIR BELLA: That's great. Thank you. Darin, on this, and then Martha.

COMMISSIONER GORDON: There's one comment that was made earlier about access and providers not taking insurance, and I just have watched that over the years. And what's somewhat complicating about all that is, I mean, we had conversations with a lot of those provider groups and they just had no interest, and they would do cash pay, and members would seek reimbursement from the agency.

So it really makes a complicated issue even more complicated in that there are -- there is access but not in the way that we would prefer, but you can't make people contract. I think that's evolving. I think as this problem has gotten more severe and more sophisticated, players have been getting into the business that you're seeing more come in and be willing to take insurance. But I still think that dynamic exists out there, which really clouds any accurate picture of access, to some degree, and hopefully becomes a problem that we don't have to discuss anymore.

DR. BECKER: Could I respond with what we did in West Virginia in that regard? We had a lot of concern, about 10 years ago, about cash pay, and one of the strategies that we adopted was to ask that any patient seeking to have medications paid for by the Medicaid system, for the treatment of opioid use disorder, would have to present attestation they were not paying for the visit, that the provider was charging the Medicaid system. And the provider were then monitored for the number of visits.

And so we connected payment for the medication to payment for an office visit under Medicaid rates, and that worked pretty well to get rid of quite a bit of the cash-based stuff.

DR. PATRICK: I'll just say that I worry. So we've got some work that hopefully will be out in the next couple of months, that will get at this a little bit, with a little bit more detail that I look forward to sharing with the committee. But I worry that in many states it's still pretty widespread in certain communities.

CHAIR BELLA: Martha.

COMMISSIONER CARTER: I know we are past time,

and this a can of worms, but we've got the experts here so I wanted to ask, you all have alluded to the fact that there's multi substance use, methamphetamine in particular. So are the systems that you are building robust enough to handle multi-drug use, and is there work to be done on the Medicaid side to handle the next wave, you know, the women and babies who are exposed to meth and other substances? But set aside for a moment alcohol and tobacco, because, you know, we do have some systems in place for that, but other illicit drugs? It's a can of worms. I'm sorry.

DR. BECKER: So I'll say we are worrying about it. It is very disturbing to see the trend moving from heroin to fentanyl and fentanyl to fentanyl adulterated with methamphetamine, and who knows what else. And then in our neonatal transfer units and at Lily's Place we're seeing the children with really prolonged stays because of mom taking gabapentin or Neurontin during pregnancy, and children having a hard time coming off of that drug. So there is a world of new problems that are out there in front of us, and it's not all just opiate use disorder.

We are trying to identify ways that we can appropriate detox these infants, or bring them down through

the withdrawal associated with it. Dr. Patrick is the expert, but it is really a worrisome problem, and we do meet about it and talk about it, and we're always looking at the evidence for what works.

DR. PATRICK: So the answer is twofold. First, there are -- you know, SAMHSA estimates we have 440,000 substance-exposed infants born every year, and we identify about 5 percent at the time of birth. The question is, you know, many things don't have a withdrawal syndrome and go unnoticed, and I think that's one of the worries. Methamphetamines are just different in the way they present in neonates too. I see, just in the unit now, you know, there are associations that are little less direct, so, you know, placental abruption with an infant with methamphetamine exposure. You can't draw a distinct line between the two, but I worry about it.

I think there are elements of these systems of care that could be responsive to multiple different exposures, and my hope is that what we see from this, and what we see from models like MOM, are that we develop systems that bring people together, that break down the silos, that will serve as we go from one thing to the

other. Because it is different and the issues around reporting, around stigma, they are also impede our ability to identify. So as we sort of begin to move forward to healthy systems I'm hopeful that we're going to get there, but I do worry about it.

COMMISSIONER CARTER: Can you use the MOM's funding specifically for a mother on meth? No.

MS. ALFORD: The MOM funding is for opioid use disorder only. We are hoping that we will be able to apply the lessons learned and the improvements made to other substances. I think there also is -- not a clinician, but I think there's not as much of an evidence base, necessarily, around some of the other substances, which causes issues when you're trying to implement a standard of care.

Another substance I'll just make sure is thrown out there is marijuana. We're seeing a huge increase in -- high numbers of women using marijuana during pregnancy with the decriminalization in many states, and the lack of kind of information out there about what the impact of that on the fetus is. I think that will also be an issue that's going to be on the forefront.

DR. PATRICK: Can I just add one follow-up? I know we're over on time. But that's right. If you look at NSDUH data in terms of past month use, opioids are like 1 percent. Marijuana is higher. Past month use in terms of alcohol is about 10 percent, and tobacco is 16 percent. And I think we do have to be responsive to that.

To your point too, we do know that there are some things that make withdrawal worse. Some of those are prescribed substances like gabapentin. Benzodiazepines make withdrawal more severe too. They also increase mom's risk of overdose death. And so I think there are targets in terms of thinking about the way we prescribe as well.

COMMISSIONER CARTER: I didn't mean to say that alcohol and tobacco were not important, and I know in West Virginia it's a huge problem. And we seem to be at a standstill in some places for remedying that issue. But just to the additional substances, it's a system that we really don't have built at this moment.

CHAIR BELLA: We are over time but we are not going to take our full break, so I want to say, while we have these folks here, is there any one last question from any of the Commissioners before we thank them and do a

quick transition and then come back to where we want to take our focus?

What's that, Martha? Not now. From any of the rest of us. We'll do public comment at the end.

[No response.]

CHAIR BELLA: Okay. I have a feeling we will have some more for you as we keep going on this work, so thank you very much for taking the time to be here.

For the Commissioners, we'll take like a 1-minute stretch break. You get a half an hour in like 30 minutes, or you get an hour in 30 minutes, so I would like to use the rest of our time to really keep this momentum and figure out where we want to go, but give our guests just a minute to transition out. Thank you.

[Applause.]

* [Recess.]

PART III: COMMISSION DISCUSSION AND NEXT STEPS

* CHAIR BELLA: All right. I think we're going to get started. So we have this period of time to talk about what we've heard and to give direction from the Commission where we would like to go with this work.

So what would be, I think, really helpful for

Erin and Tamara and the rest of us is to talk concretely about areas of policy that we're interested in having additional work done. Again, this is work that will continue. This is not work that we would have recommendations done for the June report, but if we can be concrete and specific about what areas we would like to pursue, then I think that will be very helpful.

So, Martha, would you like to kick us off?

COMMISSIONER CARTER: I'm going to defer to Peter because he and I were just having a conversation, and I think you go ahead and articulate what you're thinking.

COMMISSIONER SZILAGYI: No, I'd actually -- you know it was striking to me about the questions that many of us asked about possible recommendations or changes in policy or statute or barriers, what Tom was asking. We were all asking kind of the same questions, and it almost struck me that the elephant in the room is not that there are legal or statutory barriers. There's not enough funding. The big problem to me, the gap between some of these evidence-based services and what's really needed in these states may not be that there's some sort of policy or legal limitation. It's sort of just a scaling up; it's a

matter of resources and funding. So that doesn't lead toward a recommendation, but -- and I must admit, practicing, serving mostly Medicaid patients in California, I see this not so much with substance use disorder, but with other conditions. There aren't specific legal, statutory policy things that are limiting me providing optimal care to my patients. It's lack of resources.

CHAIR BELLA: Brian, then Kit.

COMMISSIONER BURWELL: I'm glad there was at least some mention of managed care at the end there, because I've got to believe that most of these women are in managed care since most of that population in most states is managed care enrolled. So I think there are opportunities for us to dig into that more deeply in terms of how states are working with their managed care contractors to support these types of programs for people with -- women with NAS children.

CHAIR BELLA: Do you have specifics on what you would want to dig into?

COMMISSIONER BURWELL: Well, I mean, since the programmatic response that people were advocating was more integrated models, whether states are incentivizing their

MCOs to also do that, or whether there is kind of bundling payment, bundled payment provisions that would target this population and improve outcomes.

CHAIR BELLA: Okay. Kit, then Chuck, then Tricia, then Bill. And I'm probably missing hands.

COMMISSIONER GORTON: So I, like you, was struck -- I was, like you were, struck -- God.

[Laughter.]

COMMISSIONER GORDON: Wreck of an Ivy League education -- by the lack of push for changes at the federal level. But I do think there's a role for us to potentially highlight, since more people are reading our stuff, if there are authorities that the states have been given that they're just not using, if there's technical assistance -- and maybe our colleague from CMMI can after the meeting help us figure out how it is that we can in the context of the stuff that we're going to put out say states have these authorities, some states are doing it, other states are not. You don't need to be a managed care state to do this. I think that was a very useful set of observations, for many fee-for-service states absolutely can do this.

And then to build on Peter's point, it's not just

resources at the point of care, although there's clearly a lack of resources at the point of care. But the states lack the -- I mean, this is our old song, right, but I think we need to sing it here. Part of the issue is the states lack the state resources, the technical expertise, and so are there things -- are there ways or do we just need to rehearse the usual list in terms of technical assistance and subregulatory guidance and some of the other things? -- to help states move things long? And I am -- you know, there's this -- CMS has been in recent years doing this sort of, okay, you need to do infrastructure building, right? There's sort of the million dollar infrastructure grant. How can we move beyond the usual suspects, you know, 10, 15 states doing this and trying to more broadly impact so that everybody's building some infrastructure? I just think there -- I would like to -- from a policy perspective, I would like to see if there's -- this scope and scale thing, this is a place where it seems like from hearing the experts, we know what has to be done. And the question is then from an operational implementation point of view, how do we help the states get past their various barriers in order to do what we know

needs to be done? And we need this not to take the 17 years it usually takes for evidence-based practices to percolate their way into the clinical setting.

VICE CHAIR MILLIGAN: Good discussion. I'm going to sort of offer a couple of comments that I want to be mindful of kind of the line as a Commission we have to tread around recommendations that might increase federal spending, because we have to be cognizant of fiduciary issues and federal treasury issues.

There are a couple thoughts. One, Peter, to your comment, there are particular policy initiatives in which the federal government offered enhanced match. We've talked about it in the context of Money Follows the Person. We've talked about it about driving other things. Those kinds of possibilities are out there for us to consider whether we want to at some point down the road take a position about whether this kind of initiative merits that kind of recommendation.

Second, related -- and I do say this without advocating it, but I just want to put it on the table -- you know, we heard, I think, from some very thoughtful, very kind of thought leader states today. There are moms

in other states, and so I do think part of the issue here is areas that are optional to states maybe aren't picked up by states, and so I do -- I personally have concerns around two aspects that came out toward the end of the discussion. One is the fact that pregnancy-related coverage is really typically eight weeks postpartum and you're done. And so there is a potential recommendation around whether there's a federal change there. And then, second, pregnancy-related coverage, that eligibility category, is also traditionally -- the mandatory part is limited to treatment of pregnancy-related conditions, not things that are a little further afield from pregnancy-related conditions. And so that element, again, states had the option to expand to full Medicaid for pregnant moms, but they're not required to.

Again, I'm not sitting here saying we ought to take a position of recommending some new mandates in federal law that would be obligatory to states, but I do think that that domain is out there because states do have options, and some states will take them up, some states won't, and that disparity plays out in states that maybe aren't quite as much thought leaders as what we heard

today.

I do want to endorse what Kit said. I think at a minimum just kind of an inventory of options, an inventory of what's possible, without changes in federal law, without changes in federal regs, just kind of disseminating information, I think that by itself would be a tremendous value-add for MACPAC.

I'll leave it there.

CHAIR BELLA: Tricia, then Bill, then Martha, then Stacey, and then Kisha.

COMMISSIONER BROOKS: So my question gets probably a little more specific than maybe we want to be right now, or my comment. It does seem like there is momentum for extending coverage after pregnancy, and, you know, while we may not want to have individual recommendations, it seems like that that's a recommendation that could be ready for prime time. But I want to point out a couple of potential hiccups with that, even.

You have five states that do not provide full Medicaid benefits to all pregnant women. They offer full Medicaid to pregnant women up to the old AFDC levels, and above that, pregnancy only. So the question is: What does

coverage after pregnancy look like if it's only pregnancy-related benefit? So that's one issue.

There's another issue where we have about a third of the states that have picked up the unborn child option, where they're covering pregnant women who don't qualify for Medicaid, and I think that's a real hiccup in providing them with extended coverage as well.

CHAIR BELLA: Bill.

COMMISSIONER SCANLON: My comments were very similar to Brian's. In my mind, we heard a lot about what should be, but there's the question of how do we get there. How do you create the incentives to move from the status quo? Maine was the case. We heard about bundled payment, but then there was the caveat that Maine is a fee-for-service system, and so you can think about bundled payment.

Having said that, though, bundled payment creates incredible incentives and also can create incredible risks and can be a real deterrent to changing things. So I think we need to go into this in depth.

Then it gets even more complicated when you bring this into the context of sort of managed care, and when we talk about working with the plans, states working with the

plans, what does that mean? What does it mean in terms of accountability requirements? What does it mean in terms of quality reporting requirements? What does it mean in terms of payment? And, you know, do these things -- for this particular issue, how far do they rise in terms of the nature of the contract between a state and the managed care plan? So I think this is an area where we've got to avoid sort of being too superficial if we want to get to the point where we identify things that will be meaningful incentives to make a system change.

CHAIR BELLA: Martha.

COMMISSIONER CARTER: I heard at least two issues that I think we could get more information on and make recommendations on. One is scope-of-practice issues. I think we could recommend that the states open up their scope of practice or their -- actually, it's more of a Medicaid billing issue. Who can bill for what codes? I know when the first two midwives in West Virginia were ready, they got their DATA 2000 waivers, and they were ready to provide office-based MAT services. You know, we had to figure out how to get those codes open -- the codes were there, but how to get them open for the midwives who

were ready to bill them. So that's a process of examining what provider types can bill what codes and make sure it all flows well, because obviously you're not going to get people providing services if they can't bill and collect for those services.

So I think that's a very practical recommendation as far as, you know, scope of practice within what we could recommend. We can't tell the Board of Nursing to change -- I don't know. I don't know where the barrier is in Tennessee, but to the limit that we can recommend that kind of thing, I think we should.

The other is around telehealth. I'm like a broken record on telehealth and community health centers, but you know there's a problem. I think we should advocate for as much flexibility as possible in the states to allow as much telehealth as the states feel like they can support. I'm not sure what the barriers are there, but I -- and kudos to West Virginia. Jim, are you still in the room? I think they just put in a pilot where the FQHCs can be the originating and distance provider so that the psychiatrists, which are few on the ground, can actually provide service within the same organization to distant

rural sites. I think they're just piloting that. I think that's hugely needed. And we know that we've got a dearth of psychiatrists. We've seen those data earlier. So, you know, we need to support that as much as possible because those are the folks that are also doing MAT. The psychiatrists are often the ones providing -- or prescribing. So we need to make that as accessible as possible.

CHAIR BELLA: Stacey.

COMMISSIONER LAMPKIN: One of the things that we heard about from the panel was the silos of the different players and funding sources that have a piece of this or an angle of this and that potential misalignment there. I wonder, are other people as interested as I am -- it seems like there's maybe a potential for us to just help tell that story and explain the complexity of the variety of players that need to be navigated and coordinated and potentially aligned to help serve the women and the children better. What is the role of Title V in this? What is the role of child protective services and the different players that come -- that were discussed and appear to have different pieces of the puzzle?

CHAIR BELLA: Kisha, you're up next, and do you have comments on that since you raised that?

COMMISSIONER DAVIS: So thank you because that leads very nicely into what I was going to say. So, one, I think highlighting the experience of patients and so really that patient-centered model of integrated care, and a lot of what they talked about their successes, they've been successful because they've figured a lot of this stuff out that other states haven't. They've figured out that it's beneficial to expand Medicaid to benefits beyond pregnancy. They've figured out that it's helpful to have benefits that last for a year. They've figured out how to get around Part 2 and HIPAA. And so highlighting a lot of those things that are helpful, how we integrate care so that the patient is not running around to different providers, I think highlighting in a chapter is really helpful.

You know, also using that as a place to highlight state best practices, and as Kit was saying, just what's available. I got the impression that folks don't really know what they can do, what they already have the authority to do, and so highlighting that for them, what Olivia mentioned, how helpful it was to have that very clear

guidance from CMS. And so as much as we can be that resource for what is there and what's possible, I think is really helpful.

CHAIR BELLA: Other comments before we do a bit of wrap-up?

[No response.]

CHAIR BELLA: Anne and I had a running bet that we would go well past the half-hour, so I'm about to lose. We had so many hands, I kind of said, "I told you so," and --

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: That's not fair. Now they're all going to start raising their hands.

CHAIR BELLA: No. I have comments and we're going to take public comment, but Fred?

COMMISSIONER CERISE: Stacey brought it up, and so I would echo -- I mean, you did hear it's so confusing, there's so many pieces that play into this. And, you know, with bundled payments as one approach to trying to pull the pieces together, I do think that Medicaid, since Medicaid is covering all of these services, that it would make sense for us to try to describe what the important pieces are and

how perhaps they would be woven together, including, you know, the payments that come outside of Medicaid today. You know, you heard one of them talk about maternal health block grant payments that would cover home visits and public health nurses that would do various things. And that's just too difficult to try to navigate, and so if you could describe those pieces and then somehow work towards -- I think, you know, it's no accident that Vanderbilt has put a lot of these pieces together. It's a big place. They've got a lot of players, and, you know, they can do that, and they've been able to do it. But for most providers out there that just own a piece of the solution, it's very difficult. And so to the extent that we could kind of describe that complexity and maybe drive toward some solutions or take some of the experience and describe some of the solutions, I think that would be helpful.

CHAIR BELLA: Thank you. I'm going to end by anyone in the public who is interested in commenting.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Or we could just pick on one of you. Surely someone has something to say.

All right. So I think I'm just going to summarize some of the key themes and see, then, if Erin and Tamara need anything else. So it sounds like there's interest in, Kit or Chuck, one of the two of you called it an inventory, and kind of understanding -- that would obviously be a good education for me, because I thought there were more barriers than there are -- but understanding kind of what's out there and then the take-up of what's out there to understand. And I think that ties into what Stacey and Kisha and Fred were talking about, which is some descriptive work, both illustrating challenges, the complexity, the pieces you have to put together, the best practices for those people that are figuring out how to put that together. Those things seem to tie closely.

We've talked in the past, and it came up today, and I think you are hearing some interest in continuing to look at, I don't know if you want to call it eligibility or coverage issues, but everything around pregnancy-related coverage -- the length of time, the scope of what's provided, what impact that would have in terms of where states are today, and what kind of costs that might have.

There was a lot of discussion, Brian and Bill, talking about bundles and incentives in managed care, and sort of a bucket of things around that, it sounds like, we could decide that we want to do more work in.

Telehealth has come up. I do know -- I mean, telehealth, I think we have to sort out both telehealth and scope of practice, kind of where the Medicaid piece of that is. It sounds like DEA is doing -- maybe is the telehealth piece, Olivia, that you mentioned, and so figuring out where we play in that. But thinking about it as a solution to access and kind of where our piece might be with that, and I would say like the scope of practice probably deserves more conversation, given the stickiness of that. But it's an important point to raise.

And lastly, I would just say, you know, I know it's 23 days in, but kind of reminding ourselves to keep an eye on what's going on with the MOM model, in particular, and seeing like what the expectation is for that program and sort of what milestones they're going to be hitting when, so we have a sense of when we might be getting pieces of information, even if it's illustrative or descriptive, that might inform our work.

And so I guess those are the key themes I was hearing from all of you. Clearly interest in continuing to do this. And just to clarify, my expectation would be that we would make recommendations in this area as well, but we're earlier in that work, in terms of our most -- you know, our reports that are coming out more quickly. And so I think we have some work for the staff to do to bring back to us.

So Erin and Tamara, do you have what you need, or do you have any clarifying questions for us?

MS. McMULLEN: No. This was really helpful.

CHAIR BELLA: Any last comments from anyone? Anne, anything?

[No response.]

CHAIR BELLA: Okay. Thank you very much. We are going to take a lunch break. We will begin back at 1 p.m. Thank you all.

* [Whereupon, at 11:55 a.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:01 p.m.]

CHAIR BELLA: All right. Welcome back, everyone.

We are ready to start our session on duals. So we will turn it over to you guys to take it away.

INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES: ANALYSIS OF GEOGRAPHIC AVAILABILITY

* MS. BLOM: Thank you, Melanie. Good afternoon, everybody.

So, today, Kristal and I are going to talk about the geographic availability of integrated care illustrated through a series of maps.

Let's start by quickly recapping our recent work on integrated care, discussing what we mean when we talk about integrated care, and then looking at the maps themselves and discussing some key takeaways.

Last year, we heard from two panels -- first, a panel on federal and state integration efforts. We heard from Tim Engelhardt, Director of Medicare-Medicaid Coordination Office, as well as the state Medicaid Director from Idaho, Matt Wimmer; and Bea Rector, the Director of

Home and Community Services from Washington. Both of those two talked about their unique state experiences in integrated care, and Tim provided an update on federal efforts in this area.

After that, we also heard the beneficiary, provider, and health plan perspectives from a second panel made up of Amber Christ, directing attorney from Justice in Aging; Griffin Myers, Chief Medical Officer from Oak Street Health; and Michael Monson at Centene, Medicaid and Complex Care Director there.

In December, we presented, Kristal and I, on barriers to integrated care, including state concerns around their limited capacity on Medicare, and then over this last report cycle, we've let several contracts on the topic listed here, which we talked to you about over this past year, including things like factors affecting enrollment in the Financial Alignment Initiative.

Looking ahead to our June 2020 report, this report is likely going to include a chapter or chapters on integrated care. Within that, we'll be providing some descriptive information about the dually eligible population. We'll be discussing what we mean again by

integrated care and the pull in what we've learned so far through the work that we've done.

All of that is going to provide a rationale and support for potential recommendations that the Commission might want to include in that report.

These chapters will also include some of the geographic analyses that Kristal will be presenting on in a few minutes.

So to make sure that we're being clear and consistent in our language, especially as we begin to think about a chapter in the June report, we wanted to just spend a few minutes on what we mean when we talk about integrated care. It's designed to align the delivery, payment, and administration of services in both programs to improve care and reduce spending that may arise from the duplication of services or poor care coordination in an unintegrated environment.

For example, I think we've all talked before about the idea that beneficiaries have to transition from an acute inpatient hospital setting, which is paid for my Medicare. They may go into a home- and community-based setting just paid for by Medicaid, which could help reduce

their hospital readmissions, which saves money across the board.

When we talk about promoting integrated care, we're thinking about two broad goals -- increasing enrollment in these models and then making care as close to as fully integrated as possible, meaning that beneficiaries' needs are being coordinated. This can also mean a more seamless experience for the individual.

So CMS and states have adopted different models to achieve integration. There are Medicare-Medicaid plans, which are part of the Financial Alignment Initiative. On the Medicare Advantage side, there are dual eligible special needs plans, which are often combined with managed long-term services and supports programs, as well as fully integrated dual eligible special needs plans, or FIDE-SNPs.

Outside of the capitated arrangement, there is the managed fee-for-service model, which is an agreement between states and CMS to set up a coordinated program that states can benefit from, that states can share in the savings from, the retrospective payment from CMS.

There's also PACE. PACE is a very small program, although a lot of states have these programs. It's small

in terms of enrollment, but many states have adopted the adult day center model that this program uses to provide care to people age 55 and older. And there are new opportunities in this area as CMS has released recent guidance about expanding it to younger populations, for example.

So to set up the maps that Kristal is going to talk about in a couple minutes, I just wanted to talk for a second about the variation in the availability of these models across the country.

Some states operate integrated care in limited areas, for example, to gain experience before taking an integrated program statewide. A good example of this is Virginia, which participated in a Financial Alignment Initiative and only offered that in certain regions but then moved out of that and into a statewide MLTSS and D-SNP program.

Also, things like low-population density can impact the availability of choices in the integrated care area. For example, low-population density might make it difficult for states to attract managed care organizations to certain areas, thereby making it difficult to implement

integrated model. We heard a little bit about that from some of the states that came to speak to us.

Then D-SNP availability might also vary because states choose not to contract with D-SNPs or because, for example, a potential D-SNP might not meet the Medicare network adequacy requirements in order to get approval.

So discussions of integrated care often focus on variation and state adoption of these models, but we wanted to make sure to point out that there is also a variation in the availability of what's out there for states to work with.

So, with that, I'm going to turn it over to Kristal for the exciting part of this session to talk about the maps themselves.

* DR. VARDAMAN: Thanks, Kirstin.

Before I walk through the maps, I'd like to recognize our colleague, Jerry Mi, who created these for us. Thanks to him and also to John Wedeles for working on our mapping capabilities.

On this first map, we're just setting some context as to where concentrations of dually eligible beneficiaries reside. This is based on some point-in-time

figures, but we expect ever-enrolled through the year to follow the same patterns.

As you can see, large numbers of dually eligible beneficiaries per county are often found in metropolitan areas and also in the South and Northeast. There are fewer dually eligible beneficiaries per county in much of the Great Plains and Alaska.

This next map shows the availability of the Financial Alignment Initiative by state, which is what we normally show. Ten states are currently participating in the demonstration. Nine are using capitated model, and one is using a managed fee-for-service model. We didn't include Minnesota on this map, given its focus on administrative improvements.

But this next map gives us more information on where within a state the demonstrations are offered. So you can see that only Washington offers a demonstration statewide, and that's the managed fee-for-service model.

In the nine states that are using a capitated model, about 21 percent of counties are participating in a demonstration, but of course, given the residence data we just showed before, they are often, but not always, offered

in areas of the state that are more densely populated by dually eligible beneficiaries than others. So, as a result, nearly two-thirds of dually eligible beneficiaries reside in those counties where the demonstrations are offered.

This map depicts managed long-term services and supports availability by county. MLTSS is statewide in 21 states. It's limited to certain regions of California and Idaho. Again, although they may be in a minority of counties, a disproportionate share of dually eligible beneficiaries reside in those counties.

This next map depicts D-SNP availability by county based on data on MA plan offerings in 2020. D-SNP availability largely follows the enrollment data with a few exceptions. For example, Nevada and Illinois do not have any D-SNPs, despite having regions with high numbers of dually eligible beneficiaries per county. This may reflect state decisions not to contract with D-SNPs at this time.

In comparison, there are states that you can see here have D-SNPs but where they're not statewide. So given that these states are already contracting with D-SNPs in order for them to be operating at all, the lack of

availability statewide may be due to reasons other than state choices, for example, some of the things Kirstin mentioned about the ability to meet network adequacy requirements or other factors that affect the viability of the business model in these areas.

So this final map puts those last two together and shows where states operate MLTSS programs and also have contracts with D-SNPs by county.

So there are 20 states that have both MLTSS programs and D-SNPs, so those are in the dark blue. The light green are places where there are MLTSS but no D-SNPs, and the darker green are places where there are D-SNPs but no MLTSS.

So the presence of both, again, in the dark blue, does not mean that the state is always going to fully be pursuing integrated care in all the ways that we've talked about through a combination approach. However, we know many of these states that are shaded in blue are aligning MLTSS and D-SNPs, and we've heard from some of them in the past, such as from Arizona and Virginia back in 2018.

So what we really wanted to emphasize here is that where both are already in place, there's a more

immediate opportunity to either begin to build upon integration efforts.

In contrast, other states have some interim steps to take. So in states with D-SNPs but no MLTSS programs, integrated care requires either starting an MLTSS program or moving straight to a FIDE-SNP. The only state that has MLTSS but no D-SNPs is Illinois; however, portions of other states have MLTSS but no D-SNP availability as we saw in the last slide. So there may be some more digging to do here to understand why that is and what can be done there.

So the key takeaways from these maps are that the best opportunities to integrate care we see are currently where both MLTSS and D-SNPs are both available or where there's an active demonstration in the financial alignment initiative.

Second, even in the states that have pursued and implemented integrated care programs, they may not be available statewide.

And given the lack of coverage in certain regions of a state, states may need to pursue some combination of approaches in order for more dually eligible beneficiaries to have access to an integrated care option.

With that, I look forward to your questions.

CHAIR BELLA: Thank you.

I just want to clarify because Illinois was mentioned a couple times. Illinois doesn't have D-SNPs because it focuses its plans on its demonstration. So it's a Financial Alignment Demonstration, and so when we talk about using the MIPPA lever contract, that state has said, "We want to promote the integrated care demonstration plans. We don't want those to have to compete with D-SNP products." So they don't give a MIPPA contract to non-demonstration plans, if that makes any sense.

So, if you look, they're not shaded in any of the D-SNP pictures, but they are fully shaded in the demonstration picture. So I just wanted to make sure that because that state was mentioned a couple times, we clarified that.

So can we go back to the last map, please? I think this one is where we should spend a little bit of time, because as we get into our next discussion, we'll be talking about the relationship with MLTSS and the relationship with D-SNPs and these things called FIDE-SNPs. So making sure that all the Commissioners understand what

these colors represent and how to think about the state of play as we go into that next discussion, I think, would be really helpful.

Because I know all of you don't live and breathe duals like some of us do, is everybody clear on what all these acronyms mean and who controls whether it's Medicaid or Medicare and what we're seeing here on this picture? Right now would be a great time to ask questions.

COMMISSIONER GORDON: I'm just curious. When we're saying D-SNP up here, is it purely a D-SNP or FIDE-SNPs included?

DR. VARDAMAN: FIDE-SNPs were included in the data, but we didn't call them out separately.

COMMISSIONER GORDON: Okay . So if I'm interpreting it correctly, it says D-SNP, it could be FIDE-SNP or D-SNP is what you're saying.

CHAIR BELLA: Why don't we give everyone a refresher on what a FIDE-SNP is.

DR. VARDAMAN: Sure. Fully integrated dual eligible special needs plans called a FIDE-SNP, and so that is a way for beneficiaries to get access to their full array of Medicare-Medicaid benefits through a single plan

as opposed to if they're in an MLTSS plan and a D-SNP, they're technically in two plans, even if it's offered by the same parent organization.

CHAIR BELLA: For me, personally, for what it's worth, it's helpful to think of these things on a continuum in terms of kind of how many services are in these particular products in an integrated way, and so the way I think of it is, at this end, you have fee-for-service, and at this end, based on what we're looking at today, you have what we call the MMPs, which are the capitated demonstrations, the FAI on this map, I believe.

And sort of one notch down from the MMP would be this FIDE-SNP that we're talking about because that means the FIDE-SNP is offering either behavioral health or long-term care or both and also the Medicare benefit.

And then sort of one step back from that would be your regular D-SNP, so not a FIDE-SNP, but a regular D-SNP that's also offering Medicaid long-term care.

And then like one step back from that might be -- it would be up for debate on whether it would be sort of a straight managed long-term care program or a Medicare Advantage program, I think, depending on what the needs of

the person were.

So it's hard to say we have one standard of integration. We have sort of a continuum of integration, and I think what we're trying to think about is how do we keep moving that further and further so that more people can get as many services that they need as possible from an entity that's financially accountable and also has flexibility to get people what they need kind of under either program.

And so -- Martha, just one second.

So I just think if you wonder why I think of the MMP as the most integrated, it is because the payment. It's a blended payment rate, which is different than any of the other options, and PACE would go on that far end of the continuum as well, even though those are not rates that are set together. So those are still separate rates. So, arguably, you can still get a little bit of cost-shifting in there, but PACE would definitely go on the far end of that continuum as well. We're just not really talking about PACE as much today.

Martha and then Kit.

COMMISSIONER CARTER: Just a clarification. So

the MMPs, the Financial Alignment Initiatives aren't on this map?

CHAIR BELLA: They are not on this map.

COMMISSIONER CARTER: Okay.

CHAIR BELLA: They're certainly in some states, Martha. There are MMPs and D-SNPs and regular MA plans. So I think in the future, if we wanted to, we could layer MMPs on here. It's not a mutually exclusive thing in most states.

COMMISSIONER CARTER: Okay. We do have a map on that. I'm just trying to get it all straight. Thank you for that overview, but I got stuck on where are the FAIs.

CHAIR BELLA: Yeah.

Kit?

COMMISSIONER GORTON: So I just want to underscore, Melanie, what you were just saying. So what we've been focusing on is integration of payment. I don't think for a moment you can say that MMPs are more clinically integrated than other models, and the MMPs are perhaps not more administratively integrated. So you have these pieces of the program operation, how it gets paid for, how they build a network. That's part of the

administrative piece and appeals and grievances and all of those other things.

And then there's the real work that clinicians do with the beneficiaries out in the field, and those are three different -- if you think about a three-dimensional schema on top of Melanie's payment, we would have the other layers. So that's where some of the confusion around integration comes because my experience is that when you go out and you talk to ACOs and other more clinically oriented organizations, what they're thinking about is clinical integration.

Remember when we talked this morning about Part 2 and people getting substance use services. That was less of a conversation about payment integration. We had a little bit of a conversation about administrative and operational integration, but the real focus there was clinical integration and how you get people the services they need.

I think at the risk of falling into the theory of everything, I do think it's important that we keep those things, and it may be useful, actually, to somehow draw a picture so that people can know what we're talking about.

CHAIR BELLA: Darin and then Bill.

COMMISSIONER GORDON: Just to add some further color to that, Kit, I don't disagree with you, but we saw this even back in the day of just integrating physical and behavioral health and looking at a lot of different research that was done back in the day that said if you ever hope to get to clinical integration, you have to somehow simplify the different folks involved in payment. So it's an enabler, I think, when you take out some of the sophistication of having to do with two different entities with different rules, with different relationships.

What we had always thought about is if I can simplify at that level, then it allowed providers to start going in a path to more clinically integrated offerings, which we did, in fact, see.

So I totally agree with you how to think about it, but I did want to make that one caveat that if we ever want to see clinical integration, if you keep these things separate, your chances of getting there are much more complicated.

COMMISSIONER GORTON: Oh, I agree, 100 percent. It's just I think as we are communicating to the broader

audience, we need some modeling, some level of precision in how we talk about it so that people understand, because I've been out talking to ACOs, and they're just like, "There's no integration going on here." So that was just the point that I wanted to make, but I agree with you, absolutely.

CHAIR BELLA: Bill.

COMMISSIONER SCANLON: Today's my day for derivative comments, since I'm going to follow on Darin on exactly the same point. I mean, to me -- and I'm not a duals person so I may be sort of going beyond what I know -- the issue is that Medicaid's instrument is payment, okay, and differences or separations of payments has been perceived as a barrier. And so overcoming that sort of barrier by integration is a premise. Can this promote the clinical integration that you're talking about ultimately?

Having said that, then there's this question about, is the form of integration important in terms of promoting what you want, okay, because, I mean, I've heard about these different arrangements, and, I mean, sometimes I hear about two checks, you know, and basically we're integrating two flows but they're not totally just becoming

one flow.

And so there is that question of sort of how do you integrate, using your instrument, which is payment, to accomplish what your goal is, which is clinical integration.

CHAIR BELLA: Okay. We're going -- I took us down a bit of a rabbit hole, kind of trying to use the continuum to explain these colors and these dots, but let's circle back to these maps and this sort of level-setting for us and see if there's any questions we have on these in particular.

If anybody want to go through any of them again or have any questions about, basically, as we seek to make recommendations and try to understand where we should play in this arena, if we believe that we want to be creating more opportunities for integration, like this is a good view for us of where are we starting, right. This is what this is intended to do, and so let's close out with any -- we'll get to all the meaty, substantive comments, but any other questions about this or any additional information that folks would like to have, while we have Kirstin and Kristal on this piece?

Peter.

COMMISSIONER SZILAGYI: Yeah. This is actually really helpful for those of us who don't live duals. And I know you had a little bit of this in the chapter, but it would be helpful for me, in terms of the big picture, to try to get a sense of what percentage of the nation's overall duals are in green, or in different areas. And you had kind of pieces of that in the chapter, or the potential duals. So what's the, you know, the current duals or who could be duals, just in terms of the magnitude of the issues and the potential improvements?

DR. VARDAMAN: Sure. I know we had pieced it apart, but are you asking for -- we could put it all together and show like how many counties, how many duals there would be --

COMMISSIONER SZILAGYI: So at the national level.

DR. VARDAMAN: Sure. We can -- we can --

COMMISSIONER SZILAGYI: It would be helpful for me.

DR. VARDAMAN: We can definitely sort that out.

CHAIR BELLA: You would think that would be the most straightforward answer in the world, and it's not

quite, but I think they have information that can help give you a sense of magnitude.

Stacey?

COMMISSIONER LAMPKIN: I just -- it just jumped out at me, the white box in the Northeast, which appears to be white for all of the different models, even FAI. Is that Vermont and New Hampshire total states? Is there any particular insight as to why there's no models in either one of those two states?

DR. VARDAMAN: I think Brian looked like he might have something.

COMMISSIONER BURWELL: Well, Vermont is single payer, so they don't have any medical and they had a MLTSS program for a number of years. But they're having significant issues with just their regular managed care initiative, because they don't pay anything. So if you can't do regular managed care then MLTSS is even more of a problem. I mean, they have an intention of doing it at some point, but they haven't gotten very far.

COMMISSIONER LAMPKIN: Okay. Thanks.

CHAIR BELLA: But when CMS offered states an opportunity to do one of the demonstrations, Vermont was

very interested, but Vermont has a very unique model. And so Vermont was more interested in managing the totality of the benefit and the dollars and pulling Medicare in, and having the state be the integrating entity, and that was -- they were just a little bit ahead of their time.

So I think the interest is there in figuring out how to make it fit for their specific circumstances, has been challenging.

CHAIR BELLA: Did I miss a hand over here? No. Anyone else, questions or comments?

[No response.]

CHAIR BELLA: Toby, you want to explain why California isn't more colorful, since you have over a million duals there? No? Pass? Okay.

[Laughter.]

CHAIR BELLA: Anything else from the two of you on these maps? Anything that jumped out to you as surprising?

[No response.]

MS. BLOM: Oh, you mean in the work or in what you guys have said today?

[Laughter.]

CHAIR BELLA: The second is probably a loaded question, so in the work.

MS. BLOM: The only thing, I thought it was interesting to see the demonstrations, to compare the maps, the national map versus the county map. I tend to think of them as, oh, you know, X state does this so that's the whole state, but of course that's not true. And although the demos are generally concentrated in areas where the population is concentrated, it's still not in the entire state. So it's helpful to think about only, you know, 9 or 10 states participated in that, and then within that it's not across the whole state. So it's not as extensive as, you know, I sometimes think of it.

DR. VARDAMAN: I'd say I was a little surprised about, looking at the D-SNP map and some of the areas that aren't covered. I'm sure Chuck could give us some insights on some of that. But a lot of states that where, you know, it's not state-wide, but it is state-wide in other states with large rural areas. So some of those things jumped out to me.

CHAIR BELLA: Okay. So now that we've set the stage and you all can reference yourselves as duals people

now, you are ready for the next part of this discussion which is to really get into policy options. So as was noted in the intro to the --

VICE CHAIR MILLIGAN: I had a couple of comments about that. I didn't know we were jumping to the next part of the agenda. I did have a couple of comments. All right. I'm not following the thread very well. My apologies.

Kristal, to your last comment, there are just some states that haven't -- have misunderstood authorizing D-SNP as imposing a burden on Medicaid, and because they don't have MLTSS they just decided they don't want to go there, and, you know, I think the Dakotas, Nevada, some of the ones that just kind of represent that.

But a couple of specific comments. I just want to highlight, if we can maybe just go back to the last slide that was up for a second. And again, I just want to -- this is me trying to help frame a little bit of what's coming next. So just the map, the overlay. Again, my apologies for not following the thread for the sequence today.

One of the things I just want the Commissioners

to keep in mind is the vast majority of dual eligibles on the Medicare side continue to be in fee-for-service Medicare. So I just want to focus on the word "availability" here, because availability of integration doesn't equal integration. There are a tremendous number of dual eligibles who are in Medicare fee-for-service or in MA plans that aren't D-SNP at all or MMP. So just -- when we talk about integration, we're talking about a subset of people who are choosing, on the Medicare side, to be in some form of integrated model.

The second comment I want to make is, when we talk about integration, and as we get into kind of the next part of the agenda, partial duals who don't have full Medicare benefits, there's not as much to integrate to, because they're not eligible for Medicaid long-term services and supports. They're not eligible for Medicaid special behavioral health. They're not eligible for Medicaid.

And so I just want to help keep in mind, for framing integration as a topic, that you really need to be getting full Medicaid benefits to have something to integrate with, in terms of benefits and models, clinically

and otherwise.

And I guess the last sort of framing comment I want to make is, there can be an individual who is one of these counties that has access to Medicaid MLTSS and access to a D-SNP, and that they happen to be in different organizations for the two. And so don't -- I think we should also recognize that if it's not a FIDE type, where you kind of really need to be in the same organization, somebody can be in a D-SNP with one health plan and an MLTSS for a different health plan. There is a path about how to coordinate care, and there's a lot of work on the federal side and the state side to deal with that, but the fact that they overlap doesn't mean that even somebody who chooses to be in a D-SNP is in the exact same parent organization as who they are getting Medicaid from.

So I just wanted to frame up those pieces heading into the next part of this.

CHAIR BELLA: Thank you, Chuck. We are ready to go into the next part. I just want to remind Commissioners what our purpose is today. So several of these topics that are about to be presented have been discussed. A few of them have reached a point where we have had comfort saying,

yes, we want to make a recommendation in this area.

The recommendations that we talk about today will be for the June report, which means we would be voting on them in April. And so as Kirstin and Kristal will go through, we've kind of bucketed the potential policy options and we will have discussion around those things. But keeping mind some things have had more discussion in the past than others, and there's a meaty set of policy options that we haven't had much discussion about, that we'll spend the majority of the time focusing on today, I believe. So thank you.

POLICY OPTIONS FOR INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES

* MS. BLOM: Thank you. So as Melanie said, now we'll turn to the options themselves.

So just to do a quick review of where we've been, we did start talking about some of these in December, as Melanie said. Those are the ones we'll kind of not spend a ton of time on today.

And for February, Melanie also sort of covered some of this, but we're planning to do these three things that are listed here. We do have some work ongoing right

now, contract work, looking at D-SNP lookalike plans, which is kind of an ongoing or growing concern for policymakers about how those might be drawing people away from integrated products.

We're also going to be bringing the specific language, draft language for recommendations to potentially be included in the June report, and we'll talk about which ones of the options fall into that bucket. But that -- you'll be seeing that in February, to then vote on it in April.

And then we'll continue our discussion of other policy options. So we do have a lot of options to share with you today. We're not planning, you know, for you to make decisions on all of those today. We are hoping to include -- we see some of those potentially being in the June report, but we see this as a broader project that will continue probably into the next meeting cycle.

So these are the groupings Melanie mentioned. We have 14 options grouped into these buckets. The first three are thematic groupings, so all the options in the first group have to do with encouraging more enrollments. The second group is making integrated offerings available

to more people, promoting greater integration among existing offerings, and then the third one is this sort of create a new program for the dually eligible population. There's only one option under that, which is the same as the name of the group.

I'm going to walk through options in the first two buckets and then Kristal will take us through the last two and talk about next steps. All of the options are numbered, so hopefully that will help us refer back to them as we go through these.

So this first one is one that we talked about last time. This is just a modification to the new special enrollment period for 2019, which, from what we heard last time, Commissioners seemed interested in pursuing.

The second option is to allow states to passively enroll beneficiaries who have previously opted out of passive enrollment. This is currently prohibited in the financial alignment initiative. There is an idea that it would give -- that passive enrollment gives beneficiaries a chance to experience integrated care before making a decision to stay or not stay, so that's the thinking behind that one.

The third is addressing the role of enrollment brokers, of Medicare enrollment brokers. We've touched on this topic, I think, many times, but wanted to, you know, list it here for you guys. This would be something that we would need to do some additional work on.

The final one here is creating a common enrollment period. Medicare Advantage and Medicaid managed care often have different enrollment periods. Medicaid's enrollment periods are sometimes different for populations within the Medicaid program. So this is something, again, that we've touched on, but something that we could spend some time on, to the extent you guys are interested.

So making offerings available to more people, we have enhancing state capacity to implemented integrated care. This has to do with states' concerns around their limited capacity on Medicare. We also talked about this in December. We heard, actually, from some of the state folks that spoke to us about their concerns around this issue.

Encouraging the development of non-capitated options. CMS has put out guidance giving states the option to do a managed fee-for-service type of model, like Washington has done, or something else along those lines.

This would involve potentially -- well, so actually I should back up. So numbers 5 and 6, one question here is around the financial aspect of it, so that is something that we'll have to think about, and Kristal will talk a little bit more about that. But this one related to non-capitated options might include a component of additional funding for states to act as a bridge for them.

Creating permanent authority for the Medicare and Medicaid plans. As Melanie mentioned, that's a really highly integrated model, so it might be something that we would like to take out of a waiver or a temporary authority, get rid of the need to continue extending those models.

And then encouraging states to use MIPPA authorities, those existing authorities available through MIPPA. States could maximize that authority. There are minimum requirements in MIPPA but then states can go way beyond that.

And then, finally, allowing D-SNPs to operate in areas where they can meet Medicaid network adequacy standards, even if they cannot meet the Medicare standards. And with that I'm going to turn it over to Kristal to talk

about the other two buckets and our next steps.

* DR. VARDAMAN: Thanks. The next bucket is about promoting greater integration among existing options and offerings. Option 10 is to limit enrollment in D-SNPs to full-benefit dually eligible beneficiaries. As plans cannot integrate benefits for dually eligibles beneficiaries but for partial-benefit dually eligible beneficiaries but whom are still part of the model of care that plans establish.

Option 11 is to limit D-SNP contracts to companies with MLTSS contracts, to encourage integration. A disadvantage to this option is that it could like further incentivize the growth of D-SNP look-alike plans, so Commissioners may want to consider this along with Option 12, which is to require that D-SNP look-alike plans meet certain D-SNP requirements.

As Kirstin noted, next month we'll be bringing you the results of some contracted research on this issue so the Commission will have some more time to have an in-depth discussion then.

The next option is that states can increase integration by approving default enrollment of Medicaid

beneficiaries into D-SNPs. And as we note in the memo, things like data sharing and prompt eligibility determinations can facilitate default enrollment.

And then this final option is a new program for dually eligible beneficiaries. Any decisions would have to be made about factors such as financing, how do we administrate it, and how beneficiaries are transitioned onto a new program.

Looking ahead to the June report, we're hoping today to get your feedback on how we should prioritize these policy options. Some may be ready for recommendations in this report while others we might highlight as areas of interest for the Commission but hold recommendations until the next report cycle.

You might also want to take some options off the table, and we also wanted to note that the Commission can always have a substantive discussion of the advantages and disadvantages of options in the report, even where a formal recommendation is not made.

And on the next few slides we have reorganized the options. So this time they are organized by their stage of development. So I'm going to put these up

quickly, and we can go back and forth in the slides, as needed, during the discussion.

So this first group are things that we think the Commission could include as recommendations or areas for recommendations in the June report. This would include some things we've talked about several times over this report cycle, and this includes changes to the special enrollment period, funding to support state capacity, and encouraging the development of non-capitated options.

On these final two, 5 and 6, there are some decision points still to be made on how best to achieve those. So, for example, whether funding could be provided through a grant program versus an enhanced FMAP. So we look forward to your feedback there.

The second group are areas where staff feel like there is some more work needed to be done before the Commission may be ready for making recommendations, but are a number of things that you've discussed throughout the past several months. Some of the work that we could do here would include reaching out to states and other stakeholders to find out about their experiences and get feedback on some of these options.

And the final group are areas that are in earlier stages of development, some of which might require some more in-depth analytic work, could possibly require some contracts, and there are also some of these things here also have a lot more of the overlap with Medicare policy, that we can further discuss.

And with that I will turn it over to Melanie.

CHAIR BELLA: Thank you very much. Really nice work. Thank you. It's a bit overwhelming, I'm sure, but quite a nice problem to have, to have 14 options to be discussing. In addition to taking some off the table, if there are things that we want to put on the table, we can also talk about that as well, although personally I think you've done a great job of putting a very comprehensive set in front of us, that are sort of micro and macro, and so thank you very much.

Let's try to see -- I'm going to talk about Group A, because I think that requires the least amount of discussion. These are ones, again, that we've discussed as a Commission. It does sound to me like the biggest question for us is if we're -- so the first question is if there are any concerns with these, we should raise those.

Second item for discussion is talking about if we are going to recommend some sort of enhanced funding, if we want to recommend that that's through a grant or through enhanced FMAP, or if we just -- if we could recommend that Congress investigate either. I mean, there's any number of ways we could take that.

I will remind folks in the financial alignment demonstrations the mechanism was to give each participating state a grant of $1 million, and they use that -- most of them, I believe, use that to hire staff. Some of them use that to bring in contractors to help them with rate-setting or analytic work. In any event, the $1 million, which is not a big amount in the grand scheme of things, was a big amount for these states to be able to sort of move along.

And so I think we could think about, do we want to model some enhanced type FMAP thing similar to other programs that we've used enhanced FMAP in, or do we want to create some sort of option for grant funding.

Either way, the result is the same, to try to get dollars to help the states.

Martha?

COMMISSIONER CARTER: So do we know whether that

million-dollar, one-time funding was enough to allow the states to continue their programs? And also, if there's an FMAP bump, was it time-limited? Was there an FMAP bump?

CHAIR BELLA: There was not an FMAP bump in this.

COMMISSIONER CARTER: Okay.

CHAIR BELLA: Go ahead.

EXECUTIVE DIRECTOR SCHWARTZ: Well, so I was just going to provide a little bit of context on past things that we've done that don't necessarily bind us for what we're doing going forward. When we did the CHIP work, there was a recommendation to create a children's coverage demonstration grant program for planning and implementation, and we did not specify in that recommendation the dollar amount.

I don't have the chapter in front of me. I think we might have used some illustrations in the rationale to talk about it, but we didn't say it should be X-million dollars total or X-million dollars per state.

The other thing I was going to mention, to Martha's point, and it's mentioned in the materials, is on the health homes option that was created by the Affordable Care Act. There's an FMAP bump in that for the first two

years and then -- and, again, meant to support sort of the startup costs, but it's not an FMAP bump in perpetuity. So just some context for your consideration.

CHAIR BELLA: And I imagine -- you check me on this, if this is wrong -- we could also indicate we're interested and have you all bring back a couple of different options that we could discuss in February as far as how we might want to word a specific recommendation.

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

CHAIR BELLA: I don't want to kill a ton of time on kind of a nuance of whether it's a two-year thing or a million dollars or $5 million. I would trust the staff to bring that back to us, as long as there's support for that.

So if anyone has strong feelings for or against or strong feelings in what mechanism you would like to see it take, then we should hear that now. Any takers on that?

Darin.

COMMISSIONER GORDON: I like your idea of having the staff come back with different options for us to consider. I think that's probably the best use for our time, and then we actually have something concrete for us to react to.

COMMISSIONER SCANLON: This is about one. It's actually trying to understand sort of what one truly means, and I think in reading the text that, currently, one has the option of joining every quarter. Is that correct?

MS. BLOM: Yeah. You've got three -- you can join for the first three quarters. It used to be that you could join anytime. The narrower SEP, the new one for duals, is three times a year.

COMMISSIONER SCANLON: Okay. I mean, I guess when we talk about anytime, I think, administratively, we're probably thinking about it could be on a monthly basis. The issue is that's the gain.

Then I guess the second issue is, is there an implication here about opting out? Is one then able to opt out at any time?

CHAIR BELLA: I think the work has been to allow opting in to the integrated program. The opt-out would continue on the same cycle. So it would be now once a quarter.

COMMISSIONER SCANLON: Okay.

CHAIR BELLA: That's my understanding of where this work has gone.

Is that correct?

MS. BLOM: Yes. That's right.

COMMISSIONER SCANLON: All right. I just think we need to be clear about that because otherwise, if you're allowed to opt in at any time, then aren't you allowed to opt in to a different plan at any time? So there would -- as an implication for opting out.

CHAIR BELLA: Yes. We can clarify. The intent of this is to allow more people in and not to make it easier, not to go back to getting out, jumping around every other month, but to not lock somebody out if they want to get in, in a given month.

Stacey.

COMMISSIONER LAMPKIN: This would only apply to MMPs, not D-SNPs, the way it's framed right now. Can we clarify why it's set up that way?

MS. BLOM: The MMP states are the ones who opted out of the narrower SEP, and the reason, we think, is that they were concerned about people not being able to come in. So this would be targeted at those states that opted out of the narrower version. They would presumably come in if

people could opt in at any time.

CHAIR BELLA: This makes perfect sense, doesn't it?

[Laughter.]

CHAIR BELLA: It actually does make sense in the ill-sensical world that we're in, right?

Does that answer your question, Stacey?

COMMISSIONER LAMPKIN: Yes. I hadn't picked up on that twist in my reading, so thank you.

CHAIR BELLA: Okay. We can cycle back to any of these at the end. I'm going to suggest that we move these along.

You two have what you need from us as far as next steps on this?

DR. VARDAMAN: Yes.

CHAIR BELLA: Okay.

COMMISSIONER BURWELL: Can I ask a question on this? So I see a relationship between Option 1 and Option 4. Option 1 is limited to MMPs; is that correct?

CHAIR BELLA: Correct.

COMMISSIONER BURWELL: Not to MLTSS, D-SNP combinations.

CHAIR BELLA: Option 1 is to solve the problem that they just explained with the MMP states.

COMMISSIONER BURWELL: Right.

Option 4. So like the model that I'm more familiar with is mandatory MLTSS with an option of also enrolling in an aligned D-SNP.

CHAIR BELLA: Option 4 is about the period in which people make choices.

COMMISSIONER BURWELL: Right. So --

CHAIR BELLA: Not so much No. 1. So it would be aligning when you're making a Medicaid choice if it's aligning it with a Medicare choice, period.

COMMISSIONER BURWELL: What if Medicaid is --

CHAIR BELLA: In MMP states, you're not even doing that.

COMMISSIONER BURWELL: Right.

My understanding is that many states that use the mandatory MLTSS with the D-SNP option, you can or can't -- you know, you can choose to enroll in the aligned D-SNP or not when you're enrolled in --

CHAIR BELLA: But you can't choose -- why don't we go ahead. Can we put A to bed and move on to B?

COMMISSIONER BURWELL: Okay.

CHAIR BELLA: Okay.

COMMISSIONER BURWELL: I'm just saying --

CHAIR BELLA: Let's move on to B.

COMMISSIONER BURWELL: -- I see they're disconnected.

CHAIR BELLA: Let's give us a little refresher on No. 4, and then let's finish this conversation.

COMMISSIONER BURWELL: Okay.

MS. BLOM: So, basically, No. 4 is trying to make consistent when people enroll in Medicaid managed care with Medicare Advantage.

So Medicare Advantage has very specific open enrollment periods that occur at the same time every year, and Medicaid doesn't always -- Medicaid managed care doesn't always follow that. And Medicaid might even have different enrollment periods for different -- like for the new adult group versus a different group or different periods in part of the state. This was just meant to sort of bring Medicaid in line with where Medicare Advantage is and make it a more standardized thing. That's different from a special enrollment period that we were talking about

before. This is broader.

VICE CHAIR MILLIGAN: I can give an example about what this -- with Medicaid managed care, I'll use an example from a state I'm familiar with.

On the anniversary of when your eligibility started -- so let's say your eligibility started March 1st. On the anniversary of that, that's when you have your open enrollment period for Medicaid if you want to switch MCOs, and yet that's not synced up with AEP or open enrollment for Medicare. So if you want to jump from your Medicaid health plan to a different Medicaid health plan and you want to jump to the new health plan's related D-SNP, you can jump on the Medicaid side, but you can't jump at the same time on the Medicare side to stay aligned.

So I think what four is getting at is to align the open enrollment or the plan selection between the Medicaid MCO sort of schedule and the Medicare schedule, so that you're not asynchronous, switching Medicaid plans because it's March 1st on your anniversary and yet you've missed the window of opportunity for AEP. I think it's getting at that so that you can switch both programs the same time.

MS. BLOM: Thank you, Chuck.

COMMISSIONER BURWELL: I can give a different example. So the state I know about is Pennsylvania. So you're not a dual. You're just Medicare only, but then you develop a need for LTSS. You apply for -- I need LTSS. In order to get LTSS, you need to apply for Medicaid. So they applied for Medicaid. Once you are eligible for Medicaid, then you have to go into their MLTSS program, so CHC, three choices, wherever you are.

Each of those Medicaid plans has an aligned D-SNP. So, okay, you're enrolled in -- you get to choose your Medicaid plan. You also can enroll in the aligned D-SNP at that point when you come into the program. You're allowed to.

VICE CHAIR MILLIGAN: If you become a dual because of MLTSS, but if you're not -- I mean, it's just it's --

COMMISSIONER BURWELL: Okay. There's nothing preventing people now from enrolling into a D-SNP at that point, anytime of the year.

VICE CHAIR MILLIGAN: If you're in a separate MA plan. If you're not in a D-SNP, you're just in a regular

MA plan and then your MLTSS eligibility kicks in, it doesn't mean Medicare is going to let you change --

COMMISSIONER BURWELL: Change to --

VICE CHAIR MILLIGAN: -- to D-SNP on the Medicare side. Yeah. I mean, you'd have --

COMMISSIONER BURWELL: Not until --

VICE CHAIR MILLIGAN: It's subject to Medicare SEP and Medicare AEP.

COMMISSIONER BURWELL: What if you're in an unaligned D-SNP? Can you switch D-SNPs?

VICE CHAIR MILLIGAN: I'm going to stop being a staff person for a second here.

[Laughter.]

MS. BLOM: If you're in an unaligned D-SNP, can you switch?

COMMISSIONER BURWELL: Well, no, you're not a dual. So you can't be in D-SNP. Okay, I got it.

CHAIR BELLA: Let's set the stage here for just a second. Of all the things that are on this list, this was not one that the Commission has been super excited about. This is not something, to my knowledge, that we've heard from states about as a problem, and this would actually be

-- all of the burden for doing this would be on the state.

So I just want us to keep that in mind. What we need to do about B is figure out there is -- many of these things on B and C where the next step is go talk to states, right? And we need to have some understanding of where's the bang for the buck and which things do we want to go talk to states about. And so I would encourage you not to consider this like we're solving what the solution here is. It's really are we advancing it to the next level to say we want to find out more about this. And so I do think we should talk about these and then come back and say, yeah, of these, these kind of rise to the top, and these might be nice to talk about later, but they may not be as potentially impactful.

So I would say we're going to move on from this one; otherwise, we're never going to get through them, unless somebody has the most important point in the world to make on this. There's three hands over here, if any of you fall in that category.

[Laughter.]

CHAIR BELLA: Bill?

COMMISSIONER SCANLON: Well, I just think -- I

thought -- I mean, maybe my information is out of date. I thought Medicare does have rules for how Medicaid eligibles can move in and out of MA, and so that there is more freedom, and this may be more of a state issue than it is a Medicare issue.

CHAIR BELLA: This is 100 percent a state issue.

COMMISSIONER SCANLON: Okay.

CHAIR BELLA: The state is the one that would have to move to Medicare. Medicare isn't moving to the state.

COMMISSIONER SCANLON: Okay.

CHAIR BELLA: Okay. We are going to go back up to the top, so number two is about passive enrollment. Just to remind folks when we had -- this was discussed at one of the panels, as was mentioned. People have strong feelings about this on both sides, and so the question here is: Is this something that we want to go gather more information on, that we want to understand is this a huge problem, and would this help us significantly in increasing enrollment in these programs? And the notion, again, just to make sure everyone understands, is that this, again, is for the financial alignment demonstrations only. When the

passive enrollment happened and people were put in the demonstration with the chance to opt out, there was a requirement that if someone has opted out, they never could be eligible for passive enrollment again, the belief that they made their choice and the state wasn't going to be able to passively enroll them again.

There has been discussion about reopening that because some of these folks may have been offered this product five or six years ago, and the question is: Would the state be allowed to passively enroll them again? Also, they would still have the chance to opt out, but that's not what the original policy was. And so the question for the Commission -- and we're going to come back to all of these. This is just for the discussion. Is this something we think is worth kind of our time and attention in talking -- we would want to talk with beneficiary advocates. We would want to talk with states. We would want to talk with plans. So that's what this one is.

EXECUTIVE DIRECTOR SCHWARTZ: Could you also -- modify this so you got a second crack at this. It's almost like you wouldn't want to be doing this every single year. Like now we've had five or six years, the models are more

mature, you know, things have happened, change of policy. But you wouldn't want to be putting people into a situation where every year they're having to go through this rigmarole.

CHAIR BELLA: And you may remember when this came up a couple of -- when was that, November? When was Amber here? I've lost track. Sometime in the fall.

EXECUTIVE DIRECTOR SCHWARTZ: October.

CHAIR BELLA: October. There was a question about -- the states today have an option to do passive enrollment for people that are newly eligible, and there was a question of are they doing it today for that group. So, again, this would be one where we'd have to find out what is the demand out there by the states, what problem are we solving, and then we'd have to weigh that with concerns about beneficiary choice, particularly beneficiaries that have made a choice in the past to not be a part of this, no matter how long ago that choice was. Bill.

COMMISSIONER SCANLON: Yeah, I think this is one that needs a whole lot more detail in terms of how it might work, and this idea of a gap between sort of the times of

passive enrollment is potentially one key feature. You mentioned, I think, Kirstin, earlier, that if you do passive enrollment, it gives people a chance to in some respects experience integration. But if they've opted out after passive enrollment in the past, they already may have experienced it, and they've said, "We don't want this." So if there is that kind of a question, I think that the detail is going to matter.

The other thing that I do worry about this -- and this goes back to one of Chuck's comments -- when we look at Medicare beneficiaries by choice, where are they? Okay. Medicare freedom of choice has been a very strong tenet of the Medicare program, and so the question is how much this starts to straddle the area between Medicare and Medicaid. So that I think is something we have to -- and we should be thinking about what the details are, again, and have a discussion of that, because that's a part of -- would be a part of making a recommendation.

CHAIR BELLA: Yeah, and I think what we'll want to hear from the Commission is: Is this one of those ones we want to advance to have more work done to get into those details? And it may not rise to that level at this point.

Kirstin?

MS. BLOM: Just to add that I think part of -- this was born in part out of the idea that some people kind of opted out en masse on the advice of, you know, an external party, so maybe they didn't have the time to experience it. And now they're out; they'll never be enrolled again in this way. So just --

COMMISSIONER SCANLON: Right, and I understand the motivation, but I think in terms of specifying a rule, you have to bring into the circumstances that you're trying to sort of correct for as opposed to just having it too broad.

CHAIR BELLA: On this, Kit? Okay.

COMMISSIONER GORTON: So two thoughts. One, as you said a few minutes ago, people fall on both sides of this, and there are strongly held beliefs on both. There ain't going to be a consensus view on this probably in the Commission or anywhere else. And so -- and particularly since we're just talking about the MMP, I would question whether this is where we want to spend our time, energy, and what limited influence we have.

The second thing I want to say, going back to my

earlier multilayered approach to integration, I have a problem -- these people don't experience -- when members experience integration, they experience clinical integration. They don't care about payment integration very, very much. And Bill talked about two checks. It's a minimum of three checks, because Part D is different. And so what these people experience is essentially their provider's reaction to them being in the program. And that's not about integration. That's about provider choices and the kinds of advice they give to people.

Melanie said earlier -- and I agree with this -- that we should think about picking the ones here that are going to be impactful. And I just don't think this one's going to be impactful. I also think that there's a beneficiary advocacy argument in terms of these people made a choice. And there's nothing to stop them from choosing to go back in. Right? They can freely choose to go back in. So it's sort of a Brexit -- right? They chose to go out, for whatever reason, and they're grownups and they get to make those choices, or whoever made the choices for them get to make those choices.

So, personally, I would like to spend as little

time on this -- I've already spent more time on this than I want to, but that's just my point of view.

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: I can be persuaded, but I guess as much as I agree with that this is such a small group, this issue of passive enrollment, it's a perfect area to focus on. There was so much misinformation, and I could give many reasons why, Kit, you're wrong, that they knew what they were doing, that you could test by doing another round of passive, better understanding about this balance between choice and education informing and really seeing if we can learn more from realignment programs through more enrollment.

COMMISSIONER GORTON: Just for the record, I didn't say they knew what they were doing. I said they made a choice. If I sounded like I said they knew what they were doing, then I misspoke.

CHAIR BELLA: Okay. In the spirit of not spending too much time on this, moving on to the -- we have heard in, I believe, every panel we've had, someone has made mention of enrollment brokers in the context -- and these are Medicare enrollment brokers, so these are folks

who get a commission to put a person in a plan, and there oftentimes are not as strong incentives to put people or suggest that people might want to try an integrated plan. And in some cases, in some states, some of the integrated products like the demonstration products are not eligible for any sort of broker compensation, and so it could create sort of an incentive problem. And is there more of an incentive to put people in other products?

So what this recommendation is suggesting, if we said we were interested in this, then staff would go back and do a little bit more digging. There certainly is -- I think it's pretty clear, like what -- it would be -- there are a couple of ways we could go, whether it's regulatory and subregulatory or whether there's some funding to try to do some education about integrated products and try to make brokers more aligned with that.

So there's a couple things they could come back to us with, but, again, the choice for us right now is how much do we want to pursue this. And so do folks have questions about the intent of this or sort of the context of this? Bill.

COMMISSIONER SCANLON: When I read it, I think

there were two parts. One is the issue of regulation of brokers -- okay? -- which is that you just basically say these are the rules that you're going to operate under.

The second part was about the incentives that you create, and the issue that came up, I think, in the materials was did the incentives create sort of incentives for bad behavior. And so I think there needs to be attention paid to that, because to go to the monetary reward step is much further than going just to the regulation step. The regulation step, though, has its challenges in that you can put out regulations, but if you don't establish mechanisms to assure accountability, you haven't accomplished anything.

CHAIR BELLA: And this one is also -- my guess is we're going to head to -- when we get to C and we're going to start to get some things that have to do with the really tight Medicaid-Medicare sort of workings, like this is very conducive to that bucket of things, too. And so I think we can talk about it in that framework as well.

The next one, since we've talked about 4, we're going to go to 8. This is one where I feel actually the Commission has had a fair amount of discussion, and this is

really -- you know, states have an awful lot of lever or authority to decide how they work with Medicare D-SNPs and how that aligns or doesn't align with any sort of Medicaid integrated products. And, again, as we're thinking about continuums, there's sort of the bare minimum requirements that a state has to do with a D-SNP for the D-SNP to be able to operate. And then there are states that are really aggressive, and they're really using this MIPPA authority to require plans to share their Medicare bids or to do a lot of other things.

And so the intent of this recommendation is to, I think, send a signal that this is a pretty powerful tool for states and try to understand where states aren't using it, why is that? And what could we do to reinforce that this is a powerful tool and it could be used to drive integration?

This also will get into the discussion we'll have in a second about look-alikes and unintended consequences, because as states get more aggressive, on the one hand, about integrating, they could inadvertently then make it an environment where you would have look-alikes or other things pop up. So this will come up in that context as

well. But the intent of this, again, is really to shine a light on and to have the Commission give voice to using this tool pretty effectively. And this is a tool that Congress gave the states, and so I think it is appropriate for the Commission to think about kind of endorsing the use of that tool and kind of stepping it up by some states.

So are there questions or thoughts on number 8? Anybody have concerns about kind of pushing the use of MIPPA? Brian.

COMMISSIONER BURWELL: So I do think that one contribution we could make is to write a chapter or something that shows, you know, how to use MIPPA agreements to promote integrated care models. I would agree it's an extremely powerful tool. For example, some states say you have to have an MLTSS contract in order to be a D-SNP. I think there are five or six states that do that. I mean, that's another one of our recommendations. So I think there's an opportunity for a lot of guidance to states about the use of the MIPPA agreement as an integration promotion mechanism.

COMMISSIONER DOUGLAS: Yeah, I was just going to say I think it's really important for us to uncover both --

just to understand more why states aren't using it as well as we explore other ideas, like, for example, number 13, default enrollment, while there's a lot of value in doing it, there's unintended consequences for those D-SNPs that don't have a Medicaid contract. And yet you could -- if you could look at number 8 and understand why aren't they also at the same time taking into account some of the levers they could use with the MIPPA authorities to deal with that and be able to do both together, but without understanding the problem of why they're not using the full authority, we can't -- we're going to get stuck on some of these other ideas, I think.

CHAIR BELLA: Chuck.

VICE CHAIR MILLIGAN: I support including this for more analysis needed. I just want to point out that sometimes the risk, the unintended consequence isn't just kind of a look-alike piece, but if the way states leverage the MIPPA drives up the cost of doing business on the D-SNP side, it can also lead to challenges.

I will say, you know, some of what states are doing now are things like prohibiting the use of offshore resources to do claims administration, and states are also

mandating Medicare supplemental benefits. States are doing other kinds of things. And so to the extent that states are using their MIPPA authority to drive integration, I think it's worth looking at, you know, how -- like best practices, options, tools. I think that's all completely valid and fair game. But I do want to just note that some of the unintended consequences aren't simply that health plans say, "I don't want to be a D-SNP. I'll try this look-alike route." They might say, you know, "I want to support you, State, except you just added costs that are prohibitive in the context of what Medicare's going to pay me to deliver D-SNP."

CHAIR BELLA: Kit.

COMMISSIONER GORTON: So following on what Chuck said, which I agree with, another potential unintended consequence -- and we saw this with the rollout of the initial managed care programs in the '90s and early 2000s -- is if you crank up the requirements, then you drive consolidation and market access. And so then what happens is you get to a place where you only have three options to contract with in a particular part of your state, and one of them decides to exit or go out of business or whatever

else, and all of a sudden you've got market forces to deal with. We saw this in Massachusetts in the financial alignment as well.

And so if we create all the expertise in a small number of large, powerful organizations, then ultimately that drives cost as well. And so I think -- and it limits beneficiary choice, right? Because part of how the plans are going to control their cost is through their network architecture decisions, and they're going to choose -- they're going to build as narrow networks as they can get away with in order to drive volume and keep their cost down.

So I think we should talk about these things, but I think -- you know, a professor I had always said if you have a really powerful tool, that usually cuts both ways. And I think this is one of those cases, and it may be, to Toby's point, that what we find when we ask states, you know, why are you using MIPPA the way you're using it or why aren't you using it at all, we're going to find out that in some of their contexts it will cut the wrong way, which they want to avoid. They don't want to lose a plan. They have a key player that they need to keep in, you know,

these four counties or, otherwise, they don't have enough choice. When we talk about passive enrollment, you've got to have at least two plans to have passive enrollment.

So, anyway, I just think I agree we should do more analysis on this. I would like to have the analysis focus not only on the advantages and some descriptive work on why states have made the choices they've made so far, but also talk about some of these other potential downsides that might cause us not necessarily to encourage them to use the authorities, but to -- they should assess whether they are -- they could use these authorities to accomplish their policy goals.

CHAIR BELLA: Yeah, and to be clear, I think our contribution is understanding where the states are in that. You know, there's other groups, the Integrated Care Resource Center and the Center for Health Care Strategies, that do technical briefs on how to build a MIPPA contract. But I do think it would be helpful to understand the current thinking on a variety of states. Darin.

COMMISSIONER GORDON: Yeah, just a real quick comment. Kit, you were talking about one extreme of where it could go. I've talked to states who say they just sign

the MIPPA agreements that are put in front of them. They've never thought about using them as a tool. So I think there's that other end of the spectrum that I think is helpful to understand, because maybe the happy place is more in between.

CHAIR BELLA: All right. On number 13, can you just give us a brief refresher for the Commission on default enrollment? Because it's another one of those technical things.

MS. BLOM: So default enrollment is an option that states have. States have to approve default enrollments of Medicaid beneficiaries into D-SNPs. So D-SNPs come to them and then states decide whether or not to make that approval.

There's also some data sharing that has to happen in order for this to work, and states need to do things on their end, like promptly redetermine eligibility in order for the D-SNP to then meet the requirements in place around how much notification they need to give the beneficiary.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: Yeah. I definitely think we should do something here.

I think along the same lines, though, one thing that I've seen with this particular approach where the states have done it -- and I think there's been some early look at how these things will work, which I think is just helpful context. I don't think it's very well known, but when you do this, you know, it's when someone is becoming eligible for Medicare, but there isn't really an avenue, I guess, unless it's passive enrollment for folks who are already on your program -- they're already duals – to avail themselves of the same integrated product or the aligned product.

So I just think I believe default enrollment is a great mechanism for promoting some level of integration. I just think that we need to recognize there's a bolus of folks on these programs existing today that are already duals that then don't always have, you know, as you think about default enrollment also thinking about that group as well about what mechanisms do you have as a state for those legacy dual eligibles in your program to create opportunities for them to avail themselves of that same integrated product. That makes sense.

CHAIR BELLA: Bill?

COMMISSIONER SCANLON: Yeah. I think also default enrollment provides you an option to create an incentive for performance on the part of plans, that you can skew the default enrollment. It doesn't have to be proportional to all plans. It can be weighted toward --

CHAIR BELLA: Well, default would be making sure the person is in the same plan. So it would be going to a specific plan. You might choose to use it as a carrot or stick to say you're not eligible for default if you don't hit certain performance, but you wouldn't round-robin people into the plan.

COMMISSIONER SCANLON: So this is not the same as if someone is coming into a choice of plan. Okay.

CHAIR BELLA: This would be -- like say it's me and I'm in a Medicaid plan already and I become newly Medicare eligible. I automatically go in that Medicare plan, and I have the chance to opt out, but I'm going in because I already have a relationship with that plan.

And Darin's point is -- let's say like Darin already is in that same Medicaid plan, but he's already 68 years old. How does he know to get into that integrated product? The state doesn't have a mechanism to sort of

default-enroll him because he's already -- he's older than me. He's already on Medicare, so yeah.

Any questions on this one?

[No response.]

CHAIR BELLA: Now, this is nothing that -- we will come back to all this at the end, but what I am hearing from folks about the things on this list is not much interest in 2 or 4 and more interest in 3, 8, and 13. Again, we can come back to this, but just to sort of put a stake in that ground, that's sort of where I'm seeing people's interest as we're talking about potential impacts and other factors that we need to weigh.

So we will circle back around, and now we're going to go to Group C. Before we start on C, Chuck is actually going to propose adding two more to C. So let's get those in the mix before we talk about those that are on here.

VICE CHAIR MILLIGAN: Surprise.

[Laughter.]

VICE CHAIR MILLIGAN: I want to talk about MMP for a second. We touched on it a minute ago about the broker and the commissions, and I could have my facts

wrong, but I think there are a couple of other ways of improving take-up and state interest in MMP. One is availability of Medicare's frailty adjustor rates, and the second is making it easier for some of the supplemental benefits that are part of the Medicare Advantage D-SNP to be available in an MMP model.

So I think having supplemental benefits in the Medicare side, what you can get in a D-SNP or any MA plan, but are harder or maybe impossible in the MMPs. Again, I'm not an MMP expert like Melanie or many others -- and the frailty adjustment.

So I think there are improvements about MMP beyond permanent, beyond the broker issue, which helped with the enrollment side of it by having a sales force, so to speak. So I think the frailty adjustment piece and the supplemental benefit piece -- the frailty piece, which is a state incentive for the financing model, but the supplemental benefit piece, which is an incentive for enrollment. So just other types of MMP is --

CHAIR BELLA: Can you just explain -- [speaking off microphone].

VICE CHAIR MILLIGAN: There's a frailty adjustor

that is available, typically FIDE-SNP, and it has to do with -- and I'm going to oversimplify, but the proportion of members who are needing Medicaid LTSS. So it's related to a kind of acuity that would raise the Medicare rates because beyond even like regular risk adjustment or it's part of regular risk adjustment, maybe is a way to think of it, because of the composition of the risk cohort in that FIDE-SNP. And it's part of kind of PACE models and other things too.

The second kind of option -- and, again, this is not one I'm -- I'm not promoting, okay? But I just want to mention early on in Texas with STAR+PLUS, one of the things -- and Bill referenced earlier kind of Medicare freedom of choice. There are ways states can try to influence how that choice is exercised on the Medicare side, and one of the things that Texas did very early on -- so this is a long time ago -- is they said if you enroll in an aligned plan, we're going to give you extra Medicaid benefits. In Texas, it was at the time, people were limited to three prescriptions, Medicaid prescriptions a month, and they said, "We're going to remove that limit. You can get as many drugs as you need, Medicaid, if you enroll in an

aligned Medicare."

So I think part of integration is whether -- again, I'm not advocating this, but how states use waivers or plan design on the Medicaid side to influence take-up of an aligned Medicare plan because it will produce more Medicaid benefits in a tiered way.

So there's a relationship there that I just -- to me, this is like maybe not worth doing and certainly not worth trying to get primed for any kind of recommendation by April, but I just want to put out there that that is a tool in terms of state waiver tiering of Medicaid benefits to influence Medicare choice that I want to be explicit about.

COMMISSIONER GORDON: Other than an MMP, then, in essence, just thinking that through, then you're basically going to spend more money on Medicaid and yet not have a way to capture savings through the benefit of an integrated product. I'm just making sure I'm --

VICE CHAIR MILLIGAN: I disagree.

COMMISSIONER GORDON: That's what I'm wanting. I'm wanting you to make sure that I'm thinking about that correctly.

VICE CHAIR MILLIGAN: Potentially.

Let me just like talk, and again, I'm not -- sorry, sorry.

COMMISSIONER GORDON: No, I'm curious.

VICE CHAIR MILLIGAN: States increasingly, as we talked about in the Group B -- maybe Group A. I've lost track now, but how they leverage their MIPPA. States increasingly are trying to extract savings, from the D-SNP, or shift costs to D-SNP around like how D-SNPs do buying down Medicaid cost sharing or how D-SNPs offer HCBS-like benefits in a way that the state is trying to achieve its Medicaid savings by virtue of cost shifting out of D-SNPs.

A state presumably could say -- I'm going to use Texas, but, hypothetically, "We're going to give you unlimited Medicaid Rx" -- or "We'll change the Medicaid benefits structure if you enroll in a related D-SNP," and they could say to the D-SNP, "We're going to leverage the MIPPA to try to get the savings in the investment that we just made to drive integration."

These tools can kind of interrelate, but state driving take-up of an -- driving choice on the Medicare side to maybe flip somebody from being a Medicare fee-for-

service, they're choosing to be in a D-SNP because it will produce more Medicaid benefits.

I've already kind of gone further down this path than I intended, and we've got lots of other stuff to cover. But I didn't see that kind of approach reflected, and I just wanted to put it on the list.

CHAIR BELLA: So let me suggest that one way we might consider this is we might broaden -- so we talk about using MIPPA, which is a powerful lever. It could be that we're talking about state levers. One of them is MIPPA. One of them is default. One of them is Chuck's No. 16.

VICE CHAIR MILLIGAN: Waiver design. Waiver design.

CHAIR BELLA: Yeah. I mean, so it could be that we do a body of work in that area and kind of group all of those in that way.

Kit?

COMMISSIONER GORTON: And maybe there's a role for brokers there. You'd have to figure out how to pay for it and what it looked like, but maybe there's a way to create a broker incentive there that fits into some of the other pieces at a state level, because if the states can

figure out some way to have the brokers be helpful -- from now as the brokers are not incentivized to be helpful. So if the state could figure out a way to have the brokers be helpful again, it might capture savings.

CHAIR BELLA: We could also just ask MedPAC to recommend that brokers can't work with duals or something like that.

COMMISSIONER GORTON: I was going to say this before and didn't. I don't think we should say anything about brokers without talking to brokers because I think brokers have a legitimate point of view that we at least should take into account before we go very far down a path that's saying, you know, there's an evil empire.

CHAIR BELLA: Okay.

COMMISSIONER BURWELL: I'll be very quick.

So I have different kind of view of brokers. Most states that have MLTSS programs or whatever use enrollment brokers as an --

CHAIR BELLA: We're not going to talk about it.

COMMISSIONER BURWELL: We're not going to talk about those?

CHAIR BELLA: What we're talking about is

Medicare enrollment brokers.

COMMISSIONER BURWELL: I know. But I think to the extent that there are opportunities to get people into aligned Medicare plans, D-SNPs or whatever, the federal government could provide an incentive to states on the cost of doing that, doing that enrollment broker function.

CHAIR BELLA: Okay. The states are already required to have enrollment brokers, though.

COMMISSIONER BURWELL: Yeah. But they could get an enhanced FMAP to the extent that the enrollment brokers are also counseling people about integrated care.

CHAIR BELLA: Okay. Group C. Again, the kind of bar here is what do we want to investigate further, and several of these group together. So, especially, like 10, 11, 12, all carry around a common theme, but No. 7, just for context, the MMPs are the demonstration plans, the financial alignment initiative, whatever you want to call them. They are authorized under innovation center authority, which means they're time-limited. The states that have wanted to renew their demonstrations have gotten approval from CMS to renew their demonstrations.

It's sort of the similar kind of thing that was

happening with D-SNPs before they were permanent. There's some uncertainty with states and MMPs about how do we know if it's going to get renewed. Do we want to keep investing in this?

So the reason to pursue this would be if we believe that permanency would increase investment in these programs and perhaps bring new states to the table, who aren't doing it now because they're not sure if it's going to be stable.

The reason not to do it is because there is a vehicle -- the reason not to do it would be because we don't know if they're working or because there is already a vehicle through the innovation center to allow innovation center demonstrations to become permanent. It's just it's a little more awkward with this one because it's not like it's a uniform demonstration. These are state-specific demonstrations, and so kind of passing that test for the Secretary to be able to make them permanent may be a little more tricky here.

Again, the point here is whether we want to look into this further.

The chunk of the things on this page, though,

have to do with inter-workings with Medicaid LTSS and D-SNPs, and we'll get to those in a minute.

But, Chuck, do you want to talk about No. 9?

VICE CHAIR MILLIGAN: Yes. Thanks, Melanie.

So this is a topic we've had come before the Commission a few others times.

A lot of times -- and it was on the map in your earlier presentation. I'll use New Mexico as an example. I'm really familiar with New Mexico.

There are counties where individuals are enrolled in Medicaid LTSS, but there aren't D-SNPs. And those counties are basically unable to meet Medicare's network adequacy standards because they tend to be rural and frontier counties. They don't tend to have the specialist and subspecialist that Medicare uses to assess network adequacy, which tends to require the specialist and subspecialist be in the county, not just having access in some other county.

So I think one of the barriers to integration is you've got Medicaid LTSS folks who don't have a D-SNP available to them because they can't meet regular MA network adequacy, and I do think that it would help tie off

that requirement if either a D-SNP could use Medicaid network adequacy, for example, being able to get transportation into an urban area like a medical center where there are specialists, or other solutions like telehealth, et cetera, et cetera.

But I think the cleanest approach to allow network adequacy to be met in those kinds of counties where they are in MLTSS On the Medicaid side is No. 9. So that's, I think, the summary.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: I will give a good example of that where we almost weren't able -- we require plans to be D-SNP statewide, and in northwest Tennessee, where there's very little population out there overall -- it's down in Memphis and in Jackson -- there was a nephrologist that was holding all our plans hostage, and it was for like 200, 300 percent of Medicare. He's like, "No, I know you can't get this whole area without me," and so I think there's actually a cost savings component to this as well for doing something in this regard.

VICE CHAIR MILLIGAN: And part of it too, again -- this has come up in earlier Commission meetings -- is if

there's a dual access to Medicaid transportation benefit, they don't need to get to that specialist in their county. They have access to that specialist in the adjacent county. So, to me, I'm supportive of this for that reason down the road.

CHAIR BELLA: And there has been some use of this in the demonstration products, a recognition that a Medicaid benefit can augment on the Medicare, what would have been Medicare network adequacy.

If you guys go back on No. 9, I think it's particularly relevant to think back to those maps we looked at and think about some of those counties that don't have anything, and is this something that could help sort of unlock some of that? That, to me, is that these maps are particularly relevant to No. 9.

Okay. Ten, 11, and 12 all have to do with, again, the relationship between D-SNPs -- well, I guess not really 10 as much.

You also have heard us say in the past that MedPAC did a chapter in its June report that really dug into LTSS and the relationship with D-SNPs and FIDE-SNPs and partial duals and all of those sorts of things. So

this is sort of the Medicaid view of looking at those same issues.

So No. 10 would be saying that if you're a partial benefit -- if our goal is integration and if we believe D-SNPs are a vehicle for integration and if we believe there's not much to integrate for partial duals because they don't have the Medicaid benefit or the LTSS and the behavioral health that has been the focus of integration, then what this does is suggest that you wouldn't have partial-benefit duals in integrated D-SNPs because there's nothing to integrate.

So states have an ability to decide today if they want their D-SNPs to cover partial duals. This would be, though, a recommendation to have kind of a prohibition across the board on that.

Do folks have comments on that?

COMMISSIONER DOUGLAS: So what problem?

CHAIR BELLA: What problem are we trying to solve?

COMMISSIONER DOUGLAS: Yeah.

CHAIR BELLA: So problems around sort of the model of care, the integration, and if you have a plan

benefit package that's serving full-benefit duals and partial-benefit duals and the partials don't have anything to coordinate, I think the belief is that it's sort of diluting the coordination of that, and you want to be focused on integrating those services.

So for part of your population, you're running a fully integrated product with all of this stuff, and then on the other part, you're not. And it takes away from the ability to deliver the integrated product is what I hear the most, and that if we're looking at this as a vehicle for sort of treatment of special needs plans as special needs plans and vehicles for integration, there's nothing for them to integrate with this population unless they were to become a full-benefit dual. And I think the data show not that many are flipping from partial to full.

Chuck, do you have insight on that?

VICE CHAIR MILLIGAN: I have some insight on this, but I think this might be to me a Group B, because I think it would be good to know the implications of this kind of recommendation if we're heading down that path.

Just to be clear, I think partial duals ought to have access to D-SNPs. I might be in the minority about

that, but I will give an example to me of why it matters.

There are partial-benefit duals who might be QMB or SLMB, so sorry about the acronyms, but think of somebody at like 100 percent of the federal poverty level who is a dual eligible. They're not getting full Medicaid benefits.

The D-SNP might conduct a health risk assessment, might recognize that the person has ADL deficits, deficits in activities of daily living, and that, therefore, they might qualify for Medicaid long-term service and supports and then refer them to the state. And they might end up getting a state Medicaid LTSS waiver slot and become a full-benefit dual. They could flip to become a full-benefit dual, and I think a D-SNP is much better positioned through how the HRA is conducted, how that assessment is done, recognition of what the state LTSS benefits are, the state LTSS eligibility pathway for a waiver slot, and flip a person into full-benefit dual.

Now, there are people who convert like that, because they meet, then, the LTSS eligibility rules at a higher income level because of all of that.

But all to say I think it would be good to know what are the conversion rates, if we could find out, how

many partial duals would be affected or potentially not allowed into a D-SNP.

But there are certainly arguments on the other side, and I think Melanie kind of alluded to them really well. If there is no Medicaid benefits to integrate with, it's not an integration opportunity for partial duals. There's no LTSS or BH -- or behavioral health or other things for most of these folks to access, and so what exactly do we mean by integration?

CHAIR BELLA: There's kind of a --

EXECUTIVE DIRECTOR SCHWARTZ: I was just going to ask a question about that. I understand the point about how there's nothing to integrate, but my question is, how does that affect a D-SNP's ability to do its work for the full-benefit duals?

CHAIR BELLA: I think we could go into great detail on that, and I don't think we have time for that. I think if we want to do that, that's a question we should -- there are people that will give you an earful on that. And with an eye toward the time, I just think we should --

EXECUTIVE DIRECTOR SCHWARTZ: Well, that seems to me --

CHAIR BELLA: Right, I think that's obviously what we would want to understand -- right? -- is that. And part of it is the benefit package that they're providing. And so what I was going to say is two things. MedPAC, I believe, in the June chapter did look at the conversion or the flip from partial to dual, and I think they found it to be very low. We should check that and make sure, but I'm pretty sure that they did, because they did this recommendation, too.

There is a middle ground, right? One end is let them be in; the other end is don't let them be in. The middle ground is let them be in but have the plan have to have a different benefit package for the partials than the fulls. So you would not be mixing partial and full benefits in a D-SNP, but they could still be in a D-SNP, but they would be all partials in there. So I think there's flavors of things that we could look at here. Kit?

COMMISSIONER GORTON: A question. Is there a scenario where people flip the other way?

CHAIR BELLA: Full to partial?

COMMISSIONER GORTON: Yes. So an argument for continuity of care for beneficiaries, right? If you have a

beneficiary and we see this particularly with the pregnant moms, right? They'd be fully aligned with a case manager. Things were going great. And then their eligibility ran out, and you've got to cut them off dead until they enrolled in, you know, some other products and then you could put them back in.

So I think there are, from a beneficiary perspective, continuities that they might experience, particularly if they flip back and forth. I'd like to know what the flipping rate is.

Then one other thing. So I agree largely with what Chuck said, and we can take it up in more detail later. But I think we should look at it.

CHAIR BELLA: Thank you. Any analysis we would do, we'd want to look at direction, going both directions. My sense is people don't flip down much. But we should look at both ways.

The next recommendation, number 11, this would basically be saying if you -- just to remind everyone, to be a D-SNP you have to have this MIPPA agreement with the state Medicaid agency. And if the state Medicaid agency is running a managed long-term care program, what this would

say is only D-SNPs that were participating in the Medicaid managed long-term care program would be able to offer the Medicare benefit in that state. This is one that has like many layers -- right? -- that you'd have to uncover to understand what that would do.

On the one hand, it is a tool for trying to foster integration. On the other hand, there are lots of -- there would be disruption to people that are in different products today. So there would be a disruption effect, and there would be some unintended consequences probably at the same time that there were positive consequences. And so it's hard for me to see how we couldn't spend time digging into this issue as more and more states go down the MLTSS route, as we see more people choosing to be in Medicare Advantage, as we see more D-SNP look-alike activity. So this one would be one that, you know, we couldn't even scratch the surface on this today. We would want to put that in a bucket of this feels interesting to us, and this is going to be a chunk of work that's going to take some time. And I would say that that would be -- you know, in that chunk of work, we would also pick up like number 12 and things related to -- number 12 is specific to look-

alikes because this is -- it's all related to this set of policies on how we want to think about how Medicaid long-term care programs and Medicare Advantage D-SNP programs fit together.

So what do folks think about -- I'm going to put a pretty strong recommendation on the table that this is something that we should spend time on and that this would go into an area of work that we would ask the staff to begin to build out a plan of how we would start looking at this. Is there general agreement on that? Does anyone have any concerns with that? Fred is nodding his head. Toby?

COMMISSIONER DOUGLAS: I agree, and I think both it will help with number 14, build -- in order to answer some of these other questions, you've got to look at this. So there are huge underlying issues with both 11 and 12 that you can maybe try to solve on your own, go back to what we talked about with number 8, or it helps answer questions related to 14. So I think it's a must, as well as learning from the financial alignment because some of these issues and implications came up there, and how did states deal with it? What were the impacts during the

financial alignment of the D-SNP intersection?

CHAIR BELLA: Chuck, and then Brian.

VICE CHAIR MILLIGAN: Yeah, actually just a question. I want to just focus on the MLTSS contracts piece. More and more individuals are aging with mental illness, and I'm wondering whether we really mean only MLTSS or whether we mean like Medicaid specialty behavioral health, too, because there are more and more duals. Maybe they don't meet long-term service and support level of care, but they might have -- they might be aging with mental illness. And there is a value to integration with Medicaid because of Medicaid specialty behavioral health benefits that are not available in Medicare.

So I guess my question is: Do we really mean limit it to MLTSS or not?

CHAIR BELLA: My guess is we've just been using that as shorthand to refer to behavioral health and LTSS and all of those things. I'm seeing nods of heads. I think it is important. And we can start to call them out separately and not kind of do that shorthand.

All right. Oh, Brian. I'm sorry.

COMMISSIONER BURWELL: So 10, 11, and 12 are

drawn out of the MedPAC June '19. These are policy options that they presented in their chapter. So I just think include in the materials for the next meeting the rationale from MedPAC. They did not recommend, but they have an argument for each of these.

EXECUTIVE DIRECTOR SCHWARTZ: They didn't recommend them, but they didn't not recommend them.

COMMISSIONER BURWELL: Right. But they have a rationale for why they came up.

EXECUTIVE DIRECTOR SCHWARTZ: Yes, yes.

CHAIR BELLA: All right. Number 14 was raised out of -- I can't remember which panel. The first panel? The second panel? The Michael Monson panel -- as kind of all this stuff is nice, but do we want to think about a new program? And this is -- it feels like this is one that could be kind of in the back of our minds as we're working on these other things, very macro at this point, and will be informed, I believe, with the other work that we're doing. And so perhaps it's not one that we're saying to the staff go design a new program today, but it's one that we're saying let's periodically ask ourselves kind of are we ready to sort of be thinking more in this area. How do

folks feel about that approach? Any thoughts on that? Kisha.

COMMISSIONER DAVIS: Yes, I mean, I think that all of these other options are Band-Aids on a broken system, right? And so we keep talking about Band-Aids and fixes, and we're not ready to go there today or tomorrow or even next year. But if our guiding thought is how do we create a better program, I think that's something that we should continue to be looking towards and coming back to periodically on how we could get there and what that would look like and how do all of these other suggestions inform what a new or better program could look like?

CHAIR BELLA: Very well said. All right.

COMMISSIONER BURWELL: Are we likely to see the Leavitt report anytime soon?

CHAIR BELLA: Brian is asking about -- Leavitt Group has a duals coalition that's working on sort of what, if you were designing a program for people today that have medical, behavioral health, functional social needs, what would that look like? I think we can certainly make that request? I can't answer whether -- I don't know if it's imminent or not, but we can certainly make that request.

And I don't...

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, and then when we have Medicare for All, that solves the problem as well.

[Laughter.]

CHAIR BELLA: All right. It's a little bit harder for me to put a straw person thing on this one. I think I'm hearing, you know, full steam ahead on actually 9, 10, 11, 12, a real interest in 14, but we're not -- that's sort of as we build the rest of this. I don't have a sense of where people are on number 7, so I would ask if this goes in the category of obtaining more information or this is not something we feel that we need to be involved with at this time. Toby?

COMMISSIONER DOUGLAS: I guess part of it was back to number 7 and 14, because part of answering -- maybe we're not ready yet to say on 7 because we're not ready on 14 either, because, you know, where are we going long term? We're still trying to figure that out. Does that make sense?

CHAIR BELLA: Bill.

COMMISSIONER SCANLON: It seemed to me that the same concern you raised about 7 in terms of the Secretary

being able to specify -- well, CMMI being able to specify that they'd save money and, therefore, this could become a permanent part of the program, would exist if you tried to create a permanent authority. You would have to put boundaries in that permanent authority that would presumably be similar to what you would have if CMMI were to say this is not going to be part of the program.

So it's something that's potentially one to take on, but it doesn't have to -- the recommendation doesn't have to be create permanent authority. It can be a recommendation to CMMI that we [off microphone].

CHAIR BELLA: I think that -- yes. So why don't you give some thought to -- as we think about the landscape and this continuum of options, let's give some thought to as we're thinking about the future of D-SNP and LTSS, let's think about the future of MMPs as part of our broader where we're going. And then, Chuck, you had two friendly amendments or additions.

One, I think there is an option to think about using the one that you talked about as part of the state toolbox or the state lever box or whatever we're going to call it. The other one, do folks have thoughts on -- does

anybody remember what it is? And do folks have thoughts on which category it goes in? People's faces are telling me they're about dual'd out on this discussion.

VICE CHAIR MILLIGAN: Yeah, my comments were made two days ago, I think. I'm not quite sure. But just to strengthen MMP in general in terms of both take-up by states and take-up by individuals with the frailty adjuster, the broker commission that we talked about, and more flexibility about Medicare supplemental benefits, which is possible in D-SNP, not so much in MMP.

CHAIR BELLA: So I'm going to suggest -- yes, Toby?

COMMISSIONER DOUGLAS: I don't know if -- are you done?

CHAIR BELLA: Go ahead.

COMMISSIONER DOUGLAS: I'm just thinking still about number 14 because there's part of me that wants to move forward now, but I think really kind of back to this point of when are we ready to assess it gets to as you were describing the continuum of what's available now in fully integrated, it gets to the MMPs, and, you know, FIDE-SNP or those that are in Option 7. And so to me it's really

assessing to the extent that we're able to be informed on how to make 7 and 8, those options, as effective as possible, FIDE-SNP, MMPs, that answer -- you know, if we keep on getting stuck, that those offerings are not effective in driving through integration, then it gets to me the question of then we need to really look at number 14.

CHAIR BELLA: So I think what we are hearing is we need to keep MMP on the table, and we may talk about modifications or what MMP looks like, and that kind of takes on some of Chuck's things. We need to keep, obviously, FIDE and D-SNP and MLTSS interlocking on the table.

There's nothing to say that we can't talk this year about number 14, because it's going to take some discussion. And so there's nothing to say that -- I mean, we're going to vote on recommendations in April for June, but we can begin a conversation about what this looks like, and perhaps we invite folks -- it's not just the Leavitt Group that's been thinking about this. We invite others who can come in and talk to us about this, and that kicks off our thinking. So we could figure out something to

bring back to the Commission about kind of kick-starting that so that's happening in parallel while we're working on these sort of fixes. Kit?

COMMISSIONER GORTON: So I like where I think Toby was going, which is if you can accomplish everything you need to accomplish with the two current programs and strengthening MMPs and FIDE-SNPS, then you don't have to rebuild everything. If you get to a place where you can't make enough tweaks to MMPs and FIDE-SNPs to get the job done, then you really do seriously have to think about a whole new program. And so I just think if we have the conversation going with that sort of context, then we can talk about it, we can explore. You know, then we always have this ability to say, look, we can't fix this problem absent Option 14. Right? So either we decide this problem is not a big enough problem, or at some point we get to a place where we say, okay, we've got these 18 arguments for why we need to think we can't solve it with MMP and FIDE-SNPs and we need a new program.

CHAIR BELLA: Head nods? Anybody nodding this way? No? Okay, good.

We're going to open it up to public comment.

Would anyone like to comment on any of these policy options or our discussion?

Oh, Camille, come on up. Yes, good.

PUBLIC COMMENT

* MS. DOBSON: I always wait to see if someone else is going to talk, and they never do. So good afternoon. Camille Dobson, deputy executive director at Advancing States. We represent state aging and disability agencies that administer LTSS programs. I'm also the project director for our MLTSS Institute, which is a collaboration of national health plans and national MLTSS leaders, and both groups actually set dual eligibles as a priority area, our Board of Directors as well as the Institute Advisory Board, for 2019 and 2020. And so we've undertaken a couple of different activities that I think would be useful.

We convened at our HCBS conference in August a set of non-adopter states, states that might have Medicaid managed care, regular managed care, don't have managed care at all, haven't done anything in the duals space, and are struggling with how to get started. And so that gave us, in partnership with CHCS some really good context about what those barriers are. I know you've heard some of that

from your panels, but I think it was -- we found it very enlightening, not just staff capacity but a myriad of issues, not understanding the tools that are available, finding the resources that are out there to be so focused on really advanced models that they don't know how to get started. And a lot of them actually don't believe that there's a value to Medicaid from integration, and so our first product that we released a paper at the end of November was the value of integration where we studied really the FAIs, because that's where most of the documentation is now, but also some anecdotal information from states that have started less advanced activities and, you know, quality of life to the beneficiary, for example, is a huge issue. Reduction in LTSS spend has actually been documented in a few places, not enough, frankly. We heard from a couple Medicaid directors that said, "I can't go in and ask for more resources if it's not a saver" -- right? -- "and I have to be able to document the savings." So that's out there that I would recommend. It's just useful context because we have our health plans and our state folks using that to go talk to their legislators this session to see if they can get additional resources.

Our next paper that we're working on now is sort of prerequisites the states need to get, so we're spending a lot of time on the "getting started" states because, you know, Tennessee and Virginia and California, the FAI states, already sort of have a pattern. We've got a lot of states, as you saw from the map, that have D-SNPs that aren't doing anything. There's a handful of MLTSS states that haven't done a thing with their duals really to integrate, and so there's opportunities there.

So our next paper is talking about sort of considerations, what you need to know about what duals look like in your state and what your marketplace looks like before you get started, because I think what some of our states told us from the FAIs is that there wasn't enough done to understand what physician, for example, and hospital readiness was for an integrated product and those kinds of things. Lots of states don't even know what their duals look like. They don't know who they are. They don't know their chronic profiles, their acuity profiles, and so some of that is really important. And, also, what other priorities are in the state that are going to prevent them from investing the time and resources they need. So that

paper will be out I think in March.

Anyway, so I just wanted to put that out there, that we're spending a lot of time on trying to figure out how to jump-start it. It's the lag of states really picking up the MIPPA contracts. Too many of them are just signing whatever get puts in front of them -- Darin is nodding -- and really don't understand the value and what the burden is to the state of more requirements on the D-SNPs, because it requires them to take in data. What do they do with it? Do they have the resources? Those kinds of things.

And then, last, just about a couple recommendations. I would say that FMAP bumps are better than grants. I think that's probably pretty clear. But speaking from the state perspective, we would prefer an FMAP bump because I honestly don't know if the demonstration states actually have any proof that the million dollars was enough, back to your core question. What happens when that ran out? And how do they continue to sustain the staffing that they need to be able to manage those programs? So ongoing FFP I think is probably more valuable than not.

And then the last thing I think I would say is maintaining state flexibility as much as possible. And so I think hopefully you'll talk to the states, and some of them will tell you they've made very specific decisions not to limit D-SNP contractors to MLTSS plans for particular reasons that made sense in their market. And so I would just -- we would just urge state flexibility in all things.

I think that's it. Those are the two points I wanted to make, so thank you. This is really good work, and I think everybody and their brother is writing about duals or doing something about duals. So hopefully jointly we make some progress moving forward.

CHAIR BELLA: Thank you.

Other comments?

[No response.]

CHAIR BELLA: Do you guys have what you need from us?

[Laughter.]

DR. VARDAMAN: Yes. Thank you.

CHAIR BELLA: I just want to reiterate this is really thorough and comprehensive, and the fact that we just discussed this many recommendations in this area is

exciting and something we'll obviously continue to be doing. So thank you very much for all this work.

We're going to take a break until 3:10. Come back at 3:10, please, and we'll discuss a chapter for the March report. Thank you all.

* [Recess.]

CHAIR BELLA: Okay. I think we are going to reconvene. Thank you all for kind of a marathon session on duals and some marathon work on the maternity care this morning.

We are now switching gears. Reorient your brain to a different topic. And we're going to talk about the draft chapter for the March report on state readiness for the mandatory core set reporting.

So you all have -- we've talked about this, obviously, and a chapter has been drafted for your review, and Joanne and John are going to walk us through the highlights, and then we can have a discussion. Thank you.

REVIEW OF DRAFT CHAPTER FOR MARCH REPORT ON STATE READINESS FOR MANDATORY CORE SET REPORTING

* DR. WEDELES: Thank you. Good afternoon, Commissioners. In this session we will be reviewing our

draft chapter on state readiness for mandatory core set reporting that will be included in the March report to Congress.

You will recall that states are required to report on the Medicaid and CHIP child core set of quality measures and the behavioral health measures of the adult core set beginning in fiscal year 2024. The Bipartisan Budget Act and the SUPPORT Act, both of 2018, established these mandates for the child core set and adult behavioral health measures, respectively.

Back in October, we presented findings from the work completed last year by our contractor, Mathematica, to look at state readiness for the mandate. This work was conducted primarily through interviews with CMS and their contractors, with state Medicaid program officials in seven states, and with representatives from MCOs and BHOs in five of those states.

The objective of this work was to understand where states are in terms of readiness, and to identify what steps CMS and states need to take to prepare for fiscal year 2024.

During the October meeting, you directed staff to

prepare a chapter on this work, which we will be discussing today. We'd like to note that the chapter does not include recommendations. However, we welcome your feedback on the tone, message, and takeaways for the chapter.

The chapter covers development of both the child and adult core sets, current reporting, and use of the core sets by both states and CMS. It then presents an in-depth analysis of factors affecting state readiness for core set reporting and steps CMS and states can take to facilitate reporting for the 2024 mandate.

As noted, CHIPRA and the Affordable Care Act established the child and adult core sets, respectively. These laws also required CMS to provide grant funding and technical assistance to support states in implementing and reporting these quality measures.

For fiscal year 2020, the child core set consists of 24 measures. The adult core set includes 13 behavioral health measures. As required by statute, the Secretary of HHS reviews and updates the core sets on an annual basis. During this process, CMS may add or remove measures from the core sets and may also modify the technical specifications that guide data collection, preparation, and

reporting. As the chapter notes, state reporting of the core set has increased over time but varies greatly by state, by measure, and by core set.

States use the core set measures for a variety of quality improvement purposes, including payment incentive programs and monitoring Section 1115 substance use disorder demonstration waiver programs. In addition, CMS incorporates several core set measures in the Medicaid and CHIP scorecard, specifically in the state health system performance pillar.

I will now turn it over to Joanne who will discuss our findings and conclusions for the chapter related to factors affecting state readiness for core set reporting and steps that CMS and states can take to facilitate reporting for the mandate.

* MS. JEE: Okay. So the next section of the chapter describes what we learned through the various interviews that were conducted as a part of this work, and we discuss here the key challenges that states face and that they'll need to address in preparing for fiscal year 2024. The chapter describes challenges that states and plans face in accessing data required for reporting of the

core set measures. We touch on issues related to data collection for medical records review. Some of these challenges included, you know, the resource and personnel intensity involved in that kind of work.

It also -- the chapter also touches on challenges accessing data from electronic health records, and these include things like lack of interoperability between systems and completeness of data. It then goes on to talk about challenges that states face in accessing data from other state entities. These include data such as state vital records data or state immunization registry data, which again are required for certain measures. To access those data, states need to enter into agreements with those entities and then develop systems for linking those data, both of which take some time, and at least some states have some limited experience doing that.

Next the chapter talks about issues related to data quality, completeness, and timeliness, and how that can affect their ability to report on certain populations. These include populations such as American Indian/Alaska Native individuals and those who are eligible for -- who are dually eligible for Medicare and Medicaid, as well as

individuals in fee-for-service delivery systems.

The chapter then goes on to talk about the technical specifications. The technical specifications define how the measures are calculated and aim to ensure consistency in state reporting. However, they do present some challenges. In some cases, states deviate from the technical specifications. This may occur, for example, if technical specifications don't accommodate certain state data coding practices, for example.

In some cases, core set measures may be similar but not identical to HEDIS measures, which the plans are, for the most part, already reporting. When that happens, states may opt to report the HEDIS measure rather than the measure in the core set, according to the core set specifications, just because the plans already are reporting it.

The chapter notes that since the core set specifications and the measures themselves change a bit from year to year, it's unknown sort of the ability of states to implement those changes right away, or whether the technical specifications are something that they can strictly adhere to.

The chapter then turns to administrative capacity. We note that core set reporting is really just one of many activities that states take on, and that states may be involved in other state-specific quality measurement and reporting activities. So states are really having to decide how to balance resources across core set reporting, as well as their other state priorities and activities.

This part of the chapter talks about the many roles that state Medicaid staff take on in core set reporting, and the point here really is that although the states rely heavily on their plans to do this work, there are still several functions that are state Medicaid agency staff roles. These include such things as establishing the data use agreements, which I referenced. Sometimes it can involve the medical records review, which is time and resource intensive, systems programming, linking data, data quality checks. Those are some of the examples of things that state Medicaid agency staff have to do.

So states anticipate that once mandatory reporting takes effect that their workload will increase and that they will need to train and hire additional staff to take on those jobs. And some of the states noted that

they've had a hard time recruiting staff sometimes to fulfill those roles because they can't find people either in a small state or in tight labor markets with the technical skills that are needed.

MCOs also have teams of staff involved in data collection, particularly around HEDIS measure reporting, and then, you know, by extension, the core set reporting, since they're related. If states delegate additional duties to plans, such as reporting on the non-HEDIS core set measures, the plans told us that they would anticipate also needing to hire additional staff for developing processes and systems to do that, as well as the measure calculation itself.

The chapter then goes on to describe factors that states and plans identified as facilitators of state readiness. These include having guidance from CMS as early as possible. The parameters around issues such as which measures are going to be included in the mandatory core set, as well as how CMS will approach any sort of deviation from the technical specifications, will affect what states will need to do to prepare and the level of intensity of those efforts.

So here the chapter notes that it's really hard to determine precisely how much time states will need, but in speaking with the states that were included in this study, we learned from some states that it would take probably, you know, at least 2 years to fully prepare, and that's 2 years from the point in time in which they have the guidance.

The draft chapter describes technical assistance needs of states, and we acknowledge in the chapter that CMS already provides quite a lot of TA to states, but note that states have identified additional areas where further technical assistance would be helpful, in particular in areas related to data collection. These are issues that are described a little bit more fully in the chapter, and they are not new issues but they are ongoing issues.

This section of the chapter, draft chapter, also acknowledges the resource constraints that states may feel in taking on the mandatory reporting in 2024. So we definitely heard that consistently across all states that were a part of this study.

The draft chapter then turns to CMS' efforts to support state readiness and the different things that they

are thinking about so far. We describe CMS' intent to provide additional technical assistance, and that it is looking to identify some options to help ease the burden on states of mandatory reporting. For example, CMS is looking at whether they can use the T-MSIS data to calculate certain of the core measures for states. The idea is that if CMS can take that on then state resources will be freed up to take on -- to address, to do the other measures.

CMS is also considering, you know, looking at ways that states might leverage other resources that are available to them. This includes external quality review organizations to see if there are any approaches where states can sort of leverage EQROs to help in their efforts to report.

The chapter concludes by highlighting its key takeaways. These include that CMS and states have much work to do to prepare for fiscal year 2024, but there is time, about 5 years, to do that work. Again, we emphasize that states really need early and clear guidance from CMS to proceed with the many steps that they need to take on and to avoid any sort of implementation delays. The chapter does note that there is -- we have some experience

with implementing new policies and lack of early and clear guidance can lead to delays.

So, Commissioners -- oh, let me just say one more thing. Sorry. We also note that so far there hasn't been any formal guidance from CMS on mandatory core set reporting, but that CMS is certainly thinking about it. They just haven't been able to issue any guidance yet.

So, Commissioners, that's the chapter. We look forward to any comments you have on tone, clarity, messages, and if you have any questions, we're happy to answer those too.

CHAIR BELLA: Thank you for the summary and the refresher, and I will now open it up to Commissioners. Tricia.

COMMISSIONER BROOKS: Sorry. I thought it was a great summary overall of the chapter. I thought you did a good job. I just wanted to comment. I don't think we can overemphasize the importance of CMS getting early guidance out. Certainly when I talk with the child health advocacy community and they're talking to their states, and the states are saying, "Well, we're waiting for CMS guidance."

Now, you know, I would say there's a lot of work

that they could be doing to get ready, but some seem to be saying, "No, we're not going to put resources into this until we have better guidance." So I think that is a really important point, and I think you made it at least twice, maybe three times in there, so I'd definitely like keeping that in.

I think the other issue -- certainly a phase-in period when a new measure comes up, I'm actually surprised to hear states say 2 years, because I think some would say, "No, 3 more," you know, with the new measures. But I think that's important for harmonizing the annual review and the recommendations that are made in terms of how the core sets should evolve. But that's an important piece because otherwise you need to pause on changing the core set for states, you know, to be ready for that mandatory reporting.

But good job, overall, on the chapter.

COMMISSIONER SZILAGYI: Kisha and then Peter.

COMMISSIONER DAVIS: I think this was a really great chapter, and I think what you guys did a really good job of was emphasizing how hard it is to get the data and how hard it is to get good data. And a lot of times we, at the table, say we want more data, and just how hard it is

to get that.

And in that light, I think helping the states to do a good job of having information that they need ahead of time. You know, when you're in a practice, trying to give this data to Medicare and to Medicaid and to private payers and all of these different players who want it on different platforms, in different ways -- you know, EHRs were supposed to solve this problem, and if anything they've made it worse because they don't talk to each other, and if you want to submit your data you've got to pay an extra fee to do that. And so just recognizing the complexity of that. And as much as that process can be streamlined, automated, and easy, that's helpful.

I think the other thing is making sure that those measures that we're looking for are meaningful, and there are -- there's lots of papers on meaningful measures in primary care. There was a good article in Health Affairs a couple of years back, but not just collecting data for the sake of collecting data, because we know how difficult that is. And so really looking at measures that are tied to outcomes and tied to things that are going to benefit patients.

CHAIR BELLA: Peter.

COMMISSIONER SZILAGYI: I also thought the chapter was very clear, important, and easy to follow, so congratulations.

Just a couple of minor suggestions. Many people put a lot of thought into these core measures. I mean, there were a large number of experts. And it may be worth emphasizing just a tiny bit more the importance of core measures. These are meaningful. There were a number of different dimensions that people who work -- I worked on the pediatric core measures and there are a number of different dimensions of people voted excluded dozens and dozens of measures because they weren't as feasible, et cetera. So just emphasizing a little more the importance.

A tiny tweak. Just to make sure that people understand that this isn't just fee-for-service or just Medicaid managed care. You know, just to clarify that this is really statewide.

And I don't know whether you've been able to gather data or information when you talk to the states about how are they already using these measures, or kind of current practices for what they are using. I like the box

about the difficulty with the behavioral health measures, but I don't know whether there could be some small -- you know, a box or something about examples of states that are using the measures in a really good way.

And finally, the last comment is, I don't know whether -- was it clear which particular measures were clearly difficult? Is there a pattern? You mentioned a couple of areas, but if any really jump out that might be worth emphasizing, not that they would be excluded from the core measures but if this is what the states have experienced already.

I was a little bit dismayed at the variability across the states, even in 2018. You know, recounting the number of measures, but if you actually overlay which measures are being measured across states, I think it's probably quite variable across the United States. So that's a little bit dismaying to me that it's already 2020.

MS. JEE: So we do have some information on those last two points that you made, and so we can build that into the chapter a little bit.

COMMISSIONER SZILAGYI: About which ones are particularly tough or pattern --

MS. JEE: Right.

COMMISSIONER SZILAGYI: I actually don't, but in talking to states, I was wondering whether you were able to kind of get patterns.

MS. JEE: Right. So the measures that are based on administrative data are a lot easier --

COMMISSIONER SZILAGYI: Are easy, sure.

MS. JEE: -- and they can rely on plans to do that --

COMMISSIONER SZILAGYI: Sure.

MS. JEE: -- as well as the measures that are the HEDIS measures, because the plans do that for the states.

COMMISSIONER SZILAGYI: Right, right.

MS. JEE: The measures that rely on the state vital records or the immunization registry data, that's a little bit harder for states to do, and the measures that require -- well, I guess there's maybe just one or two measures that require, but the measures that use hybrid method --

COMMISSIONER SZILAGYI: Right. But among those, which of those are particularly difficult, if there are patterns that already emerged among the hybrid measures,

for example?

MS. JEE: I think some of the ones in the adult behavioral core set were identified as being hard. I can't think of the specific names, but I think we have that. And we can probably build that into the chapter a little bit.

COMMISSIONER SZILAGYI: Do you find that certain states are using some of these in very innovative ways already?

MS. JEE: You know, we did hear from states a bit about the ways that they use them. I think John alluded to them a little bit this afternoon, but they are using them in some of the payment incentive programs that are in states.

And then I know that CMS -- CMS is actually encouraging states to use these, and I think it has required states to use these in the SUD waivers, the substance use disorder 1115 waivers. And there might be some other ways that we can pick out and describe in the chapter.

CHAIR BELLA: Toby and then Tricia.

COMMISSIONER DOUGLAS: I really think it's the right tone and really good. It lays out -- the one area I

want to highlight is just the administrative. There is the guidance, but it's the state administrative burden. And I think you do a really good job on that, and then also to parse it out on the health plan side, given the delegation, where most of this really is falling on the health plans.

The one thing that isn't kind of this tension between the state and the health plans, you talk about the health plans needing to hire, but really it gets to the funding and this tension. There's nowhere for additional funding for this that's built into rates. I think it's an ongoing issue as all these new requirements that go down to the plans, expectations. It just becomes more things that the plans have to do.

COMMISSIONER BROOKS: Just a quick comment. The other thing I know that states, at least one state -- I know Georgia does use the core measure for in their algorithm for auto-assignment into managed care. So plans that have higher scores get more of those bump-ins.

CHAIR BELLA: Other Commissioners?

[No response.]

CHAIR BELLA: All right. Thank you very much.

Well, let me check. You guys have no more

questions for us, right? You're good?

[No response.]

CHAIR BELLA: Okay. Thumbs-up on the chapter. Thank you very much.

All right. Our last panel is also on a chapter for the March report, and this one is on the 1115 waivers.

Kacey, thank you.

REVIEW OF DRAFT CHAPTER FOR MARCH REPORT ON EVALUATING SECTION 1115 DEMONSTRATIONS

* MS. BUDERI: Great. So, in this session, I will go over our draft chapter on improving the quality and timeliness of Section 1115 demonstration evaluations, which will be included in the March report to Congress.

This chapter draws heavily on perspectives shared at MACPAC's November 2019 expert roundtable, and you will recall I shared the high-level themes from that discussion at our December meeting.

This chapter does not contain recommendations.

This slide just provides an overview of the sections of the chapter, starting with the introduction. Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive federal

Medicaid requirements to the extent necessary to carry out a demonstration furthering the goals of the Medicaid program.

Demonstration waivers approved under this authority are subject to evaluation. However, many evaluations have not generated findings that are timely or rigorous enough to support decision-making, and historically, states and federal administrators have focused more on the flexibility offered under Section 1115 and placed limited emphasis on evaluation and the role of a demonstration to produce evidence of the effects of new policies.

CMS has taken a number of steps to improve evaluations over the last five years, most significantly with evaluation guidance released in 2019. This guidance appears to have been well received by states and evaluators, but there are still a number of challenges at the state and federal level to conducting and using evaluations, and it will take time to yield meaningful improvements in evaluation quality and usefulness.

At this time, we have not identified a need for further legislative or regulatory steps. So this chapter,

as I noted, does not contain recommendations but does say that MACPAC will continue to monitor the effects of new evaluation policies going forward.

The chapter provides background information, including on the use of Section 1115 authority in Medicaid, evaluation and monitoring requirements, concerns with evaluation quality, and recent efforts to improve evaluations.

As of January 2020, there were 65 approved Section 1115 demonstration waivers under way in 47 states. There are several different types, and they differ in scope and the policies they implement. Some policies included in these demonstrations can only be implemented under Section 1115, and others can be implemented through other authorities.

The Secretary reviews each demonstration request to determine whether its stated objectives align with those of the Medicaid program and are consistent with federal policy. The Secretary has broad discretion to approve or deny these requests and may do so in line with the administration's policy priorities.

The chapter reviews monitoring and evaluation

requirements, and I won't say too much here because we discussed this at the December meeting, except just to say that all Section 1115 demonstration waivers are subject to monitoring and evaluation, which are related but serve distinct purposes. And I'll note that the focus of this chapter is just on evaluation.

There are three main evaluation deliverables: the evaluation design plan, interim evaluation, and summative evaluation report. CMS reviews and provides feedback on each of these deliverables and must approve them before they become final, which means that CMS has several opportunities to guide the process.

The U.S. Government Accountability Office along with MACPAC and others has repeatedly expressed concerns about evaluations. The chapter describes some of GAO's specific findings between 2007 and 2019, including that CMS has inconsistency applied evaluation requirements; that many evaluations were limited by methodological shortcomings, gaps in results or selective reporting of outcomes, and that evaluation processes have provided limited opportunity for or consideration of public comments.

Both Congress and CMS have made efforts over time to improve evaluations, starting with high-level principles for evaluation published by CMS in 1994, followed by a technical assistance guide for states in 2007, and then a requirement in the ACA for CMS to establish a formal process for evaluations.

In general, these early efforts have been focused on establishing basic expectations and consistent processes for evaluation content, timing, and transparency. More recent reforms, including the 2019 evaluation guidance, have emphasized improving quality and rigor.

As I mentioned, states, evaluators and CMS seem to view the guidance as helpful; however, I'll note that we do not yet know the full practical effects of the new guidance, given how new it is. No evaluation findings are available for demonstrations subject to the guidance, and also, there are many demonstrations currently operating that will not be subject to the guidance until they are renewed.

The chapter goes on to describe some of the issues in conducting evaluations and using findings. Many of these were raised at the roundtable discussion, which I

talked about in December, so they'll look familiar.

Starting with issues related to evaluation planning and funding, including how state's role in directing and funding evaluations can reduce the independence of evaluations and can be affected by the extent to which the state values evaluation.

The chapter also describes evaluation budgeting issues and considerations for early evaluation planning.

It goes on to discuss methodological challenges in designing and carrying out Section 1115 evaluations, including comparison group challenges, data availability issues, and the difficulty of estimating the effects of specific policies in multifaceted demonstrations.

The chapter also discusses issues with timing requirements for evaluation deliverables. One is the timing of evaluation designs relative to demonstration implementation and considerations for whether states need to conduct evaluation planning or baseline data collection before going live with their demonstration.

Another issue is the timing of interim reports, which are due one year prior to demonstration expiration. This can result in data collection periods as short as one

or two years, which may be insufficient to assess outcomes.

Summative evaluation reports are based on more years of data but are generally not available until after CMS decides to extend the demonstration; however, they may be of use to other states considering new demonstration policies or to federal Medicaid policy deliberations more broadly.

The chapter then describes the difficulty of setting standards for evaluation quality. Currently, there are few standards for the specific elements of an evaluation, methodological rigor, or overall quality. For example, there are no standards for when a state must conduct a beneficiary survey.

One approach raised by several participants at our roundtable would be to vary the standards and requirements related to content, rigor, and timing of evaluation deliverables by demonstration, type, and scope.

For example, CMS could require more rigorous evaluation features for demonstrations that pose a high risk to beneficiaries. However, it would be difficult to establish criteria for doing so, given different perspectives among decision-makers and stakeholders about

what constitutes risk or otherwise merits a higher standard of scrutiny.

And then the chapter turns to issues related to using evaluation evidence to inform policy. Evidence gathered from formal program evaluations can inform whether demonstrations meet their objectives in state and federal decision-making. However, there are several longstanding demonstrations or demonstration policies that have been repeatedly extended with minimal evaluation evidence.

Some examples include waivers of retroactive eligibility and non-emergency medical transportation.

In other cases, evidence is available, but there is no mechanism to say that we have enough evidence on the effects of a policy to decide if it should be extended, incorporated in the state plan, or not used at all.

Lastly, even strong evaluations have limitations. Findings from one state's demonstration are not likely to be definitive, given state-specific circumstances, differences in implementation design, or other factors.

The chapter concludes by discussing public comment and transparency issues. Currently, there are few opportunities for the public to comment on evaluation

designs or evaluation findings. Although some roundtable participant said that they use public comments to inform demonstration hypotheses and research questions, it's not clear if this is a common practice.

And then although states and CMS are currently required to publish evaluation findings to their websites, roundtable participants discussed how wider dissemination of evaluation findings through different mediums could help improve transparency.

So, as I mentioned at the beginning, we will include this in the March 2020 report to Congress, and any feedback you have on tone, clarity, additional information to include, or the chapter's messages would be helpful.

And so I'll turn it over.

CHAIR BELLA: Thank you, Kacey.

Comments or questions from Commissioners?

Brian.

COMMISSIONER BURWELL: So I really enjoyed this chapter. I really want to comment you on a successful product in a very murky are. What I really liked about the chapter was its tone. I think given what I perceive as a very kind of murky area, I think it set just the right tone

about how CMS should go about enforcing the evaluation, monitoring an evaluation component of 1115s. It gives a very excellent history of 1115s and the criticisms that have been directed at CMS around insufficient evaluation rigor. I think that's really well laid out, and the chapter kind of identifies that this was an area where things were really let slide for a long time. But now CMS has made a number of -- is really trying to improve the quality of the evaluations and make these demonstrations more useful to further policy developments.

I just again want to commend you, for I think the chapter strikes exactly the right balance, and the fact that we aren't really coming out strongly with new recommendations or where it should go, I think, is also the correct position for the Commission. And I really think it was a really good job.

CHAIR BELLA: Other comments?

Fred.

COMMISSIONER CERISE: I agree. I think it's a great summary of the issue.

In the area of timing, you kind of give a balanced argument of problems with delayed implementation

plans, getting your waiver approved, and then coming up with an implementation plan. It just seems to me to have 180 days after you get your waiver approved to then have an evaluation plan, it doesn't -- I might come down a little strong on -- it doesn't seem so much of a balance to me to say there are arguments on both sides of that. I know that there are, and I thought you did a nice job of using the Arkansas example and talking about sort of getting ahead of the evaluation plan.

But things that we think just make total sense -- you just saw in the New England Journal, the last issue, about the Camden work that we all thought putting all those intensive resources for how utilizers would show reduction, which they talked about, but then when the evaluation came out, they didn't show those benefits.

I can't stress enough that if there's 65 of these, we ought to be able to have an evaluation plan that's thought out. I would just stress the need and not downplay the arguments of, well, it's going to divert resources or timeliness is an issue.

That's not to take away that I thought you did do a good balanced job there, but if we had to push on one

side or the other, I think I would push a little harder to say we think we should have evaluation plans at the time a waiver is approved. I know that may be going further than people might want, but it just seems like kind of common sense.

CHAIR BELLA: Martha, then Peter.

COMMISSIONER CARTER: Well, I don't have as strong a research background as some of the rest on the Commission, but I agree with you. That section struck me too. It's just sort of a basic of quality improvement in an evaluation that you have a plan. You have a baseline. You track your changes over time. It's sort of fundamental.

To be wishy-washy about it, I can't really say I understand all the reasons why you wouldn't do that, but I see a lot of reasons why you would push for an evaluation plan before you implement a program. So maybe the rest of you can speak to that more clearly. I'd like to be stronger on that point. Thank you for bringing that up.

CHAIR BELLA: Peter?

COMMISSIONER SZILAGYI: I agree that the chapter is very good, very complete. The tone is, I think,

balanced, and I had exactly the same critique about the timing of the evaluation. I mean, can somebody give me a rational argument for why one would put a proposal in without an evaluation?

CHAIR BELLA: Anne.

EXECUTIVE DIRECTOR SCHWARTZ: Or unless Kacey wants to.

MS. BUDERI: Just to make sure I understand --

COMMISSIONER SZILAGYI: I mean, I've put in so many proposals in my life, not at this level, but not only was the evaluation an important part of it but it was a critical component of the evaluation of the proposal. So I don't -- so how would CMS effectively evaluate a proposal without an evaluation plan?

EXECUTIVE DIRECTOR SCHWARTZ: I guess what --

COMMISSIONER SZILAGYI: -- a proposal --

EXECUTIVE DIRECTOR SCHWARTZ: The argument that we heard is --

COMMISSIONER SZILAGYI: -- because I didn't get that from the chapter. What's the counter-argument?

EXECUTIVE DIRECTOR SCHWARTZ: Well, I mean, we can do a better job of that too. Presumably, when you're

submitting something for a research grant, you know what you're doing and they're saying yes or no, or strengthen these parts of it. When a waiver proposal is submitted, it's the starting point of a negotiation, and the negotiation could significantly change the character or the nature of the evaluation, including what data that you might have to collect. So that's the argument that states are making, that it was -- that they can't do the evaluation plan when they submit the proposal, because they still don't know what it is that they would be evaluating.

There's another point at which we also had a discussion with, which CMS, in particular, pushed back strongly on, which was to have an evaluation plan in place at the time of implementation; at which point you would know exactly what you were going to do.

And the two cases that came up, which I think were sort of interesting, thinking about Kentucky and Arkansas, you know, as we know from our own discussions of Arkansas, Arkansas did not have an evaluation plan approved at the time of its implementation, and still did not have an evaluation plan in effect at the time that the court stopped it. Kentucky had a very aggressive evaluation

activity, and all of that was in place well before the implementation was to happen, but it actually did not have an evaluation plan approved by CMS either.

So those are some of the arguments around the timing of the thing.

COMMISSIONER SZILAGYI: An argument to that would be, wouldn't CMS want to approve the final evaluation plan before approving -- I mean, I get the back-and-forth, and the fact that the demonstration project may change based on feedback, critique from CMS. But in the end, shouldn't somebody -- shouldn't some governing body approve the final evaluation plan before the demonstration starts?

EXECUTIVE DIRECTOR SCHWARTZ: I mean, I think that's an argument that can be made. I'm just telling you, you know, what we heard at the roundtable. I think that was some of the concern, you know, when we were talking about Arkansas a year and a half ago, that data were not being collected, that people were concerned you would need to know not just whether the evaluation worked 2 years from now but whether it was achieving its goals, you know, early on.

CHAIR BELLA: Darin.

COMMISSIONER GORDON: I mean, there are some cases where you're basically asking to do a demonstration similar to what some other states have been doing for decades, and the fact that you have a legislature that says it needs to start by X day, you have something that, you know, you feel has actually been fairly well proved out, do you delay that in those instances?

I mean, I think it's -- you know, I think it's always interesting when you think about Medicaid and Medicaid administration that unless you're in it you sometimes think they have more resources than they do, because the whole time they're doing this they're keeping a plan in the air. In some cases, these demonstrations are actually, you know, offering some benefits that are optional benefits to populations they weren't offering before. Do you delay?

You know, I just think it's -- I hear the point. It's like ideally you do have -- you've thought this through and you've gotten everything worked out. I think it's a case-by-case situation of whether or not it is always going to work out that way, and it's always in the best interest of the beneficiaries that way.

So I don't think -- and it's always an ideal situation to where all that's going to work out unless people are going to be willing to say, in some cases, we acknowledge that we will be delaying additional services and benefits to people until we get this worked out. I mean, I know went to look at like the work requirement, you know, situation, and use that as an example. That is an example. That's not will all 64 of these waivers are about.

So, you know, you look at many, many states. The same people that are actually trying to continue to provide services to beneficiaries are the same people that are trying to stand up the additional new programs, and the same people that have to think through the evaluation plan. And you do tend to figure out, yeah, you have to try to prioritize. I don't claim to think that every state prioritizes that well, in all situations, and in some cases I would think ideally you would have more clarity around the evaluation plan. But I don't know if I can say that in all cases that is an imperative.

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: Yeah. No, just building

on what Darin was saying, and I think the report -- the chapter does a good job. I mean, this is -- so much of the waiver is about policy goals and negotiation, and the people that are doing that have no understanding about evaluation or thinking about evaluations, about driving their policy goals. And so we just have to remember that, and that's not to, what Peter, you were saying is accurate on -- I would say is answered on the implementation. That could be something that, whether it's in this chapter -- and I know it doesn't have recommendations -- we could put more emphasis.

But it does then get to what Darin is saying, is just that's changing, shifting fundamentally expectations about waivers which, in the eyes of states, is really about policy goals, and in the eyes of us it's about -- well, not us, but you know, D.C. and others -- it's really a demonstration, a laboratory that should be evaluated.

And if we're going to say that there needs to be really strong expectations that that evaluation is the first step and will slow everything down, which then eats into, you know, the five-year demonstration, you know, because it takes a while to do exactly what you're saying,

and that can't happen until once you're clear on the design. And so it's shifting, fundamentally, the way the process would work.

COMMISSIONER GORDON: Again, not taking away from him but just additional context. In some cases, it is requiring new reporting that isn't necessarily available to you, which then requires you negotiating not with -- you know, you don't have the authority to say everyone shall do, but it's working with a whole bunch of different providers across the state, of differing size and capacity, of whether or not they can, by timing, by which they can do those things, what kind of standardization takes place.

Again, I'm just trying to add additional context to -- it isn't as simple as I think we can try to make it at times, that there are some complicating factors. I think, in a lot of cases, if it's something completely new there isn't, at all, any experience with it, I think in those situations ideally you have something thought out before you actually start implementing it. I feel less compelled when it's situations where many, many states have done some of these things already, they're, in some cases, decades, and you're trying to do that. I feel less

compelled in that situation to hold it up.

COMMISSIONER SZILAGYI: So, you know, in summary, I mean, I hear you, and maybe it's worth expanding a little bit more on the fact that these demonstrations have, in a sense, multiple purposes and different types. And so there are potentially some legitimate reasons to not have evaluations. But I still think, you know, a little bit of a greater push on the rigor would help us learn from these natural experiments.

EXECUTIVE DIRECTOR SCHWARTZ: So I just want to harken back to some of the conversation. I mean, some of this conversation happened at the roundtable as well. One of the points brought up there was that, as a matter of statute, these are waivers that are meant to be testing new ideas and evaluation is contemplated as a matter of statute.

But where we find ourselves today in the history is that states have not always been demanded very much of, and therefore have made a bunch of program decisions. Folks that have been doing this for a long time can kind of feel like the sand is shifting underneath them. Folks that are doing this for the first time, you know, it's like, oh,

this is now what's involved.

So I think, for that reason, there has been some sort of hesitancy. There was a lot of conversation at the roundtable about, well, maybe we would have a stronger standard, depending upon how much expenditure authority is involved, or a stronger standard if there's a lot of risk for beneficiaries. And the conversation was, -- yeah, those are great ideas in concept but, in fact, operationalizing them is really hard.

And CMS, even though they, I think, from the state perspective, hold all the cards in the negotiation, from CMS' perspective, the thing that they hold is that I'm not going to improve your evaluation plan until I think it meets a standard that we feel comfortable with. But that decision is often independent of a political imperative to give states the go-ahead.

So maybe we can do a better job in the chapter in describing some of these tensions a little bit better and building out the arguments a little bit, but that's pretty much what we heard in the roundtable.

CHAIR BELLA: Does CMS guidance talk about this at all?

MS. BUDERI: No. You mean the timing of the evaluation design plan relative to implementation? No.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, I mean, some states are having an argument like, well, we're not going to procure a contractor until the evaluation plan is approved, because we don't know what we're procuring. Whereas you have other states where evaluators -- and this was said at the roundtable -- are like, oh, well, we just do an evaluation design, like literally on spec, the way researchers do everything. So you had different experiences in different states.

COMMISSIONER DOUGLAS: [Off microphone.]

EXECUTIVE DIRECTOR SCHWARTZ: Your mic.

COMMISSIONER DOUGLAS: Sorry. We don't even know -- an evaluation design, as we know, can be multifaceted. It can be anywhere from, you know, a couple hundred thousand to millions. And so, you know, then that gets to where's the budget authority? There's a lot of things --

CHAIR BELLA: That's kind of like the rules of the game. You want to do this? The expectation is you do the evaluation.

COMMISSIONER DOUGLAS: But it's not.

CHAIR BELLA: I mean --

COMMISSIONER DOUGLAS: That's what I'm saying. So we need to -- this is what chapter needs to be clear. It's never been --

EXECUTIVE DIRECTOR SCHWARTZ: I think both points were present. I mean, I --

COMMISSIONER DOUGLAS: It is in there. I mean, it's not saying that -- it's just we need to -- if we really care we could put a little bit more emphasis on it.

CHAIR BELLA: How about Kacey and Anne and team take this feedback back, on that particular point, see if we can blow it out a little bit more and get into a little bit more detail, and see -- Peter and Fred, in particular, how that looks to you?

VICE CHAIR MILLIGAN: I was scared you were wrapping up and I was on the list.

[Laughter.]

VICE CHAIR MILLIGAN: She acknowledged it. Oh, yes. so Kacey, as somebody who is on the list, I had a question, as much as anything, totally different dimension of this chapter. You referenced, in the chapter, that 1115 waivers predate Medicaid. In fact, they were used for

welfare reform and they go back a long time. I'm wondering whether some of the issues that are endemic to the evaluations and the 1115 waivers of Medicaid are also present in the use of 1115s for other social service programs.

And I'm not proposing that you kind of go chase that all down. I'm wondering whether it came up in the roundtable, whether -- when I read that part of the chapter that it kind of predates Medicaid, it's been used for other social service programs in the Social Security Act, I'm just wondering whether there's any context in which the Medicaid use of 1115s is or is not different from, from an evaluation perspective, those other programs? And if there's any context, without doing any additional research or follow-up, I think it might be helpful. But I'm curious if there's anything that you have to say to this already.

MS. BUDERI: That did not come up at the roundtable, and I haven't read anything. You know, in my course of doing this work I haven't come across anything like that. But we can look into it.

VICE CHAIR MILLIGAN: Yeah. And again, I don't want to, this late in the game for a March report, propose

a lot of additional work on it. I just think contextually, we talk about it as if it's really a Medicaid-specific thing, and although a lot of us recognize it's not, and you referenced that in the chapter, but, you know, it underpinned how, you know, welfare reform came into being in 1996, and underpinned a lot of other things.

So I just -- I'm just curious whether it's that the issues are related or unrelated across programs.

CHAIR BELLA: Any other comments for Kacey?

[No response.]

CHAIR BELLA: Okay. I will now turn to the public to ask if there are comments on either of these draft chapters, the one on the mandatory core measure reporting or this one on 1115 demonstration evaluations.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: All right. No public comment. Kacey, do you have what you need from us?

MS. BUDERI: Yes. Thank you.

CHAIR BELLA: Okay. Thank you. Thanks on both of these chapters. Nice work for the March report.

We are finished for the day. We will start

tomorrow at 9:00 on maternal morbidity. So have a nice evening, everyone.

* [Whereupon, at 4:05 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, January 24, 2020.]

PUBLIC MEETING

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

Friday, January 24, 2020
x:xx a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
CHARLES MILLIGAN, JD, MPH, Vice Chair
THOMAS BARKER, JD
TRICIA BROOKS, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
STACEY LAMPKIN, FSA, MAAA, MPA
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[8:59 a.m.]

CHAIR BELLA: Good morning. Welcome.

We are super excited about our panel this morning. Dr. Kozhimannil, welcome. Thank you for taking time to be here. Martha, thank you. I'm going to kick it over to you to get us started.

MATERNAL MORBIDITY AMONG WOMEN IN MEDICAID

* MS. HEBERLEIN: Sure. Good morning.

So, as you all know, with pregnancy-related mortality and morbidity on the rise and significant racial and ethnic disparities in maternal outcomes, attention has turned to how to address this crisis.

As we discussed at the October and December meetings, given Medicaid's key role in providing maternity-related services for pregnant women, we are working to compile data on the experience of pregnant women covered by Medicaid and gather information on state and federal initiatives to improve outcomes.

So, at today's meeting, we will share the second piece of data analysis related to this work.

Under contract with MACPAC, Dr. Katy Kozhimannil

examined the risk of severe maternal morbidity and mortality among Medicaid beneficiaries. She will present her work describing differences in maternal morbidity by payer and the predictors of maternal morbidity among Medicaid beneficiaries by race and ethnicity and rural and urban residents. We will then open it up for questions and discussion.

Dr. Kozhimannil is the director of the University of Minnesota Rural Health Research Center and an associate professor in the Division of Health Policy and Management at the University of Minnesota School of Public Health. She conducts research to inform the development, implementation, and evaluation of health policy that affects health care delivery, quality, and outcomes during pregnancy and child birth. Her research also focuses on racial, gender, and geographic disparities and policy changes that address social determinants of health. In addition to conducting research, Dr. Kozhimannil teaches courses and works with community organizations and state and federal policymakers on efforts to improve the health and well-being of individuals, families, and communities.

With that, I will turn it over to Katy to present

her work.

* DR. KOZHIMANNIL: Hi, everyone. Good morning. I am so pleased to have the opportunity to be here with you. I really look forward to the discussion that we're going to have and welcome questions at any point about the research that we've done and especially engagement on the implications of this work and how to make things better so that we are keeping moms alive all across this country.

I am very grateful to be here today and grateful to be a visitor in this meeting. I also want to acknowledge Nacotchtank and Piscataway people on whose ancestral lands we are meeting today.

So we're going to start with high-level information about maternal morbidity and mortality in the United States. This first graph that I'm sharing here, it speaks for itself. These are the rates of severe maternal morbidity in the United States, with and without blood transfusion. This is how they're presented. These are data from the CDC.

What we see is a mounting crisis, and when we look at mortality data, we see a similar upward trend and curve. These are not new data. These are data that are

increasingly in the public eye and are haunting all of us, as they should. Particularly notable is the fact that the United States is an outlier in the trajectory that we have in maternal mortality compared to other developed regions in the world.

In addition to looking at these overall rates, attention has turned toward the fact that these horrible trends also mask deep inequities in who is experiencing the greatest burden of maternal morbidity and mortality.

So we'll turn to that in a moment, but I want to pause for just a second and talk about -- I, first of all, want to acknowledge that I'm using the abbreviation SMMM to mean severe maternal morbidity and mortality. I can talk a bit about how we measured that, and I'm happy to answer any detailed questions as we go forward.

But the role of Medicaid in addressing this crisis is crucial, and Medicaid has an opportunity to truly transform the way that child birth happens because nearly half of all U.S. births are financed by Medicaid. Unfortunately, many of the very important evidence-based strategies that are happening at national and state levels to address maternal morbidity and mortality doesn't

necessarily focus on the specific needs of Medicaid beneficiaries, and one of the biggest challenges here is the lack of data that focus on primary payer at the time of child birth that would help to tailor efforts toward Medicaid beneficiaries and to addressing those gaps. So that's one of the holes that we're hoping to fill with the information that we prepared for MACPAC.

Again, as I mentioned, there are inequities that happen across the country, and there's great data showing increased, elevated risk of severe maternal morbidity and mortality for black mothers and for indigenous or American Indian mothers and also for rural residents. These are also groups of people that more commonly have Medicaid coverage. So there's a confluence and intersectionality of risk here that is important to consider when thinking about implications.

So the goal of our analysis, as Martha pointed out, was to describe differences in severe maternal morbidity and mortality by payer and among Medicaid beneficiaries by race/ethnicity and by geography.

The data that we used for this analysis were 2007-2015 data from the Healthcare Cost and Utilization

Project's National Inpatient Sample. So this is a 20 percent sample of all hospitalizations across all payers in the U.S.

I want to emphasize that the severe maternal morbidity and mortality that we measured in our analysis was what you could detect using diagnosis codes during a child birth hospitalization. Maternal mortality encompasses death that happens during pregnancy or in the year following child birth.

About a third of all maternal deaths happen at the time of a child birth hospitalization or in the week following that hospitalization, and that one-third is the slice that we focused on here. So I want to recognize that two-thirds of maternal deaths were not possible to look at in these data. Again, I just want to make sure that I'm being clear about what we are showing here.

I'm presenting very brief snippets of our findings here. What I want to emphasize right away, right up front is the key finding that Medicaid beneficiaries have an 82 percent greater chance of severe maternal morbidity and mortality during child birth hospitalization compared with privately insured people.

There were other key predictors of severe maternal morbidity and mortality across the nation as a whole, and that included folks that live in a ZIP Code in the lowest-income quartile, folks that had a cesarean birth, folks with substance use disorder, depression, and a range of different chronic diseases that we know are associated with greater risk.

I'm going to move on now and show some results among Medicaid beneficiaries.

The key finding when we looked among Medicaid beneficiaries was that people of color, especially black and indigenous people, and rural residents were at greater risk of severe maternal morbidity and mortality. We also found some of the same predictors when we looked at all women and when we looked at those with different, other payer types. What this shows is that the patterns that plague the nation with regard to severe maternal morbidity and mortality are similar among Medicaid beneficiaries. So it's not equalizing or minimizing the sort of racial disparities in risk.

One of the key questions is, why are these risks greater among Medicaid beneficiaries? Why are the risks of

severe maternal morbidity and mortality greater here? I want to emphasize again that the risks among Medicaid beneficiaries reflect national risks. Medicaid beneficiaries are not immune to the structural risks that affect the nation as a whole, structural racism, structural urbanism, and others topics.

Medicaid beneficiaries are also more likely to be among high-risk groups generally and also have fewer resources to ensure good health.

There are a number of important implications for Medicaid policy, and I recognize with great humility that I am saying this to a group of people with far deeper expertise than I have in this space. So I really invite your comments and feedback, and I hope that I as a researcher can help answer some of the questions that you may have about this.

But Medicaid policy does have the potential to address maternal health generally and some of the equity concerns that we see, given its disproportionate effect and coverage rate among those populations that are at greatest risk of severe maternal morbidity and mortality.

I want to take just a moment to step back and

look at the national data, just to provide some context here. We can see that data that were released by the CDC in May 2019 showed that black and American Indian women were about three times as likely to die from pregnancy-related causes as white women. We see that that's a gap that's been increasing, racial inequity that's been increasing over time between black and white women, and so it's important to recognize that this is a national trend that's also occurring among Medicaid beneficiaries.

I'm going to move on and talk about the geographic context that we sometimes hear a little bit less about and is particularly important, given the way Medicaid is structured across states, and the disproportionate role that Medicaid plays in ensuring rural residents compared with urban.

So this is information about the geographic equity context, showing heightened risk of maternal mortality that follows a geographic pattern, with the most rural places having the highest risk of maternal mortality, and on the right, you'll see an exhibit from a paper that my team recently published, looking at severe maternal morbidity and mortality among rural and urban residents and

showing a discrepancy there that puts rural residents at greater risk, about 9 percent greater risk, compared with urban residents, with all the same diagnosis codes, all the same characteristics. We see a greater risk that comes just with living in a rural area compared with an urban area.

So a couple of key takeaways. Our analysis showed that Medicaid beneficiaries are at 82 percent greater risk of severe maternal morbidity and mortality than privately insured people. Among Medicaid beneficiaries, black and indigenous people and rural residents face the highest risks. We also found risk factors among people with clinical risks, and those are known risk factors as well. These data are new, but they're not at all surprising, given existing evidence.

Because of Medicaid's role in providing insurance for some of these groups, there is a great potential for improvement.

I want to put forward a few spaces where I think Medicaid policy has an opportunity to make some changes and where Medicaid policy could have an impact on this, and I really welcome discussion around this space and other

spaces.

One key point is around payment, and I want to say that this is a question around payment rates as well as payment models.

Data show that on average, Medicaid pays about half of what private health plans pay to health care delivery systems and health care providers for providing child birth-related services. That masks a lot of variability within Medicaid between fee-for-service and managed care, and among managed care organizations, most of the folks who are pregnant Medicaid beneficiaries get their services through managed care. The contracting process makes it very difficult to see exactly what it being paid, but there is variability across, within Medicaid and between Medicaid and private plans, that create some financial incentives, such that health care delivery systems are always aware of their payer mix.

It is nowhere more evident than in obstetrics, which is known as a loss leader in many health care delivery systems in terms of finances and where Medicaid is covering a substantial portion of births. So I think that's one space to look for change.

Another is on payment models and looking at alternatives to fee-for-service or ways to manage bundled and blended payment rates. Again, that's something we can discuss.

The second point is around eligibility and coverage. I know this is something that you all have discussed before. I believe it's something that you discussed yesterday, which is the fact that a third of those maternal deaths are happening in the postpartum year, and pregnancy-related Medicaid eligibility ends 60 days after giving birth. There are a lot of state and national proposals right now looking at reducing insurance churn or gaps in coverage in the postpartum period.

There's a great study by my colleague, Jamie Daw, that showed that about half of Medicaid beneficiaries have some gap in insurance in the year after giving birth, and those insurance gaps can really affect access to care, especially for folks that have substance use disorders and other challenges that we know are associated with severe maternal morbidity and mortality. So that's something that is, I think, an important policy discussion to have that could have an impact on this area.

The other is coverage of nonclinical services. We know that so many of the causes of maternal morbidity and mortality extend beyond clinical risk and into social risk factors, and there is a potential for the coverage of community-based and nonclinical services, in lieu of services through Medicaid managed care contracts, and other creative ways of addressing these social determinants that lead to these disproportionate morbidity and mortality rates among Medicaid beneficiaries.

So that is what I have. I wanted to be very respectful of my 10-minute time period. Apologies if I spoke too quickly, and I am happy to answer any questions that you have. I am really, really grateful to be here, and I honor the work that you all do in caring for so many of our nation's moms, babies, and others that need these services, so thank you.

CHAIR BELLA: Thank you for being here.

Would you mind going back to your last slide, so we have some of the policy things up there? And then could you just say one more time the one-third that are included in these data and why the two-third are not, just to make sure that we're all level set on particularly the data

challenges?

DR. KOZHIMANNIL: Absolutely, yes.

The data from the CDC show that about a third of maternal deaths happen during pregnancy. About a third of maternal deaths happen right around the time of child birth, and a third happen in the postpartum year.

The data that we used for this analysis were hospital discharge data. The unit of analysis was the child birth hospitalization, and we looked at diagnosis codes that occurred during the child birth hospitalization to indicate severe maternal morbidity and mortality. So we have a very clinical lens on this problem in the data that we are looking at, and it's focused on that time period of the child birth hospitalization.

CHAIR BELLA: Thank you.

Peter, then Martha.

COMMISSIONER SZILAGYI: First of all, thank you for the work you do in general on this and for this work, Katy. I think this is really, really important.

A couple of questions. I know with this data, with the HCUP and the NIS -- and I've analyzed both of those datasets -- you can't speak with this dataset to the

third of deaths that were post-hospitalizations. Are there racial disparities in that third?

DR. KOZHIMANNIL: Yes.

COMMISSIONER SZILAGYI: Using a different dataset, the CDC data.

DR. KOZHIMANNIL: The CDC data do show racial disparities in maternal death writ large, so pregnancy through the postpartum year.

COMMISSIONER SZILAGYI: Okay. And is that third rising as well?

DR. KOZHIMANNIL: Are the racial disparities doing that? So I haven't seen data that distinguish each of the time periods that we're talking about here that distinguish maternal death, racial disparities in maternal death during pregnancy, racial disparities in maternal death at the time of child birth, and racial disparities in maternal death in the postpartum period.

COMMISSIONER SZILAGYI: Because, obviously, one of the policy levers, extending to one year, it can't affect or it's unlikely to affect, except for potentially subsequent births or something.

DR. KOZHIMANNIL: Mm-hmm.

COMMISSIONER SZILAGYI: The third that you examined in the HCUP dataset, but it would affect the third of deaths that happened within first year --

DR. KOZHIMANNIL: Yes.

COMMISSIONER SZILAGYI: -- after pregnancy potentially.

DR. KOZHIMANNIL: And I would argue that your initial point about how that would affect subsequent pregnancies is actually a very important one as well. I think that the postpartum time period, many people, especially if they're having their first child, will have another, and so having access to continued services, including family planning services and other health-related services may be helpful during that time period.

COMMISSIONER SZILAGYI: Yeah.

DR. KOZHIMANNIL: I see what you're saying.

COMMISSIONER SZILAGYI: I'll have more questions later, but this is a rare -- it's a tragedy. Every death is a tragedy. It's also rare, and it's, I think, pretty obvious that it's multifactorial.

DR. KOZHIMANNIL: Absolutely.

COMMISSIONER SZILAGYI: And the solutions are

going to be sort of many individual solutions rather than one big one.

DR. KOZHIMANNIL: Yes.

I want to comment on that last point as well that maternal death is a rare outcome, and it's increasing. And every death is a tragedy, and I believe we can do better with regard to the quality of maternity care in this country than did you die. Talking about severe maternal morbidity and mortality, we're so focused on these data. We can do more with just having access to a high-quality, high-value maternal care, and I think that is a place where I want us, as a nation, to feel more empowered to do better. Obviously, the maternal deaths are just the tip of the iceberg, so yes. Thank you very much for your questions.

CHAIR BELLA: Martha.

COMMISSIONER CARTER: Thank you so much. I had a couple of questions and observations. I would think that we would want to, sort of to Peter's point, add to the potential interventions Medicaid expansion overall, for the same reason that if women enter pregnancy healthier then any chronic condition is picked up, diagnosed, taken care

of more timely. And, you know, pregnancy is actually a very short period of time. We work with the mother for, at best, 7 months. And so it's really hard to do what really need to -- take care of what you really need to take care of in that short period of time, especially in social determinants and chronic illnesses.

So I think there's a really good argument for Medicaid expansion overall to save women's lives.

DR. KOZHIMANNIL: Mm-hmm. I've heard that spoken as well at a number of different venues where this is a topic of discussion.

COMMISSIONER CARTER: And I would say babies' lives too, because I think it's tied to infant mortality as well.

DR. KOZHIMANNIL: Mm-hmm.

COMMISSIONER CARTER: I'd like to hear you say more about the coverage for nonclinical services, what I'm going to generally call relationship models, because I think that's the commonality of doulas, community health workers, birth centers, midwives. All of these interventions individually have good data behind them, shown to be effective, but I think the fundamental behind

all that is the relationship and the trust-building that then is protective somehow of the mother and baby.

So say more about that, and also then, how do we really know, on a national level, when we make these interventions, that they're working when we can't access the data, which I've been on a tear about, because it's really just astounding to me that we can't get state-level mortality data. I understand that there are problems that data are small, but still, how do you measure what's working?

So I really -- it's a two-pronged question.

DR. KOZHIMANNIL: Sure. So your first question was about these coverage of nonclinical services, and I want to -- and the point about relationship-centered care I think is a very important one. This is something that a couple of teams that I'm working with have been -- we've been publishing on this topic, looking at a model of care that's provided in Minnesota's first and only African American-owned birth center. It's located in north Minneapolis, which is the neighborhood in Minneapolis that has the highest rate of infant mortality in the state of Minnesota, and really looking at that model of care and

trying to understand what the outcomes are of these relationship-centered care and how to finance and organize care to support relationship-centered models.

And I want to -- I think that's a very important piece. It's always been a very important piece of birth, and so when your systems and structures that are designed to support that will support healthy outcomes.

I wanted to distinguish clinical and nonclinical services in this context, because freestanding birth centers, midwifery care, those are clinical services and clinical care, and that's a much more straightforward path to Medicaid coverage. I think the nonclinical services -- and I would also, in the former you can put lactation consultants and even community health workers, which are generally part of medical care.

It gets a little bit more tricky when you start looking at providers who do not provide clinical care, that are providing other types of supportive services, and how to do that, whether it's nutrition, housing, transportation, those types of topics. The doula support sort of straddles that, where a doula is a nonclinical support that is supported in the clinical context, and

we've started to see a lot of change around state-level intervention around doula support and access, and I think that's a good model for moving forward.

I've done a lot of research on the topic of doula supports for Medicaid beneficiaries. The state of Minnesota was the second state to cover doulas through Medicaid, and I did an evaluation study of the implementation of that process, which was well-intended on all parts, on all parts, and was very painful, difficult, and slow, and still has problems.

And so -- and I'm happy to speak to that in greater depth if that would be useful to you, but I think that, you know, one of the challenges of state-by-state innovation, one of the benefits of that is you get proof of concept and you see whether or not something can work, and you learn lessons. One of the challenges to that is that it can further exacerbate some of the inequities if people, Medicaid beneficiaries in one state, have access to something that Medicaid beneficiaries in other states don't have. And so it can run the risk of exacerbating the very disparities that they're designed to address.

Your second question was around how do we know

this works, given the data challenges. I spend every day working with this, because it's -- I am incredibly frustrated by the lack of data, especially across payers and across the sort of reproductive time frame of pregnancy, childbirth, and the postpartum period, because so many people switch payers during this time. It is nearly impossible to find a data set that follows human beings over this time period, rather than a payment stream. So many of our regularly collected data are related to billing, and so it's difficult to follow people over time.

One of the things that we can do is, looking at outcomes that aren't death I think is an important way of analyzing this, and also pushing forward the data that are collected and reported by state maternal mortality review committees to be correlated and available for research with all of the appropriate caveats around confidentiality. Those of us that analyze data, I have been through every data training. I am so happy to protect the confidentiality of these data. There is just no structure right now for accessing, for collating and accessing those data, and I think that's something that needs to change if we're going to be able to have evidence to inform the type

of work that folks want to do to address this.

CHAIR BELLA: Kit and then Stacey.

COMMISSIONER GORTON: So thanks for coming. I really appreciate it.

So just quickly following up, before my questions, following up on what you were just talking about, we had the opportunity -- we created the opportunity to pilot doulas in a region in Massachusetts when I was still operating a health clinic. And to the data point, health clinics are not research organizations, and while we proved to ourselves and to our state customer that this was okay, you know, those data will not ever become public data. And so I do think that's a challenge in using private business partners as state partners to run these programs, is that you create a level of opacity that gets in the way of that.

But we found both of the things that you said to be true in our pilot. The first was that it was a terribly useful and very cost-effective intervention, and the second was that it was administratively enormously painful to work through all of the details. And I would add a third piece, which is the provider capacity piece.

DR. KOZHIMANNIL: Yes.

COMMISSIONER GORTON: So coming up with provider partners who could offer high-quality, culturally competent doula services. I mean, we only managed to pilot it in one county in the state because of provider capacity issues. So just to sort of underscore what you were saying.

I have two questions for you. The first, if you can go to your Slide 3 with the two charts.

DR. KOZHIMANNIL: Is it this?

COMMISSIONER GORTON: No. The one with the --

DR. KOZHIMANNIL: Oh, back here. This one? Yes.

COMMISSIONER GORTON: Yes. So what would you have us make of the left-hand chart, and in particular, blood transfusions you've called out as being somehow important. I just -- I don't understand this, so if you could help me understand that.

And then my other question I'll just throw out there so you can deal with it and we don't waste time is I'm assuming that your data are about states and the District and not about the territories, that you didn't have access to the territories in the data set. If that's true then are you aware of anybody who has looked at these

kinds of questions in the territories?

DR. KOZHIMANNIL: Yeah. Thank you so much for those questions. I'll answer the latter first because I believe that we do not have the territory data in the HCUP nationwide inpatient sample. And I am not aware of specific research that's going on around this topic in the territories. Thank you for bringing that up. I think it's incredibly important.

Your first question around this graph on the left here. So I don't want to overstep my bounds in terms of my expertise. This is a graph that's created by the CDC, and it's on their website, their overall website, and this is a measure of severe maternal morbidity and mortality that they use and have used over time. And it is a measure that has been refined by a researcher there named Elena Kuklina, who has been working on this for a long time.

The distinction between whether or not blood transfusion is part of a measure, it makes up a large portion of severe maternal morbidities and that's why it's separated, and it's a procedure that indicates that a severe problem has occurred, that someone would need to be transfused. And so that's my understanding, and again, I'm

not a clinician. That's my understanding of why that needs to be that way. If there's anyone else here that has greater expertise on that I would welcome you to help answer that.

COMMISSIONER CERISE: This is a point of discussion among our OB group as well, because, like you said, it's an indicator of problems with maternal morbidity. As they've looked to address this issue of hemorrhage, and have gotten more aggressive about it and developed hemorrhage carts and things like that, they fear that this measure could somehow skew what the situation is and come across as a bad measure --

DR. KOZHIMANNIL: Correct.

COMMISSIONER CARTER: -- in groups that are being more aggressive in trying to manage hemorrhage at the time of delivery.

DR. KOZHIMANNIL: Absolutely. Yes. So there is an element of -- transfusion is a procedure that's done in a life-saving circumstance, and it's possibly being done more frequently now because we know that it saves lives. And there are protocols in place that are encouraging the increased use of this. So we may be seeing more morbidity

and less mortality, in some individual circumstances, and that may be part of what is going on here. But we can see that, you know, if you have to be transfused at the time of delivery, that's a bad thing. It's not something -- but being transfused is better than dying.

COMMISSIONER CARTER: Not to get too far into the weeds with that, so a lot of hemorrhage is underdiagnosed --

DR. KOZHIMANNIL: Correct.

COMMISSIONER CARTER: -- or has been underdiagnosed, and that's part of the issue. So there's been a lot of clinician training on how to recognize hemorrhage, how to measure blood loss. And so, actually, if we do this well, we're probably going to see an increase in hemorrhage rates --

DR. KOZHIMANNIL: Yes.

COMMISSIONER CARTER: -- which then lead to appropriate transfusion rates. And I want to call out the California Maternal Quality Care Collaborative. They've done a lot of work on hemorrhage education.

DR. KOZHIMANNIL: And California is the state in the nation that has reversed this trend. When they started

collecting their own data and analyzing their own data, and designing interventions to reduce maternal morbidity and mortality, they turned it around. It's the only state where we've seen that on an individual level. It's also one of the only states that's large enough where we could see that happen on an individual state level, and it's a state that is very innovative in terms of the data that they're collecting and how they're analyzing it.

CHAIR BELLA: Thank you. Stacey.

COMMISSIONER LAMPKIN: Thank you so much for all this information. I have, I guess, some foundational questions that would be helpful for me as we move towards thinking about the policy options. And so they go to that CDC one-third, one-third, one-third question. And can you speak to whether the morbidity that we're talking about in this context is specifically pregnancy and childbirth related cause of death, or is it all cause of death, and how does that vary between the prenatal period, the period you were able to study in the HCUP data, and the postpartum period?

DR. KOZHIMANNIL: So when we measure -- so I want to distinguish -- there are a few distinctions I want to

make. One is the CDC data that we're discussing is maternal mortality, and maternal mortality comprises pregnancy-related and pregnancy-associated deaths. Pregnancy-related deaths are deaths that are a direct result of the pregnancy or conditions that are related to the pregnancy. Pregnancy-associated means you happen to be pregnant or have had a child in the past year, but you got in a car accident or you got cancer.

There are causes of death that are difficult to put between buckets, and this is part of what we do on maternal mortality review committees -- I've been on Minnesota's committee since 2012 -- is something like intimate partner violence. In cases where the intimate partner violence escalated as a result of the pregnancy or the birth, then that is something that is considered pregnancy-associated, in some cases, but there are difficult calls there.

So that is the process of maternal mortality review, of distinguishing whether it's pregnancy-associated or pregnancy-related. And that is all around maternal death. It does not look at morbidities. So what we were able to do in our analysis, we're looking at a broader

outcome, which is severe maternal morbidity and mortality, and what we're looking at in the childbirth hospitalization, it's difficult to think of something that would not be pregnancy-associated because it's happening at the time of childbirth -- I'm sorry, pregnancy-related, because it's happening right at the time of childbirth. However, some of -- it's -- you know, it's certainly very possible that during pregnancy and afterwards there are both morbidities and mortalities that are happening alongside of pregnancy, but not directly pregnancy-related.

Did I answer your questions? Please ask a few.

COMMISSIONER LAMPKIN: Mostly.

DR. KOZHIMANNIL: Okay.

COMMISSIONER LAMPKIN: And so I also assume that the HCUP data that you were analyzing was because it was childbirth inpatient stays, pregnancy-related.

DR. KOZHIMANNIL: Mm-hmm.

COMMISSIONER LAMPKIN: So the prenatal period and the postpartum period, did you say that one-third, one-third in the definition includes only the pregnancy-related and not pregnancy-associated?

DR. KOZHIMANNIL: The way that the CDC measures

it, it includes both pregnancy-related and pregnancy-associated.

COMMISSIONER LAMPKIN: Thank you.

DR. KOZHIMANNIL: Yes.

CHAIR BELLA: Kisha, then Fred.

COMMISSIONER DAVIS: Thank you for being here and bringing this information. I wanted to go back to the slide again that had the discussion points on Medicaid policy, and looking at the first one around reimbursement rates and Medicaid paying half of what private plans pay. And I just wanted to know if you could comment some on how that trickles down to provider access and providers being willing to accept Medicaid, especially in rural areas. We know that a lot of rural hospitals are closing. In some rural areas, pregnant women have to drive over an hour to get to a hospital that will deliver. And so if there are roles for Medicaid in that space.

DR. KOZHIMANNIL: Thank you for bringing this up. The interplay between Medicaid payment and policy and rural health care access and outcomes is enormously important in the space of childbirth. The way that the payment differences trickle down, in terms of administrative

decision-making at the hospital and health care delivery system level, that's -- I think it's something that we could -- it's something that I've certainly seen in anecdotal contexts. It's not something that's been the topic of a lot of empirical research.

And it is clear, from looking at patterns of care -- I've done research looking at differences by primary payer and the utilization of obstetric services, and can see, for example, that Cesarean delivery rates are much lower for Medicaid beneficiaries compared with privately insured folks, even after you control for all diagnostic criteria and associated demographic characteristics.

So it doesn't really make sense if the only difference is payer, and the difference there is how much money a provider is getting. I've presented this to clinicians and they will be like, "Oh my gosh. I would never make a decision to do a C-section or not based on someone's, you know, insurance." And I believe that they're right. It's that hospital systems understand their payer mix and create systems and structure to keep their doors open, and that, you know, relies on sort of information shortcuts and assumptions in ways that affect

people's lives in whether or not you get surgery.

And so I do think that these payment differences play out in important ways, and the financial pressure in rural hospitals, especially low-volume, rural obstetric units that are reliant on Medicaid -- so there's a fixed cost to having an obstetric unit and having your -- being ready to deliver a baby at any time.

And in these small rural hospitals the way that you pay for that is by each pregnant person that walks through the door and delivers a baby in your hospital. And each pregnant person that walks through the door and delivers a baby at your hospital comes with dollars attached to them, and if you're a Medicaid beneficiary it comes with less dollars. So that means you need more folks through your door to cover the fixed costs of providing services in that unit. And in rural areas, where the numbers are low and the proportion of folks that give birth are -- that are Medicaid beneficiaries is higher, that makes that math even more difficult, and is part of what we hear from hospital CEOs when they're talking about decisions to close rural obstetric units.

This is something that my team has been

researching for the past 4 years is looking at hospital obstetric unit closures and the effects on rural residents and their babies. And what we've found is that more than half of all rural counties have no place where you can give birth, and that rural counties that lose hospital-based obstetric services, that there's an increased risk of birth in an emergency room, out-of-hospital birth, and very importantly -- and this occurred in rural counties that were not adjacent to urban areas, so more remote rural counties -- higher rates of preterm birth.

We know infant mortality is higher among rural residents than urban residents. Preterm birth is the leading cause of infant mortality. So Medicaid policy is directly related to the services that are able to be offered in rural communities, financially, and that the loss of those services has real clear impacts on the health of moms and babies in those communities.

CHAIR BELLA: We have several people that still have questions for you, so we're probably going to run a little over. Are you able to stay a little bit longer?

DR. KOZHIMANNIL: I will stay.

CHAIR BELLA: Okay.

DR. KOZHIMANNIL: If I am being helpful, I will stay.

CHAIR BELLA: Wonderful. Fred, then Chuck, then Tricia.

COMMISSIONER CERISE: Thank you for the presentation. It's great information. One comment and then I'm going to ask you a question.

I'm in Texas, and a few years back there was a spike in maternal mortality that got a lot of people's attention. So they went back, and the legislature passed a law that said we'll create this commission to go study this, and then there's been a lot of rework on that, and I recently read a report of this commission. And I was curious. You explain -- you gave me part of the answer already, and that is, in this report, they noted that 56 percent of the related deaths happened post 60 days, so higher than the third. And when you look at the list, though it includes a lot of things, you know, overdose is at the top of the list, and you've got homicides on there, and you've got suicides on there and things like that.

DR. KOZHIMANNIL: Yes.

COMMISSIONER CERISE: And so I would imagine it's

sort of the more liberal interpretation or pregnancy associated, and it includes a lot of stuff maybe the CDC list didn't include. But it does speak to the importance, which is my question, around how do you cover and provide continuous care for all these other related conditions. You talk about Medicaid paying poorly, and so it's hard to have people participate. And then you're adding on all these other conditions that need to be plugged in.

We had a great presentation yesterday, and someone from Vanderbilt talked about, you know, all of the associated services --

DR. KOZHIMANNIL: My friend and colleague, Stephen Patrick.

COMMISSIONER CERISE: That's right.

DR. KOZHIMANNIL: I talked with him yesterday after he spoke with you.

COMMISSIONER CERISE: He did a great job of speaking to that.

DR. KOZHIMANNIL: Yeah.

COMMISSIONER CERISE: But I wonder, you know, if you could comment on sort of the importance of that system so that when women at 60 days roll off, if the issue is

substance use, you've captured them at a period where you've got their attention and the opportunity to make an intervention, and then to lose them at 60 days seems particularly tough. And so can you speak to the importance or, you know, maybe a strategy around having a system of care to sort of connect to all these other things -- hypertension, diabetes, things that happen, need for psychiatric services.

And then I'll ask you one more. In the context of rural, because, you know, other areas of health care, there's good data -- and I don't know the OB data -- that the more things you do, the better you get at it and the better the outcomes.

DR. KOZHIMANNIL: Yeah.

COMMISSIONER CERISE: And so this, the kind of --

DR. KOZHIMANNIL: Volume-outcome relationship.

COMMISSIONER CERISE: The challenge of low-volume providers and how you can supplement that in rural areas.

DR. KOZHIMANNIL: I'm going to take your last question first because I've done research on that and I can answer it directly, and that is, childbirth and obstetric services are distinct from other types of health care

services because generally the person's not sick. So in about 70 percent of cases where we have low-risk birth, there's not the same volume-outcome relationship that we see in other areas of clinical medicine and other areas, you know, surgical care, because for the most part high-quality, low-risk birth services -- and rural communities are actually providing -- rural hospitals actually provide more of that because what you need is sort of time and attention, which is not what the health care system pays for. So we see a really different relationship in low-risk birth in terms of volume-outcome in rural communities where you see very high quality outcomes in rural areas.

Now, pregnancy is low risk until it's high risk, and that can change very quickly, which is why it's important to have referral systems in place and transfer protocols and all of that to make sure that people have access to those high-acuity services. And those types of high-acuity care are absolutely part of -- you know, anytime you're looking at surgeries, part of the general realm of volume-outcome relationships want to get people to higher-acuity facilities where folks are more adept at using these procedures.

If you talk to folks in rural hospitals -- we did a study looking at rural residents with substance use disorder at the time of pregnancy, and the vast majority of those are Medicaid beneficiaries. And about 75 percent of those rural residents with opioid use disorder were giving birth in rural hospitals. So even though we're setting up these systems to be -- you know, to move everyone to Vanderbilt to see Dr. Patrick and others, where they have a beautiful comprehensive system, that's not where folks are going, and the risk is higher among Medicaid beneficiaries, because they don't have transportation or housing. They're not able to get to these urban centers where we are designing these clinical features and structures and supportive systems that can really wrap around people's lives and address these clinical risk factors.

So I think what there's a need for is a couple of things. One is in-community services and recognizing that rural hospitals are handling this, so the investments, whether they are Medicaid payment rates or policies or other policy investments, need to trickle down to rural locations.

Talking to a postpartum nurse or emergency

department nurse in a rural community, they will tell you about people with opioid use disorder that are giving birth in their facilities. They are handling these high-risk situations, and that's not probably the most effective or appropriate way to handle those services.

So we either need to get services down to the community level -- and that's probably part of it -- or the people to the places where the services are. And so thinking about how that could look, especially for Medicaid beneficiaries, is something that I think is a really helpful space to engage.

And then the postpartum Medicaid extension is a huge piece, and Tennessee did such a great job of acting on the data that they saw coming out of their Maternal Mortality Review Committee to make a state policy change, to extend Medicaid benefits for a year postpartum for those folks with the opioid use disorder, substance use disorder diagnosis, because we know that the postpartum period is a time when people relapse and have high risk of overdose deaths. And if you have access, you're in care and receiving services during pregnancy, it is such a shame to lose that, especially when you've got a little baby at

home. And people are motivated. They want to care for their families.

Another challenge is -- we talked about finding willing providers that will accept Medicaid, also willing providers that will accept pregnant patients, because we look at like buprenorphine waiver providers that accept Medicaid, for example, and the same thing for mental health, same thing for other types of higher-acuity services. Will they also see a pregnant person? Or are they, you know, only seeing other types of folks?

So I think that people who are pregnant and have complex clinical conditions, substance use disorder, mental illness, other complex -- like cardiovascular needs, are they able to access a provider that will see them during their pregnancy, not just because of their Medicaid, but that, too, but also because of their pregnancy and that condition. So I think looking at both of those is really important.

CHAIR BELLA: Chuck, you want to be skipped now?

VICE CHAIR MILLIGAN: Yeah, just in the interest of time.

CHAIR BELLA: Okay. In the interest of time,

Chuck passes to Tricia, and then Toby, and then we're going to wrap up. We can take a little bit more time for those of you that are trying to be kind. Tricia.

COMMISSIONER BROOKS: Thank you so much, particularly for your passion for the subject. I really appreciate that. And I know there's data out there on a state-level basis, but can you say more about the variability you've seen in the data in states? You mentioned California has done a good job of turning the curve. Where are the other model states that we should be exploring what they're doing?

DR. KOZHIMANNIL: We should be exploring what they're doing with regard to --

COMMISSIONER BROOKS: Improving --

DR. KOZHIMANNIL: -- maternal morbidity and mortality?

COMMISSIONER BROOKS: Yeah.

DR. KOZHIMANNIL: So California is the only state that I know of with clear data showing a reverse in their trends. I know a lot of states right now are using the vehicle of Maternal Mortality Review Committees to start to address this. The Preventing Maternal Deaths Act passed

Congress in December of 2018, and it provided some encouragement for greater data collection and for the establishment of Maternal Mortality Review Committees, but little in the way of like enforcement mechanisms and teeth behind that. You know, there's grant money that's available, but it's sort of a pull not a push situation.

Forty-six states have Maternal Mortality Review Committees right now, and I believe a 47th might have just passed a law to establish one. These are still very new in many states, and one of the biggest challenges with them -- and I say this as someone who has been on one -- is representation. Who is on that committee really matters. And we did an analysis looking at whether or not representation was required in statute for these committees, and if so, whether rural representation was required, in part because most of the people who create policy around maternal morbidity and mortality and maternity care generally have frankly never set foot in a rural health care facility and have no idea what the constraints are for actually handling clinical care and clinical emergencies in those settings. And that was certainly my experience. So only two states require rural

representation.

You know, whether or not states require representation from the groups that are most affected, whether that's Medicaid beneficiaries -- is someone from the state Medicaid office required to be on the Maternal Mortality Recently Committee, or is that something that could help with informing these discussions and then taking those lessons back to Medicaid to inform the ongoing changes that are happening, I would love to see a greater integration there between that mechanism that's in place for the data collection, for understanding the causes, and some of the policymaking entities, the payers as well as the folks that are most affected, rural residents and especially black and indigenous residents as well.

CHAIR BELLA: Thank you.

COMMISSIONER BROOKS: So just another --

CHAIR BELLA: Just quick, please.

COMMISSIONER BROOKS: Okay.

CHAIR BELLA: We have got to get to public comment, too.

COMMISSIONER BROOKS: All right. Sorry. Following up on Kisha's question, I actually was a little

surprised at the answer, that it's not necessarily a lack of access, it's how the care is delivered in a rural setting, you know, in terms of caesarean, and I am assuming you're talking about needed caesareans as opposed to elective. But can you say anything more about what -- you've said the clinicians are saying, "I would never treat a Medicaid patient differently", but what are they doing then that is causing -- is contributing to the poor outcomes?

DR. KOZHIMANNIL: I think it's -- I don't think it's the responsibility of clinicians necessarily. I think that the decisions that are made around clinical care, I think the choice set that clinicians have in collaboration with their patients is limited by the available resources and by the setting that they're in. So I don't want to completely absolve clinicians of all responsibility when they're making the decisions, but I also want to honor the fact that what they have available to them and what they can do in their hospital settings is limited by their own time, by whatever policies are in place there. There are hospitals that have policies that if you've been pushing for four hours, then we do a C-section. That's maybe not a

capital P policy, but it may be a norm, right? And so I do think that there are ways to -- and maybe this is a broader payment incentives question, can payments be created to -- instead of financially rewarding -- so doctors or clinicians who deliver babies get paid twice as much for a caesarean compared with a vaginal birth. Vaginal births can take like five days, and a caesarean can take 30 minutes. But the resource intensivity during those 30 minutes is very high. But those types of -- you know, if you're a private practice in obstetrics, you know that, and it's important to keeping your doors open and to paying the bills.

And so until we have payment incentives that are aligned with producing quality and not quantity in obstetrics, it's going to be very difficult to overcome that challenge, and it's exacerbated within Medicaid where the payment rate for a regular old low-risk vaginal delivery is -- it struggles to cover folks' time. I know in Minnesota Medicaid the payment for a person who catches a low-risk vaginal baby is about 700 bucks, and that's tough to cover costs, especially, again, in lower-volume settings or in places that are operating in rural areas.

CHAIR BELLA: Thank you. We're going to now turn and see if we have any public comment.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. I think we could probably pepper you with questions for a lot longer, but in the interest of time, Martha, thank you. I would just put a pin in. As we think about concrete recommendations and understanding what's working and what's not working, I would be very interested in some best practices around bundles because I think states are -- what they're including on the front and the back end is varied, and so if we could understand some of that, maybe we could talk about that at a future meeting if we have some information in that regard.

DR. KOZHIMANNIL: Absolutely, and that's another way -- because we discussed it, the coverage of non-clinical services, when those are included in bundles, that's another way to, like, shift the financing, to look at sort of what does a service package look like. It can be extended beyond what we normally look at. Again, there are challenges there as well, but...

CHAIR BELLA: Wonderful. Thank you for your work.

DR. KOZHIMANNIL: Thank you.

CHAIR BELLA: Thank you for being here.

DR. KOZHIMANNIL: Thank you so much.

CHAIR BELLA: All right. We are now going to turn our attention to the Medicare Savings Program, and Kate and Kirstin will present. Though we are running a little behind, we will make sure we have time to get through this. If we have to eat into the break, that's fine. We'll kind of see how much discussion we need to have. Talk fast, anyway. That sounds good. All right. Whenever you're ready.

IMPROVING PARTICIPATION IN THE MEDICARE SAVINGS PROGRAMS

* MS. BLOM: Thank you. So good morning, everybody. Today Kate and I are going to talk -- continue the discussion, actually, that we started in December on policy options for the Medicare Savings Programs to try to get more people enrolled.

So our plan for today is to actually start by going back to a study that we did with the Urban Institute

back in 2016 to kind of remind ourselves about what the eligible but unenrolled population looks like, the group that we're targeting to try to bring into the MSPs. Then we'll spend a little time talking about state policies that affect enrollments, and, finally, Kate's going to walk through the policy options for you guys to consider that we could use to try to increase participation in these programs.

So a couple years ago, the Urban Institute did a study for us that was focused on looking at estimates for participation or estimating participation rates in the MSPs to try to quantify those. But one thing they also did was look at characteristics of the eligible but not enrolled population so that we could better understand what might be some factors keeping them out of these programs.

So this table has two columns of numbers, and I just want to take a second to clarify. So these are two different populations. The first column with numbers is the enrolled population. The second one is the eligible but not enrolled. And this table allows us to compare characteristics between those two.

For example, the first row, age 18 to 64, we can

see that in the enrolled population, 42 percent have that characteristic, are age 18 to 64, compared to just 29 percent in the eligible but not enrolled, which tells us that the enrolled population is more likely to be younger.

There are several characteristics here that you can look at, but I think the three that are the most interesting are in the middle of the table. The private health insurance coverage, you can see that there is a higher likelihood to have private coverage among the eligible but not enrolled group compared to people who are enrolled, and then the reverse is true for enrollment in public programs like SNAP or SSI. The rates of enrollment in those programs are higher for people who are also enrolled in the MSPs.

I think that these things can tell us that, you know, it makes sense, people who are already accessing public programs might also then find access to the MSPs. And people who are more likely to have private coverage might, you know, have less interest in a program like this. So there's definitely room here, I think, looking at these results, for improvements in enrollment in these programs and potentially through things like outreach and changes to

state enrollment processes.

State policies also affect enrollment in the MSPs. Under current law, states can set more generous income and asset levels than the federal limits allow, and 12 states and the District of Columbia do this. Being more generous can occur through higher thresholds for income and assets or by eliminating the asset limits, for example. States with more generous levels tend to have a higher share of their eligible enrollees in their programs, and some, like Alabama, have reported a reduced administrative burden from eliminating the asset tests.

Differences between state policies and those of the Part D LIS program can also affect enrollment, making current law requirements that are designed to increase enrollment in the MSPs, like transferring application data from SSA, less effective. For example, some states count in-kind support from family as income, but SSA doesn't do that.

Another example is that states might define household size differently, limiting it to just the individual and their spouse; whereas, SSA often has a broader definition of that, making the state definitions

narrower, keeping fewer -- or keeping people out.

So I think that's all I wanted to say. With that, I'm going to turn it over to Kate to talk about the options themselves.

* MS. KIRCHGRABER: Thanks, Kirstin.

Each option that we're presenting today would increase enrollment in the MSPs, which would improve access to care for beneficiaries who may not be seeking it due to the cost of Medicare cost sharing.

Increasing enrollment in the MSPs would increase federal costs and may increase or reduce state spending, depending on the policy.

Policies that relieve state administrative burden or increase the number of Medicaid beneficiaries who enroll in Medicare Parts A and B could produce state savings, but policies that increase enrollment of partial-benefit dually eligible beneficiaries would increase state costs.

As we know from our earlier discussions, the MSPs and LIS program both provide assistance with premiums and cost sharing to dually eligible beneficiaries. So using one set of eligibility rules could make it possible to enroll beneficiaries in both programs simultaneously and to

automate enrollment and renewals.

This would require states to change their eligibility criteria, to make MSP income, asset, and household size consistent with the LIS. They can do that already using Section 1902(r)(2) of the Social Security Act, but it's currently a state option. And states that are using SSA verification have reported that they've been able to enroll applicants transferred by SSA with little to no work required by caseworkers. So this would help reduce administrative costs, but it may not be enough to offset increased cost of enrolling partial-benefit dually eligible beneficiaries. And states may also just prefer to continue using their existing income and asset limits.

For many low-income individuals, complicated enrollment and renewal processes may reduce their participation in the MSPs. So one option would be to use modified adjusted gross income, or MAGI, which is already used by states for the groups you see here -- children, pregnant women -- and to determine eligibility for tax credits on the exchanges.

Under current law, MAGI methods don't apply to individuals who are likely to qualify for the MSPs, so

people who qualify based on age or disability or who are on SSI.

Many of these individuals, though, have no earned income and often live in stable settings where their unearned income, Social Security number, or residence could easily be verified through data matches.

So the Commission could recommend a statutory change that would require the use of MAGI for determining eligibility for the MSPs. States are already used to using this approach. So the change could reduce state administrative burden, but again, they may prefer to keep their current rules and might not be happy about the increased cost.

A couple of options to simplify enrollment would be to extend express lane eligibility, or ELE, to the MSPs or to create a demonstration program that could test this type of approach. States can use ELE to accept findings from another public program like TANF or SNAP to satisfy eligibility requirements for Medicaid or CHIP. They can currently submit a state plan amendment to do this for children, but in order to do it for adults, they would need to submit an 1115 waiver.

Louisiana is one state that has done it for adults in their expansion group, new adult group, and they have reported that it was a cost-effective way to reach a lot of already eligible beneficiaries and enroll them.

So the Commission could recommend a statutory change that would enable states to use state plan authority rather than waiver authority to implement express lane eligibility for the MSPs.

Alternatively, we could recommend creating a demonstration program that would test this kind of approach. It could be modeled on another demonstration program that serves a similar low-income elderly population. I think one of our public commenters actually mentioned it at the last meeting, which is the Elderly Simplified Application Project, or ESAP, which is a program within SNAP that streamlines the application process for households with no earned income, and it uses data matches to verify application data and also extends the eligibility period for three years.

Dually eligible beneficiaries typically don't have big fluctuations in income that's likely to make them ineligible for Medicaid. So simplifying redeterminations

could keep people from losing coverage for failure to complete paperwork that may just show that nothing has changed in their household.

Federal law currently requires states to redetermine eligibility at least once every 12 months. So the Commission could recommend a statutory change to allow states to extend the MSP redetermination period to once every three years, and I'd just mention this is the approach that they use in the ESAP program in SNAP. And that's been shown to reduce burden on both states and beneficiaries and made it easier for beneficiaries to retain their benefits.

It could potentially lead to some individuals being renewed who are no longer eligible. I don't know that we know the extent that that would be an issue.

The Commission could also recommend or encourage states to use passive or ex parte recertification. They're already required to do this, but few states do, potentially due to systems issues or challenges like verifying assets.

So the Commission could recommend that CMS provide technical assistance to states to help them improve their processes so they can use ex parte for more eligible

beneficiaries.

The Commission could also require the use of prepopulated renewal forms, which currently is an option. That would reduce burden and increase retention rates among eligible beneficiaries, and the most recent data we have was 2016 that showed that five states were using prepopulated forms for the MSPs.

Low enrollment in the MSPs may also be due to a lack of awareness among eligible beneficiaries, particularly partial-benefit dually eligible beneficiaries who wouldn't otherwise have contact with their state Medicaid program. States have little incentive to reach out to them also because it's a straight cost to the states.

Outreach grant funding targets both MSPs and LIS and has remained fairly stable since the enactment of MIPPA in 2008. It's currently about $25.5 million. And the grant allocations to individual states are relatively low, given that that's $25 million across 50 states.

So the Commission could recommend an increase in outreach funding. It could also consider creating a state incentive to enroll partial-benefit dually eligible

beneficiaries to kind of offset, if we recommended an outreach increase.

We could recommend a permanent increase in FMAP to 90 percent. This would match the FMAP for the new adult group, which covers a similar group, beneficiaries with similar income level.

Alternatively, we could recommend a temporary increase in FMAP to test whether or not it increases enrollment.

Finally, the last option that we could discuss in the chapter would be to have Medicare assume the cost of the MSPs. It would require a change in the Medicare statute, but it probably would be the simplest solution because it would remove states from the eligibility and enrollment process. It would standardize eligibility across the states, and it would streamline enrollment into the MSPs.

It could have uneven effects across states, though, for states that already have more generous income and asset limits. If they're beyond the federal standard, it could actually decrease enrollment.

It could also have significant federal cost.

Full federal funding of the MSPs would increase cost to the federal government. It could add further strain to the Medicare trust funds, but it would probably be welcomed by the states.

A claw-back type of arrangement in which states would continue to contribute their current contributions to the MSPs would probably be less popular with the states. It was what was done as part of Part D, the drug coverage in Medicare.

States might argue too that they would have no way in managing this obligation, although they might currently say that they have no say over the premiums or cost sharing that they currently pay for the duals.

So I think that's -- yes. We're on to next steps.

So we can develop any of these into specific recommendations to bring back to the February meeting. We expect to have a draft chapter as well for review in April.

So, with that, we will turn it over to you.

CHAIR BELLA: Thank you. Appreciate this work. I think this is an important and very often overlooked area that could have a really positive impact. It's worthy of

Commissioner recommendation if we can understand where people are interested.

To start, it's Chuck and then Brian.

VICE CHAIR MILLIGAN: Thank you very much, Kate and Kirsten. Very helpful.

I guess I want to start with probably the cleanest way to increase enrollment, which is using LIS and potentially even kind of a direct data feed that states would just adopt. There are certainly precedents in other programs. Most states with respect to SSI eligibility, they're getting a feed from Social Security Administration where the disability determination has been made, the income eligibility has been established largely, and states, most states, they don't independently do that kind of eligibility work.

So I guess part of just kind of signaling, I think it's cleanest in a lot of different ways. I think there are second-level approaches that are certainly improvements but not as clean.

I have a question, and it kind of gets then to like who pays for a piece of this and what the cost piece of this is. I'm not sure whether to direct it to you all

or to Anne, honestly.

Have we done any prep work about potentially sizing, with CBO or otherwise, or estimates of the impact of any of these recommendations on federal spending and/or state spending?

For example, if we were to recommend let's take the LIS feed. Let's recommend that states be required to load it and potentially federalizing the cost of MSPs, using that as eligibility mechanism. It would be important, I think, to know what the federal burden would be, and if it's not that version, but LIS feed coming into the states, but then traditional match or enhanced match, it would be good to know rough allocations of cost so that we know at the time of recommendation, the implications of that recommendation to the federal treasury and to state general funds.

Have we done prep work? Can we develop estimates in a way that would be timely for recommendations?

EXECUTIVE DIRECTOR SCHWARTZ: We would typically get that from CBO. We've shied away from doing cost estimates ourselves because CBO is the arbiter, and we also usually don't go to CBO until we're more clear on what

you're interested in, have narrowed it down so we don't put extra burden on CBO. That would be our next step immediately after this meeting.

VICE CHAIR MILLIGAN: That would be helpful and if there's some degree of confidence that it would be timely even to have ranges or whatever the best we could get.

So I've kind of signaled where my preference is personally. My second-level preference would be to require simplification of eligibility, much like what happened in MAGI, not necessarily to use MAGI, but to eliminate the asset tests and to eliminate some of the other barriers that I think interfere with take-up of people who really need the financial support offered through MSP programs. And I think that that's, honestly, why LIS, I think, is preferable is they don't rely on asset tests. They don't rely on all of the state variability about different types of assets and all of that, which I think that creates its own take-up burden.

So I've kind of signaled where I am, and I hope that we can have a rough sizing of the cost implications of that to help inform future recommendations.

I'll leave it there, Melanie.

CHAIR BELLA: Thank you, Chuck.

Brian, then Bill, then Fred.

COMMISSIONER BURWELL: So I guess I have a comment and then a couple of questions.

My first comment is while these data in the Urban Institute study is interesting, I still feel like we don't really have a full handle on the eligible but not enrolled population on why they're not enrolled. I mean, it's a lot of people, if only 53 percent of those who are eligible are enrolled. I just don't see -- I feel a need for more information about the eligible but not enrolled.

So a third of them have private insurance coverage and may not be enrolled because they have other sources of coverage, but two-thirds don't have alternative sources of coverage. How are they getting their Medicare cost-sharing requirements paid for? I don't understand it. I don't think we have a good handle on that, and I think we need better data before we maybe come up with some policy solutions.

I do think there's also problems with the methodology in the work that has been done. I don't

understand how 16 percent of the people who are eligible but not enrolled are full-benefit Medicaid recipients. If you're a full-benefit Medicaid recipient, that means you're eligible for the full-benefit package, which includes Part B premiums and cost sharing. So I don't see how -- if someone can tell me how you could be a full-benefit Medicaid recipient but not be eligible for the same benefits that partials are eligible for, please tell me.

So I just think that we don't have the full picture of why the eligible but not enrolled population aren't participating in the program.

My second issue has to do with federalizing the MSP program, which I think has considerable merit, and maybe Chuck was getting to this. I wonder if one of the options that we were thinking of is not just that the federal government would pick up the full cost of it, but they would also operationalize the benefit. So that if you go in to apply for Medicare and you meet certain financial eligibility criteria, Medicare would just waive, "Okay. You don't have to pay Part B premium." Is that kind of the LIS approach?

EXECUTIVE DIRECTOR SCHWARTZ: I think that's what

meant by "federalize." It's not just federalizing the financing; it's federalizing --

COMMISSIONER BURWELL: Yeah. In the narrative, it was kind of unclear because we talked about claw-back, blah-blah-blah.

EXECUTIVE DIRECTOR SCHWARTZ: Sorry about that, but I think it meant -- it just becomes a part of Medicare.

COMMISSIONER BURWELL: Yeah. And they do --

EXECUTIVE DIRECTOR SCHWARTZ: Everything.

COMMISSIONER BURWELL: They determine whether you're eligible, and they waive your requirements for cost sharing.

EXECUTIVE DIRECTOR SCHWARTZ: They set the eligibility requirements.

COMMISSIONER BURWELL: They operationalized it.

EXECUTIVE DIRECTOR SCHWARTZ: They enroll the people, and however they do that, whether it's automatic or not, and they do the financing.

COMMISSIONER BURWELL: So it would be a uniform program across all states?

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

VICE CHAIR MILLIGAN: By the way, that would be

an interesting recommendation to bring forward. That wasn't what I was saying.

What I was saying was something more where they do the eligibility-related work for LIS and then send a data feed to the states to just load without further state action about eligibility, so that it would be like SSI, that the states would be taking a data feed that says, "Eligibility has been established federally. We're sending it now to the states for you to load and administer." So those are variations on the theme.

COMMISSIONER BURWELL: Well, I think that's something we can discuss.

CHAIR BELLA: Brian, just to clarify, what are we trying to -- we don't have survey data from people about why they're not participating. We know people are not participating. It's a consistent problem, and I guess if our biggest concern with aligning with LIS is that more people get on the program and that it increases state cost, then if eligible but not enrolled don't do it by aligning, then no harm, no foul to the state. But we still simplified a process, and it feels like our themes have been simplification for people and reduced administrative

burdens for states. So I guess --

COMMISSIONER BURWELL: I'm not recommending that we delay a recommendation for policy options.

I just feel like the research doesn't really give us the real full picture of any people are eligible but not enrolled, because I don't see people, a lot of people, just giving up coverage for those services. I mean, if they're not, how do they deal with the fact that they have to --

CHAIR BELLA: They have a bunch of medical debt.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. It's some way or debt.

COMMISSIONER BURWELL: Well, we don't know. You know, I'm not really sure.

CHAIR BELLA: Well, we don't know.

COMMISSIONER BURWELL: I mean, are some in --

CHAIR BELLA: We don't know that they're getting services; we don't know that they're not getting service.

COMMISSIONER BURWELL: You know, is SIPP really picking up people in MA plans where there's a buy-down of those things? You ask people, "Do you have other insurance coverage for these things?" "No. I'm in an MA plan." There's a lot of miscommunicating when you try to get these

data from surveys. There's a lot of not-accurate results.

CHAIR BELLA: Bill.

COMMISSIONER SCANLON: I'm in an interesting situation here because this has bothered me for about 20 years when I first learned about both, what Medicare beneficiaries' cost-sharing obligations were and sort of what the status of the Medicare savings programs was.

Part of what concerned me relates to your question, Byron -- or Brian. Sorry.

COMMISSIONER BURWELL: I'm not the poet.

COMMISSIONER SCANLON: Yeah, I know. Okay.

[Laughter.]

COMMISSIONER SCANLON: It was the lyrical nature of what you were saying that pushed me there.

We don't have definitive evidence of how these people cope, but what we do know -- and I think this is a potential indicator -- is that people without supplementary insurance in Medicare -- and there's only about 10 percent of Medicare beneficiaries that don't have supplementary insurance -- use less services.

Now, we traditionally ascribed the difference to the other people overuse it. Now, we don't know that,

though, and then when we look at Medicare beneficiaries' cost-sharing obligations, what we discover is the people with the biggest cost-sharing obligations are, in some respects, some of the sickest because it's the Part B drug copay, which has no limit on it. It's 20 percent of what those chemotherapy drugs are, and that can go into the thousands of dollars. And if you're talking about people that are qualifying for Medicare savings programs who are just hovering around the poverty level, that's a lot of money. So we do not sort of know.

The other question or other point that comes up in times is what's your motivation for joining a Medicare savings program. If you're above poverty, you're not getting cost-sharing assistance. You're just getting premium assistance, which until the last, I guess -- I don't know how many years. Medicare Part B premiums weren't so bad. They've gotten much worse. So that's a part of it, I think, that maybe contributes. We just don't know. To answer your question, we don't have any kind of definitive evidence, which I think is unfortunate.

In terms of the issue of the recommendations, here's where I find myself in an awkward position, because

I feel like eligibility decisions are above my pay grade. They are policy decisions, and I am here as a Commissioner, as an advisor, and so the question is, what can I say about this?

So what I want to bring to the table is the issue of, well, here are the facts about who is going to be affected by a decision that you make with respect to Medicare savings.

I very much would hope that there would be receptivity to the idea of aligning with the low-income supplement, subsidy program, because I sort of used the logic of "Policymakers, you made that decision that that was the appropriate level for support, for assistance with cost sharing on drugs. What do you think should be the appropriate level for cost sharing on other services? And here's the potential when you make a decision that's different." So from that perspective, I feel like there is a basis for saying the low-income subsidy program is potentially a model for policymakers to consider, and here are the consequences of not adopting it. That's the kind of message I would be giving to policymakers.

Administrative simplification or administrative

standardization, that's a no-brainer always. Why are we wasting our resources on things that are more difficult? I mean, we never should be going there.

I think we have a situation here where we know we're not going to, though, save on administrative resources enough to offset what are going to be increases in actual spending for getting people access to services. So I think we have to acknowledge that, but again, the principle, we should always be thinking about administrative efficiency as one of our tenets.

The last thing I would mention is this idea of federalization, and I would like to talk about it not as adding to Medicare but talk about it as federalization. Because Medicare is not a financing source. Medicare has financing sources that pay for the services within that program, but if you were to ask Medicare to do something sort of new today, you would have to ask yourself, well, where is that money going to come from?

When we did Part D there was essentially a trust fund added to Part D, but it's not a trust fund in any stretch of the imagination like the Part A trust fund, where people are contributing over time and were drawing

sort of on it. It's 75 percent general revenues every year deposited into this account to pay the bills that have been incurred. That's just pure federal financing, and it doesn't have to be deposited into a nominal trust fund. It could be that the federal government assumes its responsibility, pays for it out of general revenues because we're presumably not going to ask sort of for premium assistance or assistance from premiums, because we're talking about sort of a lower-income population to begin with.

So I think that if you want to talk about sort of Medicare options for financing, that would be one thing, but I think there's also a -- what I will call a pure federal option that would exist in terms of how the money would actually flow.

CHAIR BELLA: Thank you. Toby?

COMMISSIONER DOUGLAS: So just one major question I have is what value -- and when we think of this program in many ways this really is a Medicare program -- what value do states play in administering this program, when we think of federal-state program?

And so, you know, I just come both from thinking

about it from an administrative simplification of the state's responsibilities of either, whether you call it a federalization or having it administered through a federal process, that this just doesn't make sense just to move to an LIS as the solution but really having this be what it is, which is a federal responsibility is the approach that could then result in a lot more take-up and redirecting resources at a state level to running the Medicaid program.

CHAIR BELLA: Thanks. Fred, then Tricia? Oh, no? Tricia.

COMMISSIONER BROOKS: Just a clarifying question. I thought we don't make recommendations that would impact Title XVIII. So my question is, how do we recommend federalizing, or using a different term, MSPs?

EXECUTIVE DIRECTOR SCHWARTZ: You don't recommend. You discuss, in a pointed way.

COMMISSIONER BROOKS: Okay.

VICE CHAIR MILLIGAN: You know, Kate, when you did the presentation you talked about kind of cost-shifting to the federal government some of this, in terms of, you know, enhanced match and whatnot. I do -- I want to go back to a comment Bill just made about Part B premiums and

sort of talk from the vantage point of a former state Medicaid director.

Over time, Part B premiums have risen at a rate far in excess of state general revenue growth, far in excess of any CPI or other index. And to the extent that Medicare sets Part B premium rates and yet states are obligated for partial duals and under these MSP programs to pick up Part B costs for a lot of these individuals, there has already been, over time, a tremendous cost shift on the state general fund burdens, the cost of Part B premium rate increases that far exceed state general fund revenue growth.

And so I do think that, contextually, as this discussion proceeds, and as whatever chapter or narrative we end up delivering, wherever our recommendations may go, I think contextually we have to talk about the above -- the added burden, over time, of the trend of Part B premiums growing at a rate far in excess of the trend of state general fund revenue growth, and the inability of states or state Medicaid programs to, in any way, manage that cost.

COMMISSIONER SCANLON: If I could sort of point out, I mean, let's not blame sort of Medicare. This is an

issue of health care costs, because the exercise of setting sort of the Medicare Part B premium is purely an arithmetic problem. They have to -- they, by law, sort of have to pay that 25 percent of whatever their costs are going to be.

The issue would be if Medicare were not covering these individuals what would be the burden sort of on states. That's a question that also should be on the table at the same time. So I think we don't want to get into this.

CHAIR BELLA: I'm going to have the two of you take that outside.

[Laughter.]

CHAIR BELLA: And I think Chuck's point is, this is sort of a pass-through cost to states, and whether it was that or something else like states have, do they have to keep absorbing it in their budgets? And no blame on Medicare itself.

Darin and then Stacey?

COMMISSIONER GORDON: A couple of things. So have we gotten feedback from states with regards to those that have not aligned with LIS eligibility standards? Like have we gotten any feedback from them like on -- was there

an intentional reasoning, or was it just that they had not chosen to do so?

MS. KIRCHGRABER: We haven't yet talked to states but we were trying to kind of firm up where we were going first.

COMMISSIONER GORDON: I just think it would be helpful to understand if there's some impact that we're missing or if there's some rationale I think it would be a helpful context.

Secondly, when we talk about, you know, some folks have discussed whether or not, you know, Medicare takes over this, and we talked about CBO quantifying this, the one thing that I think will be a huge challenge is that, you know, it's the lesser of, you know, the state fee schedule, or what Medicare would have paid, or, you know, what you pay on the cost sharing.

And a lot of states -- and this has been an issue that's been well documented, about for, you know, you've even heard Tim Englehardt talk about it with regards to duals, where state fee schedules are below what Medicare would have paid and so they pay zero, in many of those cases. And if you were to change the dynamic in who was

responsible for the program, you know, I think the cost would look different than what it looks today. It wouldn't just be a transferring from the states to the federal government, what's occurring today. I think that's just something that, you know, everyone needs to be aware of, that that's an odd dynamic that's state by state.

And then lastly, your comment about the reverification period, you know, I've said this in other areas, there's a lot of areas where it makes total sense to be on the cadence that we are. There are other areas where there's just not high volatility or churn in a particular category. And I would suspect this would be one of those categories that is really just increasing administrative processes, and there's a large degree of approvals, if not 100 percent, for those who are already on their program. And so it does beg the question of whether or not an extended period for those folks in that circumstance would make sense.

CHAIR BELLA: Stacey?

COMMISSIONER LAMPKIN: Thanks. I just wanted to kind of weigh in on what I think about the options, based on my understanding so far, my level of comfort. I think I

could feel like I could recommend or move towards a recommendation in the areas of improving outreach and enrollment simplification, like try to make sure that people who are already eligible know that they're eligible and have a relatively streamlined path to enroll and get the benefits. I feel less comfortable about recommending changes to eligibility at this time, based on what we know about stuff, although some outreach to states, like Darin suggested, could change my mind on that.

But I think we could still talk about those things, present the problem, discuss it, and the same thing with federalization. But I personally, right now, don't feel comfortable with a recommendation in those areas.

CHAIR BELLA: Other comments? I'm going to hold my comments until we hear from the public, and then try to wrap up where I think we are. Public comments?

PUBLIC COMMENT

* MS. FRIED: Hello. I'm Leslie Fried from the National Council on Aging, and I had the opportunity of communicating with Kate and Kirstin during the last month. And I really want to reflect on something that Bill said about how there's this growing population of people who

might be 101 percent of poverty, and maybe just a few thousand dollars, literally, maybe have $15,000 that's supposed to last for the rest of their lives, which makes them over income for cost-sharing but also over income and asset for any of the Medicare savings programs, so they get no assistance.

And I really think it's important to reflect on the increased costs of health care, which you all talk about all the time, as does MedPAC, and the importance of really thinking through the need to expand the eligibility criteria for people who are 65 and older, or people with disabilities, who have very limited income and maybe a little bit of assets, but assets that are supposed to last for the rest of their lives. And so as we see the increase in Part B and increase in cost-sharing, I hope you really think about those costs.

The second thing I just want to mention is that CMS and the Medicaid program did a whole sort of architecture, enterprise architecture about like all the data and the changes that go back and forth, and how different all the states are. And it's really complicated. Even how often they exchange data about Medicare enrollees,

and how it goes back and forth. And I think about it because we hear from folks in the field who work with Medicare grantees, and that annual recertification -- people get lost. I think it was Darin who talked about the churn. They just get lost. They don't get the notice. They don't realize they have to do something.

And so if you could think about all that data exchange and how it would be really simplified if they could have a 3-year certification period as they do in some states with SNAP.

And finally just the MIPPA outreach and the funding, as was mentioned, I think, in the presentation about how little it is for each state. And, you know, each state gets a little bit of difference based on the formula, but it's not that much. If you do anything to recommend increase in funding to the SHIPs and the AAAs and the ADRCs and all the other trusted advisors in the communities to help people enroll, that could make a significant difference as well. Thank you.

CHAIR BELLA: Thank you. Do we have other comments?

[No response.]

CHAIR BELLA: So I would like to see us talk about eligibility and move toward recommendation on eligibility. It feels like there is a disconnect there and we can make a great impact there. So I'd like to understand from Commissioners -- Stacey, I'll start with you -- what do you need to feel comfortable moving in that direction? Because if we can't give the -- some of us have comfort moving in that direction, and now others don't. And so what do we need to do to get the rest of you comfortable that we can have that discussion in February?

COMMISSIONER LAMPKIN: So I think, for me, it's a mix of a couple of things. I don't think I'd go quite as far as what I thought I heard Bill say, which was saying that eligibility was above our pay grade. I think there may be circumstances where something is so compelling that we could say that. But I think that that is a big -- for me, it does feel like a big step that requires something fairly compelling, as an argument towards it.

And similar to some of what Brian said, we lack a lot of data that helps inform our understanding about the dynamics about what we see here, and that data, as I understand it, is not practically gettable.

And so to me it feels like the combination of taking a big step without enough data that really helps you understand the situation. Now it could be that some Commissioners have, through their own personal experience, a lot deeper understanding, and they feel there's a compelling argument to this, but that's not experience that I have and not information that I feel like I haven't seen that compelling argument.

CHAIR BELLA: I'm going to pick on this side of the table, because you all haven't had much to say on this. Well, that end of this side. All right. I just want to make sure that if there are others who feel that -- I want us to have a healthy discussion about this in February, so we can see what we have to do leading to a June report. And so it's very important that we leave this session making sure if there's something that you need, to be able to have that healthy discussion, that we communicate that to these guys so that they can get -- I mean, some of what we need doesn't exist, most likely, but if there are other things in your mind that are giving you any trepidation about further discussing this and moving towards a path of some recommendations, please get that out right now before

we close this session.

Darin?

COMMISSIONER GORDON: I said but I'd reiterate it. I'd like to have the states' perspective on this. I mean, they are impacted, they are involved with it today, they're in the weeds, and I think that would just help me fill in, I guess, a blank spot, sort of to Stacey's point. That would just help me understand if there are some blind spots that we're not taking into account.

So I'm not opposed to going down the path but I do think that's a necessary element to inform a recommendation.

CHAIR BELLA: You think if we suggested federalizing any state would say no?

COMMISSIONER GORDON: I don't know the answer to that. I'm sure, knowing states, some would say no and some would say yes.

CHAIR BELLA: All right. Others? Toby?

COMMISSIONER DOUGLAS: Well, two things. One, I agree with Darin. I think -- I mean, I made that assertion about states and I think we need to validate and hear from them. Two, I do think, just looking again on Slide 3,

because, you know, I hear states -- and Brian, I totally respect that we need more, but I do think what Kirstin was saying on Slide 3, you know, gives us a lot of insight into why they're not enrolling, around this intersection between --

COMMISSIONER LAMPKIN: That data is 2009 and 2010, right?

COMMISSIONER DOUGLAS: That's fair. Okay. But, you know, I guess the question -- so you're saying we need to get more up-to-date -- but have we seen much growth, and has there been change in enrollment over that period of time?

MS. BLOM: Participation has been pretty low across -- like there was a CBO estimate in like 2004. All the studies have kind of had sort of about the same levels of participation.

COMMISSIONER DOUGLAS: So we haven't seen change, and I guess all I'm saying is this -- I think this gives us a good idea what we would expect if we were to try to get the data that seems not available, that it's individuals who just don't -- they're not going to -- they don't want to access the system where they have to go to get enrolled,

which is, you know, either going into a Social Security office or others, and that they're more likely -- or SNAP or others -- that they're not likely to do it.

And so the question is how do we, whether it's through other means that they're already accessing, enroll them?

COMMISSIONER SCANLON: My reaction to these numbers was that if you don't have some type of contact with public programs you're much, much less likely to enroll. And the telling number is the age 65 and older, the 72 percent of them that are not sort of enrolled. It's because if you're kind of just above poverty, over 65, you sign up for Medicare with Social Security, you don't even think about this.

Most of these other groups, they have reasons to have had contact with public programs. I mean, the 18-to-64 Medicare eligibles, they had to know about sort of disability coverage and the 2-year waiting period, and all that. So I think there's a potential reason that you just don't have this much contact with public programs.

CHAIR BELLA: Chuck for the close.

VICE CHAIR MILLIGAN: Uh oh. I just -- it wasn't

in the slides but it was in the materials we received ahead of time. I want to just draw the Commissioners to -- it's page 3 of the report that we got. And I'm not going to read it, but we do have some evidence from states that don't have asset tests about administrative savings.

We do have evidence from states that eliminating the asset test -- so it would be good, maybe, Kate and Kirstin, for purposes of February, do we have different take-up rates for this slide of the states that have eliminated asset tests and simplified the eligibility process for MSP relative to other states? You do comment that Alabama, Mississippi, and New York have reported administrative savings in time and money from eliminating asset tests.

I do think there is some evidence about the barrier created to eligibility by virtue of asset tests. I do think that that -- we did hear, in previous meetings, that the asset tests were correlated with low take-up. So I want to address a little bit of the kind of comments about we don't know what we don't know. There is some evidence out there.

And the other, I guess, comment I want to make is

I think eligibility is absolutely squarely within our jurisdiction. The second A in MACPAC is "access," and access is derived from eligibility, among other things, provider capacity, et cetera. But to me, eligibility as related to access and barriers to access, that is squarely, in my view, within our pay grade. In fact, it's within our obligation.

So I think that's what I wanted to comment on as well.

CHAIR BELLA: So you have everything you need, right? So I think you're hearing we would like to come back to this in February. You have some requests to see how much you can get us back in some of these areas. I do think we can try sort of pairing some of these potential recommendations together to take us one step further. I think the biggest request is just see what you can come back with, and what you can't we will make the best out of the information that we have and continue to discuss it in February.

Do you have any last clarifying questions or anything you need from us?

MS. KIRCHGRABER: I think we're good.

CHAIR BELLA: Okay. Thank you very much.

MS. BLOM: Thank you.

CHAIR BELLA: We are going to take a break. I'm going to ask everyone just to take a 10-minute break, and please be back at 10:55. Thank you.

* [Recess.]

CHAIR BELLA: Okay. If everyone can be making their way back to their seats, please.

Chris, you have the unenviable task of going last with, arguably, a -- well, how should I describe -- you describe the subject.

* MR. PARK: This is possibly the --

CHAIR BELLA: And it's all yours.

MR. PARK: -- Nerdiest discussion that we've ever had.

[Laughter.]

INTERPRETING TRENDS IN SPENDING DATA: IMPACT OF PRIOR PERIOD ADJUSTMENTS

MR. PARK: So I fully embrace it. That's right. Okay.

So today I'll be discussing how we use expenditure data and how prior period adjustments may

create distortions in state spending trends for certain services or populations over time. First, I'll provide a brief background on state expenditure reporting, and then I'll discuss prior period adjustments and how these may create anomalous amounts in expenditure reports, such as negative spending for a particular service in a year.

I'll provide some examples of how we see large fluctuations in spending for particular states when we look at the spending initially reported, but if we realign the prior period adjustments back to the period to which they apply, it will actually show a more gradual trend over time.

How we use and report expenditure data and how these prior period adjustments are treated in analyses can have significant policy implications. For example, prior period adjustments show that the new adult group was not as costly in the first few years as initially reported. Additionally, prior period adjustments can affect our understanding of how territories are in comparison to their allotments and when they may exhaust funding. Also, for any proposals that change Medicaid funding such as per capita caps or block grants, prior period adjustments could

have a significant effect on where a state's baseline is set.

Medicaid financing is a shared responsibility of the federal government and the states. In order to receive federal matching funds, states must submit their expenditures to CMS. Specifically on a quarterly basis, states report summarized Medicaid expenditures on the CMS-64, which serves as the basis for the amount of federal funds paid to the states. States certify their reported expenditures are actual expenditures allowable under federal requirements, and they provide supporting documentation for the amounts reported on the 64. CMS has the authority to defer questionable expenditures or disallow improper expenditures.

States are required to report their expenditures to CMS within 30 days of the end of the quarter, and states may adjust their reporting for prior period adjustments for up to two years. This is also known as the "two-year filing limit." These prior period adjustments are a natural result of business processes and oversight activities to ensure that states receive the appropriate amount of federal matching funds. These adjustments may be

made for such things as the reclassification of expenditures between different types of services, recoupments from managed care plans from arrangements such as risk corridors or medical loss ratios, or resolution of deferrals or disallowances.

The CMS-64 contains a series of forms that capture expenditure data from different aspects of the state Medicaid programs, such as waivers or populations that have different matching rates. CMS aggregates the expenditures across all of these forums to calculate the state's total spending and a corresponding federal share and compiles this into a net expenditures report called the net financial management report, or net FMR. This is the primary report we use to report expenditures for Medicaid.

The net FMR includes spending on services paid during that particular reporting quarter as well as prior period adjustments. We often see fluctuations in year-to-year spending reported on the net FMR, particularly when analyzing spending at the state or service level. These fluctuations may not represent substantial policy changes, but instead reflect variations in spending that are related to when prior period adjustments are reported. We can

realign the prior period adjustments back to the period to which they apply to remove this variation.

When I say realigning the prior period adjustments, this means removing any adjustments that apply to a prior fiscal year while adding in prior period adjustments made in subsequent years to the year of interest. For example, we could realign fiscal year 2016 spending by removing prior period adjustments for the 2016 net FMR that apply to fiscal years 2015 and earlier, while adding in prior period adjustments for 2016 expenditures that were reported in 2017, '18, and '19.

To assess the effect of prior period adjustments, we compared spending using the net FMR from each state from 2014 to 2019 and compared it to spending after prior period adjustments have been realigned. We included prior period adjustments made through September 30, 2019. The results for 2019 are preliminary and only reflect the removal of prior period adjustments made during that year. We cannot add in any adjustments from any subsequent quarter since we don't have that reporting quite yet. As a result, the FY2019 results are likely to change in the future.

So these next few slides focus on the total net

benefit spending in states. At the national level, realigning the prior period adjustments did not substantially affect total Medicaid benefit spending throughout the period we looked at. This is for two reasons. First, most states did not make substantial prior period adjustments in any single year during this period, so the amount of adjustments removed were generally matched by the amount of adjustments made in subsequent periods.

Second, in most states, the size of the adjustments is generally not large enough to affect the national total. Only a few states, such as California or New York, could have a significant effect on the national total.

Please note on this exhibit that California has been excluded due to anomalous prior period adjustments that affect 2016 and '17, which I'll talk about a little bit later.

This slide shows New York's total benefit spending for fiscal years 2014 through 2019. Based on the original expenditures reported on the net FMR, which is the blue dotted line, you can see that there is a pretty large increase in benefit spending in 2017 of almost 24 percent,

followed by decreases in spending of 3.9 percent and 19.3 percent in the following years.

After we realigned the prior period adjustments, we now see a more gradual increase over time. It appears that the adjustments made in 2019 reduced spending in 2017 and 2018, and the shift of these negative payments to those particular years correspondingly increases the spending in 2019.

This is an example from Rhode Island, and you can see that based on the original net expenditures and the blue line, you see large swings in total benefit spending from 2014 to '17 where it increases a lot in 2015, decreases in 2016, and then increases back in 2017. Once we realigned the prior period adjustments on the green line, you see that these fluctuations no longer exist, and it's more of a steady increase.

This is an example from the Virgin Islands where we see large amounts of spending in 2014 and 2019 compared to the surrounding years. After realigning the prior period adjustments, you see that the spending does fall more in line with what you would expect from the prior years.

The 2019 expenditures do appear to go toward years prior to 2014. This example shows how it may be misleading if we use fiscal year 2019 spending to try to estimate where the Virgin Islands are compared to their allotment and when they may exhaust funding in future years.

The CMS-64 has been the primary source for analyzing spending for the new adult group. Based on the initial amounts reported on the net FMR in fiscal years 2014 and '15, some policymakers expressed concern that spending for these enrollees was higher than expected and the Medicaid expansion may be more costly than predicted.

The following examples show how some states made substantial prior period adjustments for the new adult group in subsequent periods that ultimately reduced the cost of these enrollees during the first couple of years. Many states enrolled the new adult group in managed care and implemented risk mitigation strategies such as risk corridors or minimum or maximum medical loss ratios. It may take several years for states and managed care plans to settle the results of these risk mitigation arrangements, and when states recoup money from the plans or make any

additional payments to the plans, these would likely be reported as prior period adjustments in a subsequent quarter.

So the experience of New Mexico shown here provides an example of this dynamic. We see that New Mexico experiences a large decrease in spending for the new adult group in 2017 followed by a large increase the following year. Once we realign the prior period adjustments, it's a very gradual increase over this period. And it appears that the negative adjustments in 2017 reduce spending for '14, '15, and '16. Because most of the spending in New Mexico was for capitation payments, this may reflect recoupments from managed care plans.

This example from Massachusetts shows a large spike in spending. They've reported no spending for the new adult group in 2014. It goes up to $3 billion in 2015 and down to $2 billion in 2016. After realigning the prior period adjustments, we see that the 2015 spending is actually kind of split between 2014 and '15. Because Massachusetts has expanded coverage to certain nondisabled adults prior to the ACA, they may have had difficulty reporting the expenditures for these enrollees in 2014 and

subsequently reclassified that spending in 2015.

This example from New York shows particularly significant data anomalies in 2017 as the state actually reported negative $5.2 billion for the new adult group on the net FMR. Likewise, their preliminary 2019 expenditures show a significant increase of over 250 percent from the prior year. Both of these years result in extreme outliers compared to other states, particularly when calculating spending per enrollee. Not only do these results produce large variations in New York spending, but the size of New York also influenced the national total. After realigning the prior period adjustments, spending for 2017 and '19 fall in line with the surrounding years, and it does appear much of the negative -- or much of the prior period adjustments in 2019 go to increase the spending in 2017.

The next few examples show how prior period adjustments may affect our understanding of spending at the service level for inpatient hospital and drug rebates.

So this example shows Texas fee-for-service inpatient hospital spending, and based on the original net expenditures, Texas experienced a large increase in inpatient hospital spending in 2015 and 2016, followed by a

large decrease in 2017. After we realigned the prior period adjustments, we see a gradual decrease over time during this time period, and it appears that the large amount of prior period adjustments in 2016 were used to increase spending in 2014 and years prior.

This example shows New York's drug rebates. States are required to break out rebates between fee-for-service and managed care on the CMS-64. Based on the original net expenditures, New York reported negative fee-for-service drug rebates shown on the green bars in fiscal years 2015 and '18 and negative managed care drug rebates, the light blue bars, which don't really show up very well on this particular graphic, in fiscal years 2017 and '19. After realignment, we no longer see these negative rebate amounts for either managed care or fee-for-service.

Additionally, the realigned prior period adjustment expenditures for the total rebates, the dark blue line, doesn't change much between the net FMR and the realigned spending. This indicates much of the prior period adjustments for the drug rebates, particularly for fiscal years 2017 and '18, where we had negative rebates reported, were likely reclassifications from fee-for-

service to managed care, or vice versa.

One thing to note about this chart is that we typically report drug rebates as negative spending amounts. Here we display the rebates as positive amounts, so positive amounts here actually reduced spending, while negative amounts actually increased spending.

When policymakers analyze spending trends or assess current policies, spending data that hasn't been realigned can be misleading. The net FMR is an accurate representation of the cash flow for that particular year. Dollars for adjustments made to prior periods were actually expended in those years that they were reported. So the net FMR may be more appropriate for certain accounting or budgetary purposes. Realigning the prior period adjustments may be better for certain policy analyses as it removes that variation due to the timing of reporting. This may be particularly relevant when significant changes occurred, such as expansion under the ACA. The CMS Office of the Actuary has acknowledged this fact and in their actuarial reports have discussed how states are expected to recoup money from managed care plans for the new adult group, and significant amounts of prior period adjustments

will be made in 2016 through 2018. That will reduce the initial spending in earlier years.

These recoupments address some of the initial concerns about the cost of the Medicaid expansion and bring spending for the new adult group closer in line with that of non-expansion adults.

In some cases, the large variation in spending on the net FMR could have significant consequences for states and territory financing. In some cases, for example, as part of our work on the territories, we have used the CMS-64 data to compare the territory spending to their annual allotments and estimate when they exhaust their funding. Prior period adjustments are applied against the respective years' allotments, so realigning these adjustments will give us a better picture of how the territories' spending ultimately compares to that particular year's allotment.

Additionally, we have been asked to estimate how much funding the territories need in the future. If we use a year in which a territory makes a large prior period adjustment as our baseline for projections, such as the example from the Virgin Islands, we could greatly under- or overestimate a territory's future funding needs.

Additionally, prior proposals for alternative financing models such as block grants or per capita caps have proposed using CMS-64 data as the data source for the baseline amount of federal funds given to the state. In our prior work, we highlighted how the choice of a base year could have a significant implication for states due to the variation of spending that's reported on the net FMR. If the net FMR is used, a large amount of prior period adjustments in the year chosen as the base period could result in certain states receiving a block grant or per capita cap amount that is too high or low. A high cap would shift more spending to the federal government, while a low cap would result in underfunding the state's program.

A rolling average of the net FMR could mitigate some of this year-to-year fluctuation. However, it could incorporate some of the anomalies created by prior period adjustments. Realigning the prior period adjustments could lead to a more accurate estimation of the amount of spending required to provide services to the enrolled population during that base period.

However, there are some trade-offs when realigning prior period adjustments. There is a trade-off

between timeliness and accuracy. Because of the two-year filing limits, states would have at least two years to report prior period adjustments. So we would need to wait about two years at least to report on these realigned prior period adjustments. For example, to get a fairly complete picture of fiscal year 2019 spending, we would want to incorporate any prior period adjustments made through fiscal year 2021.

Additionally, while realignment can correct certain anomalies, it could also introduce new ones. For example, in this table on California -- you know, we mentioned that we had excluded California from earlier exhibits due to some of these anomalies. So based on this table, you can see that on the original net FMR, California reported about $83 billion in spending in fiscal years 2016 and 2017. Once we realigned these prior period adjustments, the spending in 2016 increases over 50 percent to about $130 billion, while spending for 2017 decreases by around 50 percent to $44 billion. You know, these results definitely appear anomalous, and in future years, the subsequent adjustments may ultimately reverse some of these changes.

So, with that, I will turn it over to the Commission.

CHAIR BELLA: "Anomalous" is a good description of that. Thank you, Chris. I think you highlight some really important implications of understanding this and the nuances of that, and hopefully folks on the Hill, when they're making decisions, are heeding those warnings or signs as well.

Comments or questions from Commissioners?

Brian.

COMMISSIONER BURWELL: So this is actually an issue that's near and dear to my heart because I've been using the 64 data for over 30 years to produce our Medicaid LTSS expenditures reports, which are an extremely popular product among the states.

When I started doing this work, we didn't include prior period adjustments, just figuring that it all came out in the wash and it would be all right, but then, gradually, when we started introducing the concept of rebalancing between institutional and HCBS services, there were individual state variations that were highly impacted by prior period adjustments. And we got a huge pushback

from states that didn't like where they were coming on the ranking, and we were like, "Well, that's what you reported, so that's all we do," particularly California who always came out on the bottom because they never reported their HCBS expenditures in a timely manner.

So kind of gradually over time, we kind of learn more about prior period adjustments, particularly with waiver programs. It's important to emphasize that 64 data are still date of payment, not date of service, so they don't reflect when services are used. They only reflect when states pay the bills. So it's not like the prior period adjustments adopted the fact that for services that were delivered but not paid for is just when the bills are paid.

An example of HCBS services, many states delegate waiver programs through other operational agencies, like particularly the DD agency. So the DD agency will run the waiver program. They'll pay all the bills. They will pay all the providers through their system, and then at some point, they'll bill Medicaid. But that can take a while.

In California, the IHSS program, which is a huge HCBS waiver program, it was always late, which is why

they're -- you know, so there are a lot of reasons for this.

Also, we were very sensitive to the timeliness versus accuracy because states really wanted these reports early. They used them a lot in their legislative initiative to get more funding, more waiver slots, blah-blah-blah, but we had to cut off the prior period adjustments. We generally only waited six months rather than the full two years after. So the end of the fiscal year is October 31. We would cut off prior period adjustments the following March and then produce the report. So we really had an incomplete picture of prior period adjustments, but there was all this pressure also from CMS. There was a lot of pressure on them to get it out. So, anyway, there's a lot of issues here.

I also just want to point out everybody kind of says, "What does the Medicaid program spend every year?" There's not a number that -- to me, it's like a moving target, and I dealt with this California anomaly, and I generally didn't change any of the 64 numbers. We just reported what the state submitted, whether it was original or adjusted, but this just made no sense to me. And it

really threw total Medicaid spending out of whack.

I don't know how OMB tracks these things, but if you included that $130 billion in FY2016, Medicaid would have a huge spike in it in terms of rate of increase.

These things are important in terms of just tracking how much we spend as a country on the Medicaid program.

I would very much endorse issuing this as an issue brief, just because I think people don't understand this kind of stuff and why people --

CHAIR BELLA: I think that's the plan, right, Chris, to write about it?

MR. PARK: Yes.

CHAIR BELLA: Yep.

COMMISSIONER BURWELL: Yeah. I mean, if you look at Medicaid aggregate spending numbers from Kaiser, whatever, you get different numbers all over the place, and these kinds of data issues are relevant to those. And people need to look at those numbers with some degree -- I don't know skepticism, but at least intelligence about why these numbers are the way they are.

CHAIR BELLA: Awareness, yes. We will build

awareness.

COMMISSIONER BURWELL: "Awareness" is a good word.

CHAIR BELLA: Yes. Thank you, Brian.

Any other comments or questions for Chris? And then we will go to our small public to see if they have any comments.

Kit?

COMMISSIONER GORTON: So with respect to awareness, if we're going to write about this, I think it's important to say that it's not restricted to Medicaid. It's just part of the third-party payer -- it's the way the system works. So providers have so many days to submit a claim, if it's clean, which they're not always. Plans have so many days to pay them, and there's all of this stuff that goes on. And so the numbers are a moving target. The insurance companies on a regular basis are doing prior period adjustments quarter by quarter and year by year. At some point, you draw a line under it, and you say, "Okay. This is the number we're going to use for this period of time," and it's just the nature of the beast.

I would not want to give the impression that this

is somehow an isolated problem to Medicaid, and I don't even think it's just on the insurance side as well. Hospital and other big provider systems, there are a lot of moving parts, and it depends on when you bought it, when you paid for it, when it was reconciled, how that all happened, how you book it.

In raising awareness, we should point out to people these complex financial systems, whether they be health care or otherwise. This just comes with the territory, and it makes it hard. And we need to be aware, that you have to ask the question, "Did the state allow the prior period adjustments? For how long a period of time." And it's never perfect.

If you do program integrity, it can take years to negotiate a settlement, and some of those settlements are big dollar amounts. This is the world behind the curtain, and I think creating awareness is good. But I just wouldn't want Medicaid to be -- people to say, "Oh, Medicaid is completely incompetent." This is just how big finance works.

CHAIR BELLA: Yep. Good point.

Chuck?

VICE CHAIR MILLIGAN: Just a quick question, Chris. Is this information useful to CMS in terms of its obligation to evaluate actuarial soundness in proposed capitation rates? Because it kind of sets a truer trend than some of the fluctuations. If not, great; if so, great.

Maybe you don't even need to answer right now, but if that's relevant, it would be good to include one way or the other in the issue brief, if that's an application or if it isn't an application.

MR. PARK: Yeah. I'm not sure if when they assess the actuary soundness, they would be using more specific data that was supplied by the state in their actuarial letters and attestation of how they did the rate-setting methodology. So I don't know if they would use this information, per se, for that, but I think it does help the understanding, particularly of the new adult group. The thought was that maybe states -- because they were building in a lot of assumptions on pent-up demand and uncertainty of what these enrollees would need, they set the rates high and then eventually recoup the money later.

VICE CHAIR MILLIGAN: On the issue brief,

eventual issue brief or whatever the deliverable is, it might be good just to say this isn't as useful for this other purpose about trend.

MR. PARK: Yeah.

CHAIR BELLA: Thank you.

Would anyone in the public like to comment?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: No comments. Okay.

Any other Commissioners?

[No response.]

CHAIR BELLA: Chris, anything else?

MR. PARK: Nope. That's it.

CHAIR BELLA: Thanks for bringing this to our attention.

Thank you all for all of your engagement over the past day and a half. We will be back at the end of February, and I just want to also reiterate my thanks to the MACPAC team.

Several Commissioners have noted everything you put into this, so thank you very much, and we'll look forward to seeing you all in a month.

Thank you.

* [Whereupon, at 11:25 a.m., the meeting was adjourned.]