Medicaid and CIP Payment and Access Commission Meeting
January 25 and January 26, 2018
Ronald Regan Building, International Trade Center
1300 Pennsylvania Avenue NW
Washington DC, 20004

MACPAC Commissioners: Penny Thompson, Marsha Gold, Gustavo Cruz, Charles Milligan, Leanna George, Sheldon Retchin, Peter Szilagyi, Brian Burwell, Stacey Lampkin, Toby Douglas, Christopher Gorton, Alan Weil, Martha Carter, Frederick Cerise, Kisha Davis, Darin Gordon, Willian Scanlon

Session 1: 42 CFR Part 2 Regulations and Implications for Subtsance Use Disorder Treatment and Integration with other Medical Care in Medicaid: Themes from Expert Roundtable

Panelists: Erin McMullen and Nevena Minor

Key Points:

- Part 2 protects against significant harms; disclosure of diagnosis or treatment can expose patients to impairment and act as a deterrent to seeking care
- Agreement that sharing information within health systems is important to integrated, whole-person care
- Widespread uncertainty exists around when and to whom Part 2 applies; additional guidance is needed to improve understanding and implementation
- Electronic information sharing difficulties persistent, even with patient consent
- Stakeholder require education on Part 2 and the importance of obtaining consent to promote care integration
- The Commission will continue working within this scope in order to move towards a future recommendation

Background:
MACPAC has previously noted barriers produced by 42 CRF Part 2, as it extends to the efforts to improve behavioral and physical health care integration. MACPAC hosted an expert roundtable in November 2017 to address obstacles presented by the provision. The roundtable sought input on: why protections are needed; how part 2 affects Medicaid care delivery and information exchange; and any needed changes to support care integration, while protecting from discrimination. Results from the roundtable represent the opinions and data presented from federal and state Medicaid and behavioral health agencies, legal and behavioral health experts, Medicaid health plans, health care providers, and patient advocates.

MACPAC staff prefaced discussions with the differences existing between HIPAA and Part 2. Generally, HIPAA governs disclosure of protected health information and is permitted without patient consent for payment, treatment, and health care operations. Whereas Part 2 governs disclosure of SUD treatment and prevention records, is intended to encourage individuals to seek treatment, and absent a court order, is not able to be obtained by law enforcement. Perhaps the focal differences between HIPAA and Part 2 stems from consent and subject providers; consent

is required when treatment providers subject to Part 2 want to share SUD information. Providers are subject to Part 2 if "federally assisted" and meet the definition of a "program".

Summary:
The roundtable provided extensive insight into the current operation, understanding, and implications of Part 2. Disclosure of diagnosis and corresponding consequences is presented as a focal deterrent for individuals to seek care. Under Part 2, patients are protected significant harms, including employment or child custody loss, criminal prosecution, and discrimination within the health care system. Consequently, the limitations imposed on information sharing have hindered the integration of whole-person care. While the roundtable agreed upon the crucial nature of sharing information to achieve integrated, whole-person care, thematic differences as to what extent consent should be required prevented pragmatic solutions. Additionally, even with patient consent, electronic information sharing remains a challenge. The larger population of SUD treatment providers are not eligible for EHR meaningful use incentive payments, thus there has been low adoption rates amongst these providers in incorporating electronic health records. Irrespective of provider adoption, EHRs and HIEs general are not able to segment out Part 2 data. As a result, SUD treatment providers and information are often excluded from HER records and HIE participation. Within the context of the Medicaid delivery system, providers are held accountable for overall health outcomes, despite missing pertinent patient SUD information, unavailable due to data sharing restrictions.

The roundtable agrees that in order to address the challenges imposed by Part 2: *(1)Additional guidance is needed to improve understanding and implementation; (2)More stakeholder education on Part 2 and the importance of obtaining consent to promote care integration is needed; and (3)Discussions examining alignment of Part 2 with HIPAA.*

MACPAC Action:
The November roundtable was the Commission's first step in developing a policy recommendation. While still in the beginning stages, the Commission will continue to explore the additional research and resources that will be necessary to merit a policy recommendation. Evidential by questions raised, the Commission is seeking transparency on coordination, administrative burden of consent, scope of provider inclusion, Part 2 education, and statutory vs. regulatory requirements. Chairman Thompson expressed the sentiment that without clarifications, the issues arising will continue to grow and the corresponding "consequences are significant". A policy recommendation was not decided on at today's meeting, however, we can expect this topic to be presented again with additional data consistent with the themes and concerns raised during Commission discussion.

Session 2: Examining Residential Substance Use Disorder Treatment and the IMD Exclusion

Panelist: Erin McMullen, Yngvild Olsenn, Enrique Olivares, and Matthew Keats

Key Points:
- The Commission will continue with its evaluation at the June 2018 meeting
- Little information on IMD exclusions in outpatient and inpatient treatment gains for opioid use disorder exists

- Residential Treatment is consistent of four separate levels of care
- Patients are continuously moving between the three care continuum levels
- Variations in the quality of care persist across the care spectrum

Background:
The presentation continues the Commission's October 2017 panel on Opioid Use Disorder. MACPAC is analyzing gaps in the care continuum in two phases: (1) Residential treatment-ASAM level 3 and (2) Outpatients, Intensive Outpatient and Inpatient Treatment-ASAM levels 1, 2, &4. The panel today presented on Phase 1: Residential treatment and States' use of waivers to expand authority.

Summary:
The framework outlined by the American Society of Addiction Medicine (ASAM) has provided a common nomenclature for describing the continuum of addiction services and establishes comprehensive guidelines for placement, continued stay, and the transfer or discharge of patients with addiction and co-occurring conditions. Consistent with ASAM criteria, residential services include four different levels of care. Levels of care build from least intensive 3.1 "halfway housing", progressing to the most intensive at level 3.7 "medically monitored". ASAM dimensions for addiction symptomatology include: intoxication and withdrawal potential; biomedical conditions; emotional, cognitive, and behavioral conditions; readiness to change; relapse potential; and recovery and living environment.

Matthew Keats from the Virginia Department of Medical Assistance presented preliminary results from the implementation of Virginia's Addiction and Recovery Treatment Services (ARTS) 1115 SUD demonstration waiver. The waiver allows for SUD services administered in an IMD to obtain federal matching Medicaid dollars and Virginia Medicaid to fund SUD services provided in residential treatment facilities greater than 16 beds. Under the waiver, there is no change to treatment services eligibility and additionally Medicaid health plans and providers adopt ASAM criteria. The results represent the first five months, April-August 2017, and provide a preliminary scope of effect the program has had on the State. Prior to ARTS, Virginia had only four residential treatment providers, since program implementation, the number of residential treatment providers has increased to 78, equivalent to an 1850% increase. Keats testifies that the majority of the residential treatment expansion is attributed to traditional residential treatment centers with the number of beds ranging from 30 to 50.

In addition to 1115 waivers, IMD exclusions have been taken up by States as a method to utilize Medicaid funding to provide acute inpatient psychiatric and substance use related needs care to Medicaid enrollees. It is highlighted by the panel, little info on inpatient and outpatient treatment gains for opioid use disorder patients under IMD exclusions exists. In response to the influx of utilization of IMD exclusions, Commissioner Cerise reminded colleagues, "lifting IMD exclusions has opened government funding and we are diving on hope…these are massive demonstrations with Medicaid dollars" and the potential outcomes remain unclear.

MACPAC Action:
Considerable questions arose amongst commissioners extending to the potential for clinicians to abuse the ASAM continuum, variable degrees of care quality and monitoring, and clinically

efficacious data to support appropriate levels of care. The IMD guidelines issued by CMS in November has substantiated responsible for MACPAC to weigh in on these issues. The lack of an organized delivery system has produced increased provider supply, stated Commissioner Douglas, further expressing "there are not enough of the right providers for the right level of care." The presentation today drew out a number of clarifying points and concerns in the commission. During the conclusion of the discussion, Chairman Thompson prefaced for a "focus on 1115s, where we stand, who has them, what efforts are they reaching at, and where we stand in evaluation, this understanding might introduce where gaps in our knowledge exists and where we might need to focus on." We can expect the commission to continue moving forward to phase 2 and providing additional research on IMD exclusions as it related to the care continuum and 1115 waivers. Additionally, the commission will be posed to evaluate the data gathered from the adoption of the ASAM continuum in Los Angeles County.

Session 3: Stakeholder Experiences with Manages Long-Term Services and Supports (MLTSS)

Panelists: Kristal Vardaman, Principal Analyst (MACPAC), Dennis Heaphy, Disability Policy Consortium and Disability Advocates Advancing our Healthcare Rights, Michelle Bentzien-Purrington, Molina Healthcare, Inc., David Totaro, BAYADA Home Health Care

Summary:

Mr. Heaphy discussed his rights as a disabled person and the concerns he has for cuts made to Medicaid that otherwise support rights of disabled persons. The basic civil and human rights for disabled persons require an effective HCBS delivery system. Massachusetts advocates for its disabled population through establishment of a One Care Implementation Council and investments in external conflict-free Ombudsman entity. At the federal level, the current limitations MLTSS faces are deficient benefit packages, in which quality of care and cost efficiencies cannot otherwise be effectively enhanced.

Ms. Bentzien-Purrington discussed the national footprint of MLTSS and Medicare-Medicaid integration experience, as well as the goals, successes, and recommendations of Molina Healthcare. Molina Healthcare seeks to improve member experience by conducting member surveys and collecting consumer feedback, as opposed to merely looking at medical indicators. Additionally, Molina works to rebalance MLTSS spending and reduce waiver wait lists, lending to increased access to services and State management of costs.

Ms. Bentzien-Purrington recommends the Commission focus on stream-lined enrollment mechanisms, administrative simplifications, and integration opportunities in order to provide a more holistic and efficient healthcare delivery system, particularly for dual-eligible individuals.

Mr. Totaro described Bayada's strategy of MLTSS implementation as involving three components: (1) adequate rates and regular review; (2) State supports for a healthy and robust provider networks; and (3) federal process changes and improvements. Under the first component, States must first protect beneficiaries by setting adequate rates, rate floors, and regular rate review requirements. Under the second component, more support should be given to providers, which will ensure the focus of the system remains on client care. Finally under the

third component, the federal government should seek to level the playing field with institutional care, as well as collect data to help support better care models.

The Commission asked questions about steps that can be taken to achieve a truly holistic integrated system. The panel offered suggestions for mitigating institutional biases, utilizing alternative payment methodologies, and better engaging state stakeholders. Without MLTSS, the healthcare system is extremely binary, and health needs are not coordinated with comprehensive whole-person care. Additionally, at the state level the system is under staffed and under supported. Successful implementation of MLTSS is less about the design of the plan, and more about the execution of the plan.

Commissioner Gorton brought up dignity of risk/risk mitigation and the need to ensure that discharged patients receive the necessary care at home, beyond the hospital. Discussion then turned to returns on investment measurements, with the Commission asking how such measurements can be implemented in policy. The panel talked about defining what quality of care means, based on social and consumer value, as well as bending the cost curve and providing the correct incentives that prioritize care first. For example, the fee for service system is based on a per hour payment model, which creates a disincentive in the system that does not meet consumer needs.

The Commission then discussed the narrative of managed care and whether there needs to be more of an agreement on what MLTSS seeking to accomplish. Currently there is confusion about what the impact of care should be, where a distinction must first be made between MLTSS and LTSS. A clearer understanding of the impact being sought will help direct the path towards achieving goals.

Session 4: Medicaid Hospital Payment: Policy Issues and Commission Analytic Plan
Panelist: Robert Nelb, Senior Analyst

Summary:
Mr. Nelb explained that the provider payment framework is based on the statutory principles of Medicaid payment policy. In order to evaluate whether policies are consistent with statutory principles, information related to payment methods, amounts, and outcome are required. The Staff plans to issue a brief on payment policies for rural hospitals and review upper payment limit (UPL) policies. Additional research will look at financing methods. For payment amounts, the Staff plans to review state uncompensated care pool evaluations and analyze variation in Medicaid spending across states. Finally, for payment outcomes, Staff will look at effects of per-diem and cost-based payments on delivery system transformation efforts and will review quality measures that states are currently using to measure access and quality of hospital care.

The only additional analysis the Commission recommended looking into was how Medicaid payments are driving hospitals. Additionally, the Staff should acknowledge outside forces at play in the health care system that are beyond Medicaid. The Commission does not want to be blind to the larger picture of hospital and regional diversity when it comes to its analysis of hospital payments.

Session 5: Update on MACPAC Activities
Anne Schwartz, Executive Director

Summary:
Dr. Schwartz provided an update on ongoing MACPAC activities and upcoming projects. The report on managed care authorities, which will include a descriptive chapter on drug pricing, is due on March 15. At the March meeting, the Commission will review the recommendations that were proposed at the December meeting. There are also chapters on drug pricing and managed long-term services that are anticipated to be released by the June meeting. Other work in the pipeline includes ongoing research for reports on payment for federally qualified health centers, multi-state collaboration, and access. Lastly, Dr. Schwartz shared that the GAO recently announced a call for nominations for MACPAC appointments.

Session 6: Review of March Report Chapter and Vote on Recommendation: Medicaid Managed Care Authorities
Ben Finder, Senior Analyst

Key Points and Next Steps:
- Mr. Finder presented updates on Recommendation 1, which was initially presented at the December 2017 MACPAC meeting. The recommendation was made in regard to the upcoming March 2018 MACPAC report.
- Commissioners discussed the clarifications and voted in favor of the recommendation. The vote count was as follows:
    - **12** in favor
    - **2** abstentions
    - **2** absences

Background:
At the December 2017 meeting, MACPAC staff presented the Chairman's draft recommendations for the March 2018 report. Commissioners generally supported the three recommendations that were presented, but they had questions and concerns about Recommendation 1, which advised Congress to amend Section 1932(a)(2) to allow states to require all beneficiaries to enroll in comprehensive Medicaid managed care programs under state authority. At the December 2017 meeting, Commissioners had questions in regards to the adequacy of beneficiary protections for vulnerable populations under state plan authority. The Commissioners also discussed whether or not the recommendation should be inclusive of managed long-term services and supports programs. And third, the commissioners requested that MACPAC staff clarify the rationale behind Recommendation 1.

Summary:
Mr. Finder provided clarifying information to the Commission in regards to their concerns that were expressed in December 2017 on Recommendation 1. As for beneficiary protections, the new draft chapter provides more specificity in regards to state and managed care organization (MCO) regulatory requirements. In regards to managed long-term services and supports (MLTSS), Mr. Finder clarified that the recommendation would allow states to mandate MLTSS enrollment under state plan authority. Additional authority allows states to make other design

decisions to structure MLTSS programs. And lastly, Mr. Finder reported that the rationale for Recommendation 1 has been revised to clarify:

1. That the current legal framework includes standards and requirements that ensure appropriate access and coverage for enrolled populations regardless of authority
2. That the recommendation is not meant as incentive for states to initiate a managed care program, but to streamline administration and
3. That CBO has estimated that this recommendation will not affect federal Medicaid spending

MACPAC Action:
The commissioners discussed the updates that were made to Recommendation 1 and voted in favor of the recommendation. Prior to voting, commissioners discussed the need for better oversight and compliance. Commissioners also spoke of simplifying the administrative components of managed care, conserving resources, and continuing to explore how states can be more efficient with managed care. Commissioners also suggested a regular review of the regulatory approach. The Chair assured the commission that the chapter would include sentiments expressed in their discussion.

Session 7: Review of HHS Report to the President and Congress on Money Follows the Person Demonstration
Kristal Varadaman, Principal Analyst

Key Points and Next Steps:
- The Money Follows the Person (MFP) demonstration is soon ending, with states having received their last financial awards for the program from the Centers for Medicare and Medicaid Services (CMS) in FY2016
- The Secretary of Health and Human Services (HHS) submitted a final report reflecting the findings on MFP evaluations and the Commission is required to submit written comments on the Secretary's report
- The Commission began discussing potential comments on the report at this meeting. MACPAC staff will create a draft of official comments for submission based on today's discussion

Background:
The HHS Secretary was required to send a final report to the President and Congress reflecting the findings of MFP evaluations and to make conclusion on MFP's conduct and effectiveness. MACPAC's authorizing statute directs the Commission to review the Secretary's reports and submit written comments.

As of September 2016, CMS had awarded 43 states and the District of Columbia $3.7 billion to help Medicaid beneficiaries transition from institutions back to their communities. MFP assists beneficiaries who have resided in an institution for at least 90 days and beneficiaries receive home and community-based services (HCBS) beyond what is provided under a state's existing HCBS programs. States earn an enhanced match for certain services and the enhanced match may be used for rebalancing efforts such as reducing waiting lists and housing supports.

CMS made final awards to states in FY 2016 for the MFP demonstration. States can transition beneficiaries through December 31, 2018 and states can claim funds through FY 2020. As a part of the final rewards, states were required to submit sustainability plans. States must have a way to pay for services they are sustaining beyond the demonstration and states may not continue to provide some services because they were not highly utilized.

Summary:
Ms. Varadaman presented the findings from the Secretary's report. The report found that MFP transitioned over 63,000 beneficiaries. States encountered a variety of challenges, including an insufficient supply of affordable and accessible housing, staff shortages, and low numbers of referrals from nursing facilities. The report found that there was an estimated $978 million in savings from 2008 to 2013 due to the demonstration. The report also found evidence that MFP participants had positive outcomes overall. Participants were less likely than a comparison group to be readmitted to an institution in the year after transition and surveys showed improvement in satisfaction with care and living arrangements among MFP participants. Additionally, the report found that MFP funds were used to create programmatic changes to promote rebalancing, including transition services that went beyond the demonstration. Ms. Varadaman also noted that the lack of data provided by states was a limitation for evaluators.

MACPAC Action:
Comissioners discussed the Secretary's report and made suggestions for potential comments to be submitted to the Secretary and relevant Congressional committees. Some commissioners noted that they wanted more specific information on how the $3.7 billion was used in the demonstration. Some commissioners noted that Congress might be interested in hearing the Commission's opinion on whether or not MFP should be extended. A commissioner suggested that if states found MFP to be successful, the commission should explore financing structures that should be put in place to finance MFP services in the absence of the demonstration. Some commissioners also noted that there are many rebalancing efforts happening simultaneously and thus, MFP should not necessarily get credit for all of the rebalancing progress that has been made. Many commissioners found the inadequacy of data provided by states to be concerning and one commissioner suggested that the Commission should request the full evaluation reports from states, seeing as they were paid for by public money.

Session 8: Integrating Appeals Processes for Dually Eligible Beneficiaries
Kristin Blom, Principal Analyst

Key Points and Next Steps:
- Ms. Blom provided background information to the commission on the different appeals processes under Medicare and Medicaid. She provided information on potential benefits of streamlining the appeals process into an integrated process for Medicare and Medicaid appeals
- Comissioners discussed questions of interest in regards to integrating the Medicare and Medicaid appeals processes

Background:
An appeal is an action a beneficiary can take if he or she disagrees with a coverage decision. Medicare and Medicaid each have their own appeal processes and dually eligible beneficiaries

have to navigate both. The differences between Medicare and Medicaid appeals create opportunities for administrative alignment. The efforts to streamline the two appeals processes are focused on appeals in managed care. Creating a seamless process may be easier in managed care because there is a single entity – the health plan – that can be the starting point for all appeals.

Currently, in the appeals process for managed care, a health plan denies coverage of a service and the dually eligible beneficiary has to decide to which program he or she will appeal. The provider can help the beneficiary decide, but coverage overlaps can make the decision confusing. The beneficiary must file an appeal within 60 days and the health plan typically has 30 days to resolve it. If the health plan decision is unfavorable to the beneficiary, he or she can appeal to next levels.

Summary:
Ms. Blom highlighted recent federal policy changes to the appeals process. In the realm of regulatory policy, CMS Medicaid managed care final rule aligned Medicaid with Medicare Advantage and the private sector by aligning appeals timeframes and requiring beneficiaries to exhaust the health plan level first before obtaining a state fair hearing. Additionally, the proposed Chronic Care Act directs the HHS Secretary to align appeals and grievances under D-SNPs to the extent feasible.

Ms. Blom also highlighted a few key differences between Medicare and Medicaid appeals. First, Medicare and Medicaid have different financial thresholds for the amount in controversy. Second, whereas the beneficiary can appear in the appeals hearing by way of teleconference under Medicare, the beneficiary must appear in-person under Medicaid. The requirement that Medicaid beneficiaries appear in-person is often burdensome and results in a high level of defaults. And third, Medicare and Medicaid have different policies on the continuation of benefits during the appeal.

Ms. Blom also provided a summary of New York's Financial Alignment Initiative demonstration, which uses a single streamlined appeals process. New York is the only state to have done this thus far. The demonstration applies the provisions that are most favorable to the beneficiary. Beneficiaries, providers, health plans, and other stakeholders tend to support New York's streamlined process.

MACPAC Action:
The Comissioners discussed the issue of integrating the Medicare and Medicaid appeals processes. Comissioners agreed that they need to spend more time working on appeals integration and developing a process that works for duals appeals. Comissioners also expressed interest in researching what elements of an appeals process can make the process pleasant for the beneficiary. Comissioners specifically suggested focusing on making the process more accessible to beneficiaries and ensuring that beneficiaries feel as though their voices are being heard throughout the process.