U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

August 31, 2018

TO: Members of the Subcommittee on Health

FROM: Majority Staff

RE: Hearing entitled "Opportunities to Improve Health Care."

I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Wednesday, September 5, 2018, at 10:00 a.m. in 2123 Rayburn House Office Building. The hearing is entitled "Opportunities to Improve Health Care." The hearing will examine five pieces of bipartisan legislation that will help improve health care by enhancing the quality of patient care and curbing health care fraud.

II. WITNESSES

- Hugh M. Chancy, RPh, Owner, Chancy Drugs, Hahira, Georgia, and Member, Board of Directors, National Community Pharmacists Association;
- Curtis Cunningham, Vice President, National Association of States United for Aging and Disabilities (NASUAD), and Assistant Administrator, Long-Term Care Benefits and Programs, Division of Medicaid Services, Department of Health Services, State of Wisconsin;
- Rick Merrill, President and CEO, Cook Children's Health Care System, Fort Worth Texas;
- Matt Salo, Executive Director, National Association of Medicaid Directors;
- Derek Schmidt, J.D., Attorney General, State of Kansas; and
- David Yoder, Pharm.D., M.B.A., Executive Director of Member Care and Benefits, Blue Cross Blue Shield Association's Federal Employee Plan

III. LEGISLATION

A. H.R. 3325, The Advancing Care for Exceptional (ACE) Kids Act

H.R. 3325 was introduced by Rep. Barton (R-TX) and Rep. Castor (D-FL) to improve the delivery of care for children with complex medical conditions under Medicaid. The bill seeks to achieve three primary goals: (1) to improve coordination of care for children served in Medicaid; (2) to address problems with potentially fragmented or uncoordinated care children may access, and (3) to gather data on conditions to help researchers improve services and treatments for

children with complex medical conditions. The Committee examined similar legislation last Congress.[1] Since its introduction, the Committee has received feedback on the bill from a variety of Medicaid and health care stakeholders, which has been incorporated into an updated draft. The Draft creates a new option for state Medicaid programs by allowing states to utilize a Health Home model to coordinate care for children with medically complex conditions.

Under current law, states have used the Health Home model to improve coordinated care for Medicaid patients, increase patient empowerment, and assist with care transitions.[2] However, under current law, a Health Home state plan amendment cannot target by age or be limited to individuals in specific age range. The Centers for Medicare and Medicaid Services (CMS) has reported states have identified this inability to target Health Home services as an operational challenge. [3] The FY2016 President's Budget request included a proposal which would allow states to target their Health Home programs by age.[4] Thus, allowing states to utilize a Health Home model to coordinate care for children with medically complex conditions helps address at least in part a barrier to care previously identified by states.

Under the Health Home, a provider—such as a pediatrician, pediatric specialist, children's hospital, or community health center—or a team of health care professionals would provide comprehensive care management and care coordination services to eligible children, including coordinating access to medical services from out-of-state health care providers as medically necessary.[5] As a condition of participating in the Health Home, states would be required to collect data on the characteristics of participating children and providers, as well as applicable quality of care measures.

To address challenges that families and children with medical complexity may face when accessing care, the Draft would require the Department of Health and Human Services (HHS) to issue guidance to state Medicaid directors on best practices for providing care to children with medically complex conditions. Such guidance is to include information on coordinating care from out of state providers, practices for reducing barriers to such care, and efforts to streamline the process for screening and enrolling out-of-state providers in a state's Medicaid program.

The Draft would also require the Medicaid and CHIP Payment and Access Commission (MACPAC) to collect data and report on children with medical complexity. The MACPAC report would include information on the characteristics of children with medical complexity and would also include data on such children enrolled in Medicaid, including the delivery systems and care arrangements in which they are served, the providers that care for these children, and the extent to which those providers are located out-of state.

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[1] https://energycommerce.house.gov/hearings/examining-legislation-improve-public-health/
[2] https://www.medicaid.gov/medicaid/ltss/downloads/health-homes/medicaid-health-home-state-plan-option.pdf
[3] https://www.medicaid.gov/medicaid/ltss/downloads/health-homes/medicaid-health-home-state-plan-option.pdf
[4] https://www.hhs.gov/about/budget/budget-in-brief/cms/medicaid/index.html
[5] Building on the successes state Medicaid programs have achieved under the Health Home model in current law, under the approach outlined in the Draft, Medicaid managed care organizations could participate in the Health Home as a designated provider. CMS guidance allows this under the current health homes statute – see p. 5, https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/health-homes-faq-5-3-12_2.pdf

B. H.R. 3891, To amend title XIX of the Social Security Act to clarify the authority of State Medicaid fraud and abuse control units to investigate and prosecute cases of Medicaid patient abuse and neglect in any setting, and for other purposes.

Under current law, State Medicaid Fraud Control Units (MFCUs) operate in virtually every state to investigate and prosecute Medicaid provider fraud as well as patient abuse or neglect in health care facilities and board and care facilities. [6] As the Office of the Inspector General at the Department of Health and Human Services (HHS OIG) notes, "the MFCUs employ teams of investigators, attorneys, and auditors; are constituted as single, identifiable entities; and must be separate and distinct from the State Medicaid agency." [7]

H.R. 3891 was introduced by Rep. Walberg (R-MI) and Rep. Welch (D-VT) to improve the authority of MFCUs. Currently, MFCUs are only allowed to investigate cases of provider fraud and patient abuse in health care facilities or board and care facilities. This legislation would broaden the authority of these units to investigate and prosecute abuse and neglect of Medicaid beneficiaries in *non-institutional or other settings*.

The practical effect of this legislation is to improve the ability of Medicaid Fraud Control Units to help protect vulnerable Medicaid patients from harm, while reducing the program resources diverted by fraud. For example, the HHS OIG has conducted numerous audits identifying vulnerabilities for patient harm and improper payments involving Medicaid personal care services (PCS).[8] However, HHS OIG has noted that "in MFCUs' efforts to protect beneficiaries receiving PCS services, they are constrained by their ineligibility to receive Federal funding to investigate and prosecute complaints of beneficiary abuse or neglect in non-facility settings (such as beneficiaries' homes)."[9]

Legal experts and others involved in the operation of Medicaid Fraud Control Units have noted this legislation would significantly improve current law. In March 2018, the National Association of Attorneys General (NAAG) said the change the legislation makes is "vitally important because it eliminates the blinders current law places on MFCUs' ability to detect, investigate and prosecute cases of abuse or neglect of Medicaid patients." [10] As NAAG notes:

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[6] For more information see: https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp

[7] For more information see: https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp. HHS OIG, in exercising oversight for the MFCUs, annually recertifies each MFCU, assesses each MFCU's performance and compliance with Federal requirements, and administers a Federal grant award to fund a portion of each MFCU's operational costs.

[8] As noted by HHS OIG: "Personal care services provide nonmedical assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. Typically, an attendant provides PCS. In many States, PCS attendants work for personal care agencies, which are enrolled in the Medicaid program and bill for services on the attendants' behalf. States are required to develop qualifications or requirements for attendants to ensure quality of care. PCS is an optional Medicaid benefit that States may choose to provide under State plan options and/or through Medicaid waiver and demonstration authorities approved by CMS." For more information see: https://oig.hhs.gov/reports-and-publications/portfolio/ia-mpcs2016.pdf

[9] https://oig.hhs.gov/oei/reports/oei-12-16-00500.asp

[10] http://www.naag.org/assets/redesign/files/sign-on-letter/Final%20NAAG%20letter%20to%20Expand%20MFCU.pdf

> Since the current statute was enacted decades ago, substantial growth has occurred in home and community-based services, office-based services, transportation services, and other settings that are neither "health care facilities" nor "board and care facilities" but where services are provided and thus patient abuse or neglect may occur. H.R. 3891 proposes a common-sense change that will better protect an often-vulnerable population and will maximize the benefits and efficient use of MFCU assets.[11]

C. H.R. 5306, The Ensuring Medicaid Provides Opportunities for Widespread Equity, Resources and (EMPOWER) Care Act

H.R. 5306 was introduced by Rep. Guthrie (R-KY) and Rep. Dingell (D-MI) to extend funding for the Money Follows the Person Demonstration Program (MFP demonstration) in Medicaid for an additional five years. The MFP demonstration provides additional resources for state Medicaid programs to help ensure Medicaid patients needing long term care are served in their communities.[12] Cosponsors and the Committee have received a wide range of feedback and support from state Medicaid directors, patients, families, Medicaid advocates, and other stakeholders. Members have an opportunity to learn more about how the MFP demonstration has been helpful to states and families in transitioning patients from the institutional setting to the community.

When the MFP demonstration was created in 2005 legislation, among its objectives, the program was designed to (1) increase the use of home and community based, rather than institutional, long-term care services; (2) eliminate barriers and enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice; (3) increase the ability of Medicaid programs to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting of their choice; and (4) ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services.[13]

Under current law, Long-Term Services and Supports (LTSS) may be may be provided in institutions (nursing homes, intermediate care facilities, etc.) or through Home and Community

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[11] http://www.naag.org/assets/redesign/files/sign-on-letter/Final%20NAAG%20letter%20to%20Expand%20MFCU.pdf

[12] In Medicaid, the long-term care benefit is known as Long-Term Services and Supports (LTSS), and refers to a broad range of services and supports that are needed by individuals over an extended period of time. LTSS may include some health care services, but also non-health care services. The need for LTSS is generally measured by limitations in an individual's ability to perform daily personal care activities (i.e., eating, bathing, dressing, and walking), or activities that allow individuals to live independently in the community (i.e., shopping, housework, and meal preparation). The probability of needing LTSS increases with age. However, younger persons with disabilities may also find themselves in need of medical and supportive care offered through LTSS, which can allow them to live longer, more productive lives. In recent years, the Committee has examined opportunities to improve Medicaid long-term care, including at a hearing on March 1, 2016. More information is available at: https://energycommerce.house.gov/hearings/examining-financing-and-delivery-long-term-care-us/

[13] https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf

Base Services (HCBS).[14] Although optional, all states include HCBS in their Medicaid benefit package. HCBS includes a range of service such as personal care services received at home or in a residential care setting, services provided at adult day care centers, and supported employment services.

One of the benefits of the MFP demonstration is that it is a voluntary option for states and participation in the demonstration is voluntary for patients, thus allowing both beneficiaries and their families to seek assistance or institutions to refer residents to the program. The flexibility of the program has been popular with state Medicaid programs and Medicaid patients, families, and beneficiary advocates. According to CMS, "as of the end of December 2015, 43 states and the District of Columbia, or 44 grantee States, were actively transitioning participants through their MFP demonstrations."[15] As CMS has summarized, the MFP demonstration program is a "major federal initiative to give people needing [LTSS] more choice about where they live and receive care, and to increase the capacity of state LTSS systems to serve people in community settings."[16]

By many measures, the MFP demonstration has been successful. According to a CMS report, states have used the program to "increase access to affordable and accessible housing for individuals in need of LTSS." [17] States have also used the program's funding to help attract high quality care workers and develop new tools to increase care attendents job commitment and "the system's ability to manage the difficult behaviors of some who use LTSS." [18] States have also leveraged the program to "create new registries to link workers with people who need them" and help design or improve tools that better assess patient needs and preferences.[19] Overall, participating states have transitioned more than 75,000 Medicaid beneficiaries to the community as of the end of 2016.[20] Based on a CMS review, patients in the demonstration "were less likely than a comparison group to be readmitted to an institution in the year after transition."[21] The data

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14 Home and Community Based Services (HCBS) first became available in 1983 when Congress added section 1915(c) to the Social Security Act, giving States the option to receive a waiver of Medicaid rules governing institutional care. In 2005, HCBS became a formal Medicaid State plan option. Several States include HCBS services in their Medicaid State plans. Forty seven states and DC are operating at least one 1915(c) waiver. State Medicaid agencies have several HCBS options: 1915(c) Home and Community-Based Waivers; 1915(i) State Plan Home and Community-Based Services; 1915(j) Self-Directed Personal Assistance Services Under State Plan; 1915(k) Community First Choice. More information available online at: https://www.medicaid.gov/medicaid/hcbs/authorities/index.html

15 Ibid, page 3-4.
16 https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf
17 *Report to the President and Congress The Money Follows the Person (MFP) Rebalancing Demonstration*. Health and Human Services. Accessed August 20, 2018. https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf. See page 17.
18 *Report to the President and Congress The Money Follows the Person (MFP) Rebalancing Demonstration*. Health and Human Services. Accessed August 20, 2018. https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf. See page 17.
19 *Report to the President and Congress The Money Follows the Person (MFP) Rebalancing Demonstration*. Health and Human Services. Accessed August 20, 2018. https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf. See page 17.
20 https://www.macpac.gov/wp-content/uploads/2018/03/Money-Follows-the-Person-Demonstration-Program.pdf See slide 22.
21 https://www.macpac.gov/wp-content/uploads/2018/03/Money-Follows-the-Person-Demonstration-Program.pdf

also suggests states may be helping reduce program expenditures by improving coordinated care and overall case management. In the first year after transitioning, monthly Medicaid expenditures per beneficiary declined by an average of $1,820 (23 percent) for adults age 65 and older,$1,783 (23 percent) for individuals with physical disabilities, and$4,013 (30 percent) for individuals with intellectual or developmental disabilities.[22]

D. Discussion Draft to prohibit the use of so-called "gag clauses" in Medicare and certain private health insurance plans

It has been widely reported that some health insurance contracts prevent pharmacists from informing patients when the cash price for their prescription costs less than their insurance cost-sharing arrangement unless the individual directly asks. As a result, consumers may be paying more for their prescriptions than is warranted.

At a federal level, a number of Republican and Democratic members in Congress have recognized the challenges that so-called "gag clauses" may present to practitioners informing patients. Both Republican and Democratic members of the U.S. House and U.S. Senate have introduced a range of legislative proposals to alleviate the financial burden on consumers by banning gag clauses.[23] The Discussion Draft aims to ban group health plans offered by employers and individual health insurance plans—as well as Medicare Advantage and Medicare Part D Plans—from restricting a pharmacy's ability to inform a customer about the lower cost, out-of-pocket price for their prescription.

The Administration has also raised questions about the role such gag-clauses play in our health care system. In its May 2018 *American Patients First* blueprint, HHS noted that "some contracts between health plans and pharmacies do not allow the pharmacy to inform a patient that the same drug or a competitor could be purchased at a lower price of-insurance. What purpose do these clauses serve other than to require beneficiaries pay higher out-of-pocket costs?"[24] That same month, CMS informed Medicare Part D sponsors that the use of gag-clauses is prohibited in Medicare Part D prescription drug plans.[25]

At a state level, there has been robust interest in gag clauses as well, as state lawmakers have also sought to prohibit gag clauses. According to the National Conference of State Legislatures, "[b]etween 2016 and August 2018, at least 26 states enacted laws among at least 41

See slide 26.

[22] https://www.macpac.gov/wp-content/uploads/2018/03/Money-Follows-the-Person-Demonstration-Program.pdf See slide 24. "Estimate is a range because actual savings depend on how many beneficiaries would have transitioned in the absence of the program."

[23] For example, the U.S. Senate Committee on Health, Education, Labor, and Pensions on July 25, 2018 passed S. 2554 The *Patient Right To Know Drug Prices* Act, by U.S. Sen. Susan Collins (R-ME). More information available at: https://www.help.senate.gov/chair/newsroom/press/senate-committee-approves-bill-allowing-pharmacists-to-tell-patients-that-a-drug-is-cheaper-if-they-use-cash-instead-of-insurance In the U.S. House, several bills have been introduced, including: H.R. 5343, *The Prescription Transparency Act of 2018* by Rep. Buddy Carter (R-GA); H.R. 6641 and *The True Cost-Sharing Of Seniors' Drugs Transparency Act* by U.S. Rep. Eric Paulsen (R-MN).

[24] https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf, page 25

[25] https://www.cms.gov/newsroom/press-releases/cms-sends-clear-message-plans-stop-hiding-information-patients

state legislatures that considered prohibiting 'gag clauses' in contracts to that restrict pharmacists."

E. H.R. __, a discussion draft to codify the Healthcare Fraud Prevention Partnership codify the Healthcare Fraud Prevention Partnership (HFPP)

Currently operated by CMS, the Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and health care anti-fraud associations. The HFPP operates to detect and prevent health care fraud through public-private information sharing, streamlining analytical tools and data, and providing a forum for government and industry experts to exchange successful anti-fraud practices. According to CMS, "[s]ince its inception in 2012, the number of participants has increased to 70 public, private and state partner organizations." The HFPP was established by the Obama administration, and the Trump administration recommended codifying the partnership, solidifying the bipartisan nature of revealing and halting scams that cut across public and private payers.

This discussion draft will build on the successes of CMS's work by establishing explicit authority for HFPP and its activities, better equipping the Partnership to define the rules and responsibilities of its members, and expand the scope of allowable activities to address fraud and abuse in our health care system.

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact James "JP" Paluskiewicz, Adam "Buck" Buckalew, Caleb Graff, or Josh Trent of the Committee staff at (202) 225-2927.