PUBLIC MEETING

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

Thursday, October 26, 2017
9:31 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
MARSHA GOLD, ScD, Vice Chair
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
CHARLES MILLIGAN, JD, MPH
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WILLIAM SCANLON, PhD
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:31 a.m.]

CHAIR THOMPSON: All right. We are going to get started in just a few minutes, so if people could find their seats. We still have a few people I see signing in and coming in at the front, so let's just give us a minute or two.

[Pause.]

CHAIR THOMPSON: Okay. Our first session today is an update on CHIP from Joanne Jee.

UPDATE ON CHIP

* MS. JEE: All right. Good morning. This morning we're going to return to CHIP, which the Commission has spent a fair amount of time on in the last few years, just to give you a quick update and overview of the status of CHIP funding and efforts to renew it.

So, Commissioners, you will recall that there are no new CHIP funds after fiscal year 2017, which ended September 30th. This means that under current law there are no new CHIP allotments made to states for fiscal year 2018. And in January, the Commission issued a recommendation citing the urgent need to renew CHIP funding

and recommended a renewal for a five-year period through fiscal year 2022, along with recommendations to extend the children's maintenance of effort and the 23 percentage point increase to the CHIP enhanced match through fiscal year 2022.

There were other recommendations as well, including providing support for a new demonstration grant program to implement and test seamless systems of children's coverage, eliminating the CHIP waiting period, eliminating premiums for children, CHIP premiums for children with family incomes under 150 percent of the FPL. There were a couple recommendations on express lane eligibility to eliminate -- or, I'm sorry, to permanently authorize, not eliminate, permanently authorize ELE authority, and to consider steps that would need to be taken to implement ELE sort of going in the reverse, meaning to allow states to take findings from Medicaid and CHIP for the purposes of determining eligibility for other programs, like SNAP and TANF.

You also recommended extending funding for the outreach and enrollment grants for Medicaid and CHIP, the childhood obesity research demonstration program, and the

pediatric quality measures program. And the recommendation was for a five-year renewal of that funding.

Okay. So although there are no new federal funds for CHIP under current law, there are still some limited funds available for spending in fiscal year 2018. Those funds include states' unspent fiscal year 2017 CHIP allotments as well as redistribution funds from prior years' unspent allotments.

I think it's important here to stress, though, that although there are funds available, some funds available for spending in FY2018, those funds will not be enough to cover state expenditures in fiscal year 2018 if there are no new allotments made. And all states are expected to exhaust those funds at some point in fiscal year 2018.

And so to the point of the timing of state exhaustion of those funds, we issued a brief in January 2017 that using state-provided projections on their spending, we estimated when we thought they would run out of all available federal funds. So that is both the fiscal year 2017 allotment and the redistribution funds, and that brief noted that in the first quarter of fiscal year 2018

we expected four states; in Quarter 2, 27 states; Quarter 3; 19 states; and one state in Quarter 4. So those are data that were available to us as of May. We have since done a preliminary revised analysis based on newer data from the states, and there have been some changes in terms of where the states fall timing-wise for exhaustion of funds. But, you know, overall, the finding is the same. The majority of states will exhaust their funds sometime in Quarter 2 or Quarter 3, but all states, regardless of when they will exhaust their funds, will face a shortfall in 2018 unless there are new funds available to them.

Okay. So as you can imagine, states have really been considering what they need to do in the face of not having new funds for fiscal year 2018. So far, we're aware of five states that are listed on this slide that have asked for and received redistribution funds from CMS, and just as a reminder, you know, redistribution funds are monies available to states with shortfalls, and those monies come from unspent prior year allotments. So you can see the amounts there, and our understanding is that those redistributions are being made to states on a month-by-month basis at this point, and CMS has been really working

closely with states and been in frequent contact with them to determine the amounts of money that they'll need and the timing for that as well.

We also are aware of one state -- you might have seen this in the press -- Utah, that has actually submitted a CHIP state plan amendment. As we understand it, the amendment would eliminate CHIP eligibility and services due to the lack of federal funding. As far as we know, that's the only state that has officially submitted a SPA, but I hear that there are other states that are considering it or have been talking about it with CMS.

So states are really facing a dilemma in terms of what to do at this juncture. They are facing shortfalls in CHIP funding and are very well aware of the need to provide information to families and stakeholders. But they're really trying to balance sort of information sharing about the current state of play with not wanting to cause alarm or concern with especially families but also other stakeholders -- providers, for example.

Colorado is one state that has provided sort of updates on their website, public updates on their website, with information about the status. But that information,

they've been very, very careful and have in numerous places noted, you know, CHIP funding in our state has -- you know, we might have to change something in our state. But nothing has changed so far. Everybody still has their coverage. But we're just sort of providing information.

So I think, you know, what we understand is they're really, really trying to be very careful with their words. They really are concerned about what the families are going to take away from these messages, because they can be a little bit confusing.

Okay. So congressional actions so far. The Senate Finance Committee and the House Energy and Commerce Committee have both approved CHIP funding renewal bills. Those bills are -- the numbers are on the screen there. Those pieces of legislation, for the most part, you know, they agree on the CHIP policy. They call for a five-year renewal of CHIP funding, extending the children's maintenance of effort through fiscal year 2022 for children with family incomes under 300 percent of the federal poverty level. Reducing and then eliminating the increase to the CHIP enhanced matching rate after fiscal year 2019, so in fiscal year 2020 they provide for an 11.5 percentage

point increase to the CHIP enhanced matching rate, after which it reverts back to the customary CHIP enhanced matching rate.

The legislation also renews the contingency fund, the qualifying states option, express lane eligibility authority, as well as funding for the outreach and demonstration grants, the childhood obesity research demos, and the pediatric quality measures program through fiscal year 2022.

So although there is agreement for the most part on the CHIP policy, I think, as you know, the negotiations on the offsets are ongoing, and there had been some talk about the House moving the bill to the -- or the committee moving the bill to the full House and getting some floor time. But as far as I know, it's not on the schedule, and so I don't actually know when that will occur.

Okay. So that's the update, and given sort of where we are right now with CHIP, I would like to hear from you if you all think there's anything that MACPAC maybe would like to do. In thinking about that, a couple things come to mind.

We could do some updates to the analysis on when

states would exhaust their federal funds and reissue a brief of some sort or perhaps a fact sheet. Or another option would be for MACPAC maybe to send a letter to House and Senate leadership or committees of jurisdiction, although, as I said, the committees have largely completed their work.

Thank you.

CHAIR THOMPSON: Great. Thank you, Joanne.

I wanted to ask a couple of questions and then make some general comments and open it up. I also want to be sure to hear from Leanna, so just be prepared. I'm going to come to you in a second.

How different are our updated numbers from what was issued before? What I would say is, first of all, I think if we have updated numbers, our numbers have been widely cited. To the extent that there's any changes in those numbers, it seems right to me to update them, even if they're modest changes. But a couple of questions about it.

One, have any states moved in terms of the quarters that we expect -- you said there's a little movement in timing. Let's focus just on those states that

we project to exhaust funding by, say, the end of December. Does that picture look different than it did in our July brief?

MS. JEE: So there are a few states that have moved quarters, not really that many, though, and, you know, again these estimates are based on state projections submitted to CMS.

CHAIR THOMPSON: Right.

MS. JEE: And these are as of August. So, you know, at any point in time, they're already outdated, right?

CHAIR THOMPSON: Of course. Right.

MS. JEE: So, yeah, there are a couple of states that moved, not very many, though. I think the majority are sort of within sort of the same quarter.

CHAIR THOMPSON: Okay. Thank you.

You know, it's my view that we should update those numbers. But I also think that we should do a couple of things, if it's possible to do. One is I do think some people are using numbers based on when states are exhausting their allotments and then when states are getting a redistribution, so kind of separating those pots

I think is helpful.

I also think it's useful to think about just noting that in advance of an actual exhaustion of funds, which, you know, we've pointed out the consequences of that for families, for children. I think it's well understood that that is not the outcome that anybody wants to see. But that even in advance of that exhaustion of funds, the prospect of exhaustion creates certain kinds of harms and impacts in the program.

You mentioned states in this dilemma trying to figure out what they ought to be doing. The time and effort to be spent on contingency planning, the effort to pull down redistribution funds, the effort to think about what kinds of changes to systems might be necessary to implement, all the orderly shutdown issues, the notices to beneficiaries. No doubt many states are not starting new activities that they may have planned to do for the long-term health of the program.

So I just want to be sure that we're clear, and, you know, I don't think that we have to go into detail on all of these different kinds of issues, but I think contextualizing the timing issue and the urgency of it is

not just about that moment of exhaustion of funds, but also some of the preceding impacts and effects.

The other is just to be sure that people are clear on the idea that we are basing this on -- what is it? August quarterly data? So, clearly, there are potential differences in deltas between those projections and actuals. You mentioned that CMS is working with states on those issues, so I think we should be also encouraging CMS reporting or some kind of transparency about where those allotments are or encouraging Congress to be thinking about collecting that information so they're not relying on projections when actuals are diverging from that.

CHAIR THOMPSON: First, Leanna, in North Carolina, this issue about not worrying beneficiaries, it presupposes a certain level of awareness on the beneficiaries, that the beneficiaries are not aware that this is an issue. What is your sense of that? I mean, at one point it's not good to cause a lot of concern or action that is not useful among families. On the other hand, if they're getting information from other sources and doing the worrying kind of on their own, that's also not helpful.

COMMISSIONER GEORGE: Yeah, well, I think for

one, a lot of families don't quite realize they're on CHIP. I think a lot of families assume that they're on Medicaid. I know in North Carolina the Medicaid card and the CHIP card are pretty much identical, just one word is different, believe it or not. It's “Choice” or “Check”. Unless you know what you're looking for, you don't really realize there might be a difference in the program that you're on. So I think a lot of families may not be aware that they're even on CHIP. I think that's part of why we haven't heard as much in the waters -- as much from the public about this.

And I think also there might be some amount of wisdom in trying to hold off letting people know that the program is possibly about to end. As far as helping to stretch funds further, I can imagine some families -- okay, usually every third year, in the month of December, we go and get an MRI. If they're getting a letter -- if they know they might be running out of insurance in December, they might move it up to today to be able to get that expensive service done so that they have it done so they don't have to worry about it for the next three years, because there are some kids that are cyclically watched

like that for different conditions and stuff. I'm sure I probably would be one of them if I felt that that was going to happen to us. But, luckily, I think, Caleb's on the Medicaid expansion, so he's safe. So you don't have to worry about him; I think he's safe.

I think those are the two biggest issues around being too up front, but then again, you also do yourself a disservice by not letting families know because if they all know there's a concern or an issue, they can't do anything with their elected leaders to be able to get the ball rolling on that.

CHAIR THOMPSON: Let's see. Kit, then Chuck.

COMMISSIONER GORTON: So I guess what I would wonder, Joanne, if we could do in the context of updating the numbers, it's clearly an important milestone when states run out of money, either through the current allotment or through the redistribution. But many states have -- first of all, many states have already completed their appropriations, and those appropriations are generally not contingent on the receipt of federal funds in every manner. There often are contingencies built in, but I wonder about the impact of when the authorized funding

stops. And I'm sort of thinking in the context of for the last month the ACA plans and the state marketplaces have been wondering what do we do when federal funding drops out even though we have all these appropriations and contracts in place that say the program will behave in a certain way.

And so I wonder if there's an opportunity for us to illuminate what the range of options states have in terms of, okay, the federal funding stops, but does that mean -- it's not like a government shutdown that it's pencils down that day. So what's the range of time for when coverage actually ceases? What's the impact on states that have relied heavily on managed care companies so those premiums are already set, the capitations have already been appropriated? How does that all sort of cascade out in terms of, as Penny was talking about, an orderly unwinding of the program?

You know, clearly, at least hypothetically, there's the option that the states could continue out of state funds to fund the program. I don't think most of us think that's realistic for an extended period of time. Would a state choose -- I mean, again, going back to the ACA scenario, the CSR allotments stopped effective October.

Those policies are still in place. The premiums are being paid, and people are figuring it out.

So I just wonder if we can provide some level of insight as we refresh the numbers to what the orderly unwinding looks like and what the downstream variables are. Just because a state loses funding or runs out of funding on a certain day doesn't mean that necessarily coverage ceases for every kid in CHIP on that day.

CHAIR THOMPSON: Chuck, then Alan.

COMMISSIONER MILLIGAN: My comment follows on Kit's. So in New Mexico, which is a Medicaid expansion CHIP program, there was a legislative hearing yesterday. The cabinet secretary of the agency that administers the CHIP program testified that because it's a Medicaid expansion, it will continue as fortunately North Carolina for Leanna's son. But the delta for the state appropriation is $31 million for state fiscal '18, which begins July 1st of 2018 -- excuse me, it's fiscal '19.

So I think what I would suggest in terms of ongoing sort of data resources would be: When do state legislatures convene to make budget decisions? What is the budget information that we're seeing emerge from states,

whether it's picking it up from a state funding perspective in Medicaid expansion states, potentially picking it up for non-Medicaid expansion CHIP programs, unwinding it for stand-alone CHIP programs, and so on? I think that having kind of a roll-up or a state-specific information about the budget timelines, budget cycles, and what we're hearing emerge like the $31 million figure in New Mexico of the additional state general funds that would be necessary, I think that would helpful context.

And just to answer one of the questions you posed when you concluded your remarks, personally I don't think that there's any value-added in further recommendations or letters from MACPAC. I think the state of play is very well known at this point. And as you noted, both the House and Senate at the committee level have acted. So I don't personally think that there's a lot of marginal benefit to us weighing in.

Thank you.

CHAIR THOMPSON: Alan?

COMMISSIONER WEIL: Had I known then what I know now, I would have suggested when we adopted our recommendation that we put a timeline on it. But we

didn't, and we don't have one in ours.

I guess my perspective is slightly different. Although I'm always for more analysis -- as the editor of journal, I have to be -- I'm not sure how much our goal is going to be achieved by adding to and updating. It's good to have the information, but I'm not actually sure it leads to anything. At this point I think reality is going to overcome projections, and I guess I'm now worried about not days but weeks and months. You know, that's what I worry about.

So although analysis is good at this point, I guess I go a little bit different than Chuck. I think looking at -- somewhat the same, but maybe a little different turn. I think trying to capture those actual effects as they're playing out would be very valuable. I think trying to shift from a projections mode to a "this is what's actually happening" mode is more important.

But I also think -- and, you know, federalism runs through all of our work here. I guess I do think that this is sort of a breach of the federal contract with states in administering this program, and I think it should be said -- and I understand that the committees have acted,

so the committees aren't quite the right audience for this. But I just don't -- I think it's -- for me, it's hard to sit silent on this Commission watching what's unfolding, and having spent so long working in state government and with states to not want to say it's not just that we have a recommendation out there, it's that the success of the program depends upon a cooperative approach by states and the federal government, and it's very hard for states to do their part in this environment. To me, that's different than repeating the recommendations, and I would support some communication in that regard.

CHAIR THOMPSON: Alan, let me ask a question. Do you think that can be accomplished in the context of, you know, discussing some of these kinds of dilemmas and issues that are facing the states in the context of a brief? Or are you saying I think we should be writing a letter saying, you know, this is no way to --

COMMISSIONER WEIL: Yeah, so I guess I'd -- my thinking was time is of the essence, this is a letter. I don't know how quickly -- I mean, I very much align myself with Chuck's suggestion that we know more about the time cycles, and Kit had the same general -- I think that notion

of describing the implications and the timing is important. The variability, just like the variability in when funds run out, is substantial, by state process, by Medicaid expansion versus separate. I wouldn't want us to enter into some lengthy process that leads to a brief that's sort of too late. But we know from the work that has already been done what the early states are in this, and I think maybe a closer look at process in a few of those in an illustrative sense to feed into something, maybe that's sort of the middle ground.

CHAIR THOMPSON: Okay. Thank you.

Marsha?

VICE CHAIR GOLD: Yeah, I was going to sort of head where Alan's heading, I think. I don't object to doing any of those updates, but I wondered if we were getting a little bit too far into the weeds and sort of missing the big picture, which is, you know, behind our original recommendation, we recognize and we saw where there were data showing how much improvements there had been in people who had -- children who had health insurance as a result of CHIP and this being a bipartisan proposal which had really accomplished a lot. And I think we also

knew and it was reinforced by the CHIP directors who talked to us that these things -- you know, as opposed to legislation, which just gets passed in the states, there's a whole lot of before stuff that has to happen. And, in fact, that was part of our rationale for the five-year recommendation so that people can have some sensitivity.

I think trying to figure out exactly what might happen when in each state is difficult. States are obviously well aware of what's going on and both publicly and privately trying to finesse how they handle this. What they tell people may or may not be the same as what they're doing for very good reasons. And I think my fear -- and I sort of feel the same as I think Alan said, that it's unfortunate from a beneficiary perspective and a public policy perspective that these people are held hostage to whether we have the right vehicle and what the legislative agenda is and the offsets, whatever they are. And it seems to me that very consistent with all the analysis we did and what we've done, it would make sense to say, hey, this program really accomplished a lot. And while there are a lot of practical and political reasons why things may not have gone past, this is not good and it's hurting real

people. And, you know, we really think that good public policy warrants getting on the stick and doing something about it, and Alan's idea about, you know, the federal-state partnership being a key one there with that, I feel very comfortable with that.

CHAIR THOMPSON: Bill, and then Darin.

COMMISSIONER SCANLON: I think that no one is questioning the value of the program, and I think that in part is indicated by the fact that the committees sort of have passed -- each one has passed the bill. And the last bullet on your slide about where things are in terms of that there's a search now for offsets opens this into a much bigger arena. I mean, we search for offsets because we have a certain budget discipline, which actually the public doesn't recognize in most cases. They think of the Congress as being willing to spend money on anything at any time, and actually there is a discipline which says we really should think about how to fund certain things. And that's a process that's going on, and I think it's well beyond sort of the Commission in terms of what both its mandate and its expertise is to be able to sort of intervene or think about sort of commenting on that

process.

In fact, I would suggest that a lot of that is not known to us at this point, that it's going on sort of within the discussions in the Congress, and something may emerge. And it may emerge very quickly, or it may not. That's sort of the great unknown.

I feel like the Commission is much more valuable in terms of providing sort of information and providing the implications of that information. So I think of, you know, analysis and update as being very much our role. And in addition to some of the kind of the data, so to speak, some of the implications that Chuck was talking about may be something that you would think about adding to a brief, sort of that -- there's a recognition, these are not just cold numbers in terms of dollars, dates, et cetera, but here's what the reality is in terms of how entities are going to have to respond to those kinds of situations.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: I agree with Chuck. I mean, having -- I was looking through all the different numbers and having the actual estimate of additional dollars that would be needed for the change in the match

rate, because, I mean, you know, we have this discussion quite regularly. I feel like -- you know, I was running the CHIP program for many years -- that this kind of cyclical situation is frustrating. I personally don't understand why the time periods of the authorization are what they are and why they're not longer, because, I mean, there are several aspects of Medicaid and CHIP that we get into these -- whether it's through waivers or it's the reauthorization of things, and it does create organizational chaos or operational chaos and frustration in the system.

So, one, I think having the number is good, but also I'd like a better understanding of, you know, what are some of the limiting factors that prevent authorizations from being for longer periods of time so that, you know, the frequency of this angst might be at least minimized or spread out longer?

CHAIR THOMPSON: Well, that, in fact, was one of the reasons why we made a recommendation for a five-year reauthorization, because we prioritized and valued that continuity and consistency and the ability to make investments for future program benefit and to avoid some of

these circumstances.

COMMISSIONER GORDON: I mean, what is the limiting factor between a three, a five or --

CHAIR THOMPSON: The amount that you need to offset it.

COMMISSIONER SCANLON: Part of it relates to the offsets. If you were to enact sort of a bill that extended it for ten years, you would have to think of offsets that are going to cover the full funding for ten years.

One of the offsets being discussed right now is the prevention trust fund from the ACA, which is a fixed dollar amount. So you only have a certain number of dollars. It's not an ongoing source of funding. It's going to be used up once, and then you have to think of something else that will be the offset.

COMMISSIONER GORDON: My understanding was that that was in a discussion of how you continue to enhance funding, but you're saying it's for the base program altogether.

CHAIR THOMPSON: Okay. There's a little bit of distinction here. What I'd like to do is propose something sort of in the middle. I do think if we have updated

numbers, we should post updated numbers. I do think that we should issue the warning in the context of those numbers that, you know, they are based on August data, there is more recent data that is being used by both states and CMS to negotiate issues around the redistribution. I think we ought to, in response to some of the comments from this side of the table, particularly talk just briefly about both impacts happening to programs now in light of the prospect of losing funding and potential actions that could be taken post-exhaustion.

You know, I do think that we ought to reinforce the idea that, as we did during our discussion of a five-year reauthorization, that these kinds of disruptions or questions or uncertainties with respect to the program cause lots of ripple effects to state budgets, to beneficiaries, to programs, and it is very difficult for states to be good partners to the federal government when that kind of uncertainty exists from the federal side.

I would also just reinforce I think timing is of the essence here, so because things are moving very fast, that we should prioritize getting a brief completed and up, and make that information available to people at the

earliest possible moment.

I am going to take a pause here and ask for public comment on this. I think there might be some interested parties in the audience and want to be sure that we have an opportunity to hear from the public on this conversation.

[No response.]

CHAIR THOMPSON: Okay. Hearing none, we'll go on to the next item on the agenda. This is an update on our work on opioid use disorders, and we have Erin and Nevena.

UPDATE ON WORK ON OPIOID USE DISORDERS

* MS. MINOR: Good morning. Following publication of the chapter on Medicaid and the opioid epidemic in the June 2017 report to Congress, the Commission expressed an interest in continuing analysis in this area, and this is reflected in our ongoing work. And the topics and policies questions include identifying gaps in the continuum of care for SUD treatment, substance use disorder treatment, developing further analyses on the institutions of mental diseases exclusion, analyzing policy questions to address access barriers, and exploring whether changes ought to be made to the privacy regulations and laws governing SUD

treatment records to allow for better care coordination and integration without harming patient privacy.

So in this presentation, I'll review MACPAC's work to date as well as recent related federal requirements, and then Erin will provide an overview of current and upcoming MACPAC work, and we look forward to hearing feedback from you on our approach.

Last year, MACPAC published a compendium of 2015's state plan services commonly used in mental health and SUD treatment. In October of 2016, staff presented an analysis of opioid use and prescribing rates in Medicaid for years 2010 through 2012 and the tools states are using to curb prescribing and identify potential misuse.

This was then followed by a March 2017 panel of representatives from Virginia and Vermont in the National Governors Association to discuss the initiatives to address the opioid epidemic with a particular focus on expanding access to treatment. And all of these analyses and discussions in turn informed our chapter in the June report, as well as MACPAC's agenda going forward.

So this year, the federal government continues its efforts to tackle the epidemic. In April, HHS issued a

five-point strategy, and it calls for improving access to naloxone treatment and recovery services, strengthening the public health surveillance system to better understand the epidemic and target resources accordingly, providing for research on pain and SUDs, as well as advancing better pain management, for example, through FDA or NIH initiatives and authorities. And the following slides highlight selected federal activities that have an impact -- or implications for the Medicaid program.

CMS, the Centers for Disease Control, and the Substance Abuse and Mental Health Services Administration in August sponsored a workshop convening state Medicaid and behavioral health staff for state-to-state learning about each other's policies and programs to address the epidemic, as well as to provide updates about federal funding and technical assistance resources available to states.

Through its Medicaid Innovation Accelerator Program, CMS continues to provide technical support and educational curriculum to support states' efforts for delivery system reform, and this includes a track on substance use disorders. And you will hear a little bit later this morning from Karen Llanos about the IAP program.

As discussed in our June chapter, the IMD exclusion poses a barrier to accessing care in residential treatment facilities. And there has been a lot of congressional interest in this topic. The Government Accountability Office, in response to a congressional request, issued a report on state funding of IMD services. While the GAO issued no recommendations, the report estimated that nearly half of inpatient and residential SUD treatment facilities in 2015 may have been IMDs.

It also found significant variation in treatment capacity across states. And while some Medicaid programs have been able to avoid the IMD exclusion by paying for services in facilities that have fewer than 16 beds, some of those facilities maintain wait lists or turn individuals away.

CMS, in recognizing the challenge posed by these exclusions, is offering two pathways for federal financial participation. The first one is through an 1115 waiver for innovation in SUD treatment. States are able to cover care in IMDs so long as the residential providers are able to meet the requirements of the American Society of Addiction Medicine criteria, and Erin as part of her remarks will

provide a bit more detail on these ASAM criteria.

In August, CMS also issued some regulatory guidance on the 2016 Medicaid managed care rule and it's in lieu of service provision as it applies to IMD. The in lieu of service provision allows MCOs to pay for alternative services in settings that are not in the state plan or otherwise covered by the contract so long as these services are medically appropriate, cost-effective substitutes for state plan services that are included within a contract. CMS' guidance clarifies, among other things, the conditions under which capitation payments can be made in the event that an enrollee is in an IMD during a given month.

SAMHSA, CDC, and the Health Resources and Services Administration, among others, have also continued to award grants to states and in some cases health care providers, cities, and community organizations to address the epidemic. These grants support a wide range of activities to promote appropriate opioid prescribing, overdose prevention, and access to medication-assisted treatment, or MAT for short.

A large share of the funds that have been

appropriated to date have been authorized by last year's 21st Century Cures Act and the Comprehensive Addiction and Recovery Act.

While these grants do not go to Medicaid agencies, funds may be used to cover provision of services to Medicaid enrollees when a state Medicaid program does not or insufficiently covers a service. Grantee public health departments, for example, may also work with state Medicaid agencies on data analysis related to overdose and opioid prescribing rates.

The President's Commission on Combating Drug Addiction and Opioid Crisis is planning to issue on November 1st a set of recommendations of the President on how to improve the federal response to the epidemic.

Previously issued draft recommendations included several provisions affecting Medicaid. These include calling for a Medicaid waiver approval to all states to eliminate the IMD exclusion, a CMS letter to state health officials requesting that state Medicaid agencies cover all FDA-approved drugs that are used in MAT, and through regulation, better aligning with HIPAA, the privacy laws for SUD treatment records, so that any clinician treating a

patient with an SUD is aware of his or her disorder, and they can then tailor their care in prescribing accordingly.

And as early as this morning, there's also reports that there will be potentially a public health emergency declaration from the President this afternoon, so we'll find out more details as that occurs.

And I'll now turn over the mic to Erin to discuss MACPAC's current and planned work in this area.

* MS. McMULLEN: All right. Thanks, Nevena.

Good morning. I'm going to walk you through three projects that are already under way or currently planned. These products will build upon the Commission's previous work and will further identify gaps in the substance use disorder continuum of care as well as identify barriers to treatment.

Before we jump into those projects, we wanted to provide you with some background information regarding the framework that we're using to structure our analyses.

We'll be using the criteria set forth by the American Society of Addiction Medicine, also known as ASAM, to structure a gaps analysis of substance use disorder treatment in state Medicaid programs.

We decided to use ASAM to guide our work for a few reasons. The ASAM criteria is the most widely recognized clinical guideline for this treatment of subject use disorder. It's used by both public and private payers in determining medical necessity, and ASAM's use within the Medicaid program has also increased.

As Nevena mentioned previously, CMS is requiring the use of ASAM in the 1115 waivers, which allows for payment of substance use treatment in IMDs.

ASAM identifies five broad levels of care across the treatment continuum that I'll go into greater detail on the next slide.

To determine what level of care an individual needs, ASAM utilizes a multidimensional tool that accounts for more than just a diagnosis. So it includes things like someone's recovery environment.

ASAM consistently highlights the need for a care continuum to support an individual's recovery. It also allows someone to enter treatment at the appropriate level of care and step up or down as needed.

While the criteria promote a broad and flexible continuum of care, even ASAM acknowledges that offering

that full continuum might not necessarily be possible. Payment may not exist for some levels of care, or at other levels, provider access may be limited. This underscores the importance of the analysis we've undertaken to identify where those gaps in coverage exist.

So ASAM's five broad levels of care range in level of intensity from early intervention being the least intense level all the way up to Level 4, which would be in patient services, the most intense.

I'll quickly summarize each of these levels, but a more detailed table summarizing the levels of care is included in the memo that's in your packets. I believe it's on page 6.

Early intervention includes assessment and education for individuals who do not meet the diagnostic criteria for a substance use disorder.

The next level, outpatient services, includes up to nine hours of service per week. Those services could include individual group or family counseling. Outpatient methadone clinic services also occur at this level.

Level 2 includes two discrete levels of care that range between 9 hours or more of services a week up to 20

or more hours of services. For both of these levels of care, services provided in these programs are similar to the ones that are provided in Level 1.

Level 3 services are delivered in facilities that are staffed 24 hours a day, many of which are IMDs. While there are four different levels of intensity in Level 3, all programs serve individuals who need a safe living environment in order to stabilize and develop recovery skills before they could transition to an outpatient program.

The least intense level of residential service necessitates at least 5 hours of services per week, while the most intense Level 3 setting includes 24-hour nursing care and at least 16 hours a day of counselor availability.

Level 4, the most intense setting, has 24-hour nursing care, daily physician care, and offers counseling to engage the patient in treatment.

Now, we have listed out recovery support services separately on this slide because they're generally not clinical services and, therefore, not part of that ASAM continuum of care.

Even though support services are not included,

ASAM considers an individual's recovery environment a factor in their patient assessment advising that the quality and extent of recovery support services influences patient outcomes.

Support services could include peer support, supported employment, or a mutual aid group such as 12-step programs.

We've used this distinction between the ASAM levels of care and recovery support services to support an analysis that would identify gaps in the care continuum.

So over the winter and spring, assessing gaps in the ASAM continuum is going to occur in two separate phases. The first phase will focus on identifying state-by-state coverage policies for residential treatment or those ASAM Level 3 services that are often provided in IMDs.

Level 3 services do include four discrete levels of care that have not been analyzed by MACPAC previously. We also know that gaps in this level of care are more pronounced because of the IMD exclusion.

In addition to reviewing state plans and other materials to document coverage of the Level 3 services, our

analysis will capture the utilization of the two pathways Nevena mentioned previously that states may use to pay for IMD services--1115 waivers and then through the in-lieu-of provision in the new managed care rule.

The next step in this analysis would focus on cataloging coverage of ASAM Levels 1, 2, and 4. Some of these services were previously documented in MACPAC's 2015 Behavioral Health Compendium.

When state coverage of ASAM services has been assessed, we'll document the reasons for coverage variation by working with the contractor to conduct interviews with states. Through interviews, we would potentially seek to answer a number of questions that are included on this slide. Additional questions focused on the provision of IMD services would also be used in interviews to document whether that in-lieu-of provision is being used by states or if states are using 1115 waivers.

After documenting state-level coverage of ASAM levels of care, we're going to turn out focus to recovery support services and assemble a compendium documenting their coverage.

As I mentioned in the previous slide, these

services are generally not clinical, and many recovery supports are not eligible for federal Medicaid match. However, select states cover certain services, including peer support, family peer support, and housing support services, as well as supported employment.

A few of these services were previously captured in MACPAC's 2016 Behavioral Health Compendium. These services may be offered through the state plan but are often limited to populations through waivers; therefore, we'll look at both when we're building out the state-by-state comparison.

So the final project that we're highlighting today shifts away from analyzing gaps in coverage and is focused on addressing privacy regulations for substance use disorder treatment.

At the end of November, MACPAC will hold an expert roundtable focused on 42 CFP Part 2. The roundtable aims to better understand how Part 2 affects real-world clinical and administrative settings and to identify potential changes to the rule itself or its implementation that might better facilitate integration while still protecting patient privacy. Statutory, regulatory, and

operational changes will be highlighted throughout this roundtable, and a wide range of stakeholders will participate.

All right. So that concludes our presentation for today. We would like to hear from you on our proposed approach to analyze gaps in substance use disorder treatment and offer a few questions to help facilitate that conversation.

Because staff must decide on the level of detail to include in the compendium, are there specific outpatient services that the Commission is interested in examining?

Similarly, is there a subset of recovery support services you would like us to focus on that are more likely to be covered by the Medicaid program.

We look forward to your feedback to help further direct our work on this important issue, and thank you for taking the time to listen to our presentation.

CHAIR THOMPSON: Thank you. That's very useful.

Let's go with Martha.

COMMISSIONER CARTER: Thank you very much for that presentation.

I have a question about something that we may

want to consider, which will be monitoring the increase in access to care subsequent to opening the data 2000 waivers to nurse practitioners and PAs.

And a question specifically, were Medicaid managed care organizations or Medicaid programs required to reimburse for these services once these practitioners were able to prescribe? And just looking at that issue.

CHAIR THOMPSON: Kit, then Toby.

COMMISSIONER GORTON: So thank you for this work. I continue to be very supportive of it. It's an important line of inquiry for MACPAC, and I'm glad that you're doing it.

I would suggest that it may be useful, not in an exhaustive way, but to come up with some illustrative examples that click down below state-to-state comparisons and look at intrastate variability in terms of access to these services.

I think it's a true statement that, by and large, where these services are available in states, they're available in the urban core, and they may not be available in rural communities. Certainly, they're not available in frontier communities in most cases, and I do think it is

useful for us, particularly in the context of looking at recovery -- one of the ultimate goals of recovery is generally to repatriate people to their home community. And so how do you create a continuum of care that steps them down through the levels of care to a place where they can be supported in managing this chronic condition in their home communities?

And so I think one of the things that creates a barrier to that, to that aspirational goal, is that the different levels of services are only available -- some of this is driven by density. It's hard to come up with an economic model that supports them in areas of lower and lower density, but I do think it's worth looking at states where the density is quite variable and be able to say, okay, well, let's take a prototype state of Pennsylvania or Tennessee or someplace like that where there's wide variation and see if we can at least qualitatively describe what the difference in access are.

Is it meaningful access if somebody has to drive two hours in order to get to a service that they need to partake of three times a week? And an associated piece of that, which I didn't see here, is are there -- are there

ways to deliver these services that don't require a physical presence? SO is there a virtual approach?

There's been a lot of work in behavioral health around what's loosely referred to as telemedicine, and I would be interested in knowing where states are in terms of pursuing those things.

CHAIR THOMPSON: Okay. We've got Toby and Chuck and Sheldon and Brian.

Before Toby jumps in -- and Alan -- just to follow up on Kit's question, in the discussion, it wasn't super clear to me if we're talking, when we talk about a continuum of care, if we're talking about coverage policy or access. And those to me are very different propositions, and so I'm just opening up for a conversation about which one of those things we're really trying to do, and maybe one precedes the other, and we need to take it in certain steps, and we're taking it in bite sizes to get someplace. But that was just a point that was a little unclear to me from the brief. I don't know if you want to make a comment on that.

MS. MINOR: Yeah. I think we were first looking at what is the coverage landscape, and I think to the

extent that services are not covered, talking to states and understanding what the reasons are and acknowledging, though, that just because something is covered, there may still not be access, but I think first we want to really build out what the coverage landscape is and then, kind of taking it further, looking at the access piece.

CHAIR THOMPSON: All right.

MS. McMULLEN: Yeah. I would just comment too that I think that was one of the reasons we did want to, after coverage was documented, have those interviews with states. I think we were planning on hopefully having some questions that would get at some of those access issues.

Just for example, I know some states do have those residential services in their state plan, and they are paying for them in those smaller facilities that are under 16 beds. But some of them are trying to get waivers to pay for them in IMDs.

I would imagine that, hopefully, we could document that why states are pursuing that additional authority through those interviews.

CHAIR THOMPSON: Okay. So I have Toby, Chuck, Sheldon, Brian, Alan.

COMMISSIONER DOUGLAS: Definitely fully supportive of the overall analysis and next steps.

I think one areas as we -- and this probably dives into a follow-up. Once you go into the area around are services provided through other channels, it's really understanding the continuum not just through the lens of substance use continuum but the integration with the physical health and what's going on.

A lot of the gaps states are looking at, as well as payers, from the integration at -- whether it's at a federally qualified health center, and this will kind of go into the next discussion, or just into primary care -- of how do you create models where you're building substance use as well as behavioral health into the integrated delivery because of the infrastructure problems that might exist on building out an ASAM kind of in an isolated setting.

So I think what a next step might be is really trying to understand both payment policies that could incent that as well as infrastructure needs that could be supported, but payers are trying to figure out how to solve this and not necessarily solve it from kind of just looking

at substance use as a separate system but how it's integrated. And that gets to integrated with tele-psych and other types of tele-support approaches as well, so just something that we should think about. But while substance use on its own is important, that it's got to be integrated in with the other setting.

The second point, which is more just nuances around the IMD and the managed care rule, that we just need to acknowledge that both with a step forward and a step background depending on the state, the rule was not clear, and states were setting managed care rates on their own. And some were able to do it way longer than the 15-day that's now in setting.

So some states now -- as well as managed care plans -- are actually seeing this as a step backward, and others, maybe it's progress. So we just need to remember that.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: My comments are going to, I think, follow along with Toby, Martha, and Kit.

I think we should continue the focus on access alongside the focus on coverage and not do it sequentially.

I think we had great presentations from Vermont and Virginia in the past, and what I want to say specifically is I think it would be helpful to continue staying on top of the approaches in which treatment is infused into primary care, is integrated with primary care, some of the licensure rules and treatment approaches.

And I think that the access issue and provider licensure readiness and how treatment is expanded and developed through primary care is an important care to keep doing and including for the expert panel that's coming up.

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: Thanks for the presentation, and I'm glad that we're continuing to bring substance abuse and addiction back to the Commission.

I'm going to sort of wander into sort of sacred territory maybe. It seems to me there is a national consensus that this problem sort of defies political boundaries, and everybody wants to fix it. As I sit here and think about it, if I carry this forward, there's probably no disease or condition, chronic illness, where the delay in access to outpatient care eventually ends up to be a much more expensive proposition; that is, the lack

of coverage, I think leads to some catastrophic consequences.

One of my questions here is, in non-expansion states, are they seeing an explosion of hospitalizations that expansion states are not? And by hospitalizations, I'm actually not -- I'm concerned about IMDs, but I'm also concerned about conditions, medical conditions that actually we haven't seen in decades, like endocarditis. Endocarditis basically almost went away and now has raised its ugly head again. At our medical center, we're seeing cases of endocarditis that are populating the inpatient hospitalizations. So I'm interested in what's happening in non-expansion states.

To that end, when Kate Neuhausen was here, she -- and Virginia is a non-expansion state, and they were actually talking about waivers or ways to perhaps actually expand access.

And then one last point that Kit brought up that I keep bringing up is that rural and rural settings, substance abuse and addiction is a very different condition than in urban, different drugs, a different disease entirely, and I think that -- and the 15 counties with the

highest mortality rates in the U.S. are in rural, and they actually are in Kentucky and West Virginia, both expansion states. So I do think that's something we have to continue to bring back to the Commission.

But I'm interested in the hospitalization rates in the non-expansion states and whether there are methods for approaching that.

CHAIR THOMPSON: And, Sheldon, I'm assuming that your interest would also be in expansion states to the extent that we have expansion states but without adequate coverage or access, we can be seeing some of the same kinds of effects, right? It's not --

COMMISSIONER RETCHIN: Absolutely.

CHAIR THOMPSON: -- simply an expansion versus --

COMMISSIONER RETCHIN: Oh, no, no. It's not, although I do think it would be interesting to see if there is a marker, if you will, a sentinel event or a sentinel sign that we're missing --

CHAIR THOMPSON: Yeah. Uh-huh.

COMMISSIONER RETCHIN: -- that these catastrophic events are occurring in areas where childless adults have no access at all.

CHAIR THOMPSON: Yeah. Yeah. Thank you. Brian.

COMMISSIONER BURWELL: So I have three things. So I know -- I'm no expert in this area. I do -- I am very supportive, as you well know, of our continuing work in this area. But I know that one of the major policy issues is getting people access to medication-assisted therapies. I'm not really sure how that issue relates to the ASAM criteria, if it just covers all levels of care. But I do know that that's a big issue in terms of state policy response. It builds on what Martha was saying about the new types of providers that are allowed to prescribe treatment, et cetera. So access to medication, I think, is the -- is a big one.

I'm personally also interested in prevention. So there's potential work, I think, more in terms of trying to catalog and describe the different types of prescription drug monitoring programs that are currently being used by states and making, perhaps, some observations about which ones seem to be having a more -- a greater impact on limiting access to opioids as a prevention measure. I think that's a worthwhile line of investigation.

My third is just something that I saw on TV.

There was a -- you know, somebody was -- they were interviewing an addiction specialist, a woman who treats these people all the time, and she made the comment about, you know, just as people say we can't arrest ourselves out of this problem, she says we can't treat ourselves out of this problem either. And I was kind of taken aback because everybody's talking about getting people access, you know, to services, and that's important. But I'm wondering if we should try to broaden our thinking around policy responses and that this is more than -- you know, the solution is more than just about getting people into treatment.

CHAIR THOMPSON: Okay. And so, Brian, last -- in October we had some of the staff bring forward some information about the PDMPs and -- PDMPs, and the utilization review and monitoring. So we might want to just take another look and see if that -- if there's a deeper dive on some of those kinds of things that we're interested in, as you say, sort of more on kind of impact basis maybe, as well as a description.

COMMISSIONER BURWELL: Variations in terms of how states --

CHAIR THOMPSON: Uh-huh.

COMMISSIONER BURWELL: -- are going about that, in terms of getting -- and how they get the data and that kind of thing?

CHAIR THOMPSON: Mm-hmm. All right. I have Alan, Martha, Chuck, Darin -- did you? Okay.

COMMISSIONER WEIL: At the risk of making this even more complicated, I was nodding my head vigorously when Penny said the tie from coverage to access is critical. I think there are two more that I want to add. I was so impressed, in all senses of the word, by the presentations from Vermont and Virginia, impressed with what they're doing but also impressed with a theme that I've tried to examine a lot over my career, which is the state role in developing delivery systems. And I'm not sure if we map eligibility criteria or even if we count numbers of beds that we capture, the notion of the creation of systems that enable people to be in the right places and services. I'm not describing it well but I just want to make sure we don't think of this as boxes to check, because it's so clear that action is required beyond just changing an eligibility or a coverage provision.

And the other piece I would add is the -- for

example, seeing the ASAM levels, I don't have a clear sense of what share of people fall into requiring those levels of services at any one time. And so when you sort of ask, are there priorities, it's hard for me to know where the priorities should be. We hear a lot -- because of the IMD exclusion, we hear a lot about the residential treatment piece. I don't assume that that's the largest category of need but I truly don't know. And so I think if you can contextualize this with a little bit of sort of where are people, there's a lot of unmet need, is the unmet need in inpatient, is it in supervised outpatient, is it in, you know, long-term residential, things like that.

And then just on a totally separate note, we had a blog post on the Health Affairs Blog about Part 2 and, you know, the privacy issues. I was struck, a bunch of people commented on that post about what a big barrier it was, and a bunch of people commented on the post about what a terrible idea it would be to change it. And we have another post presenting the privacy perspective, and a bunch of people commented on that about they agree, and other people -- so there's clearly -- there's more than two sides to this, but very strongly held views, and if we can

be a resource in that regard, let us know.

CHAIR THOMPSON: You know, on that point of unmet need and IMDs, it's not also clear to me if IMDs -- is it they're there. And if you just took down this program barrier, I could get there, but if I had another place I would go another place and do a different thing. So I think that's exactly the point. Martha.

COMMISSIONER CARTER: I want to thank Sheldon for wandering into uncharted territory, and I may go a little farther, Sheldon, because I really see, out in the community, the need for prevention of infectious diseases and how the states are just beginning to tackle how they can do this, which includes real uncharted territory about syringe services programs. There's been a loosening of the requirements. We still can't use federal funds to purchase syringes, but federal funds can be used to support a program around that. And the reason that's important is because then that prevents some of the infectious diseases that people are showing up in the hospital with. You know, it intersects with our work on hepatitis B and C. We're seeing syphilis that I haven't seen in 30 years. Of course, it intersects with our NAS babies.

So I think that we really need to look at how the states are innovating in this area and what the borders are. You know, really push the borders, because I think there's all kinds of innovation going on out there out of desperation and huge community need.

CHAIR THOMPSON: Chuck and then Darin.

COMMISSIONER MILLIGAN: And I want to come back in just on the PDMP point. I'm glad it was raised.

One of the things that we're seeing in New Mexico is that one of the big barriers to the effectiveness of the PDMP is that the federal agencies that deliver health care, so the VA and Indian Health Services, they are outside of the jurisdiction of state pharmacy boards and medical boards to deal with them, because they're federal. And I think it's worth noting and looking into the effectiveness of PDMPs when we've got, in New Mexico and probably other places, a significant portion of the delivery system that is crucial for the folks on Medicaid are allowed to choose not to play with state licensure boards because of their federal status.

So maybe it's a point of advocacy but it's definitely something I think is worth exploring further in

the PDMP discussion.

CHAIR THOMPSON: Darin and Fred, and then we'll try to wrap up.

COMMISSIONER GORDON: I'll do rapid fire on PDMPs. I think the thing that, you know, just because they exist there's other -- with PDMPs, I think one of the issues that -- and just because they exist, you know, we've been doing those intensive for a while, but there were other limiting factors for the example of who all had access to that, and that's continued to evolve. So just because they exist, their usefulness can somewhat be limited by the limitation on access, so it's something that would be helpful if we had some insight into that when you look at that.

I think, you know, when we talk about access, one thing that we struggled with, particularly in this space versus maybe some of the others, is while we may have access, and we had numbers, the quality of the access was a little harder to ascertain in this particular space, you know, who was doing it right. I don't know if anyone has figured out how best to be able to look at this particular space and do that because I think -- I'm seeing more and

more providers step up but then I'm also seeing some providers that have the same members and will not see any more for years. It's the same members year in, year out, forever, and that's not helpful. But yet it shows up as a provider that we have access to.

And on the IMD, it would be helpful to have a sense -- you know, this has been in discussion for a long time from states, and I know that folks, even in Congress, have struggled with trying to understand, really, what would be the financial impact of rolling back the IMD exclusion. It would be helpful, because I firmly believe they are considerably overestimating that. It would be helpful like looking at the states and who have waivers, whether it's in lieu of or otherwise, around IMD, and/or -- this gets a little bit more difficult trying to get a sense from states what is it that they are spending -- you know, it's kind of the opposite, is what are they spending on because of the IMD exclusion, just to really help test really what is the magnitude of this shift. Because there's a lot of interest in it that seems to be one of the barriers and I think that barrier is overstated, just because states don't report to the feds what they don't

claim, and I think it's a bit of a black box.

CHAIR THOMPSON: Fred.

COMMISSIONER CERISE: So you mentioned what type of preventive services we ought to be looking at. I can tell you among primary care clinics it's incredibly -- there's an incredibly high percentage of patients that are getting treated for chronic pain, and these are practices that don't have the capacity to deal with this, and it's just a frustrating problem. And so I think there is work that you can do identifying that, looking at prescribing practices, and looking at resources available. To Brian's point, it's going to be very difficult to treat your way out of this problem, backing up to that chronic pain issue and putting some real thinking and resources around how to manage those -- that population that primary care docs see a lot of and it's very frustrating, because they don't have the resources and capacity to adequately address it.

CHAIR THOMPSON: I just want to circle back on -- I know that we don't know what the President may or may not do with respect to any emergency declaration, but can you just help us understand if there is a public health emergency declared with respect to this, what that does or

doesn't do? I'm just trying to think about areas -- you know, obviously there's a big appetite among the Commissioners for, you know, a lot of issues, and I think this has been a very interesting discussion. Does the public health emergency do anything that we should take into consideration here?

MS. McMULLEN: I think it's probably too early for us to speculate, just because even, you know, there's kind of two avenues the public health emergency could be declared under. We don't know what avenue that will be or what that means for Medicaid yet, but it's definitely something that we're going to be looking at. We'll probably have more information later today.

CHAIR THOMPSON: Okay, because obviously that is something that could result in more people coming into the system with coverage. It could result on changes in what providers are available and used to provide different kinds of services. So I think that is something that we need to keep an eye on, and, of course, there are usually time limits associated with those declarations, though they can often be renewed and so forth. So I think we ought to keep that in view.

I don't quite know how to wrap up this conversation because there was a tremendous amount of great suggestions. But it sounds like we do want to continue on this path. I think there's this interest in understanding urban versus rural issues and whether there are really significant locality issues. The integration of services and the connection between sort of the world of treatment for addiction and everything else that's going on in people's lives, including what Sheldon and Martha have brought up, which is, you know, that we may be seeing these effects and conditions emerging in the system, and the costs associated with that may help understand and put into perspective some of what else has been said about, you know, are we overpricing the cost of taking down, at least in some way, the IMD exclusion, if we are also seeing the effects of some of that lack of access showing up elsewhere in the system. I think that's a really interesting and important point.

So we look -- you know, we've given you a tough job here of sort of sorting through how to prioritize all of these different interest and where we can go, but I think everyone appreciates this work and thinks a lot of

what you've framed out here is going to be the right sort of stepping stone to those issues. And let's not forget that issue of prevention as well, and some of the other work that we've done on that side of the fence.

Thank you very much. We look forward to continued discussions.

All right. Now we're going to switch gears a little bit and move over to Ben Finder to talk about prospects and opportunities for streamlining Medicaid managed care authorities.

STREAMLINING MEDICAID MANAGED CARE AUTHORITIES

* MR. FINDER: Thank you and good morning. I'm here today to discuss streamlining Medicaid managed care authorities, continuing a conversation we started in March.

States implement managed care in Medicaid under a number of different authorities, and we'll talk a little bit more about these in just a minute.

Some of the reasons that states choose managed care is that it offers some predictability of future costs and in some cases improved care management and care coordination relative to the fee-for-service program.

Medicaid managed care authority has evolved over

time, as has the regulatory framework. And given this evolution and the Commissioners' interest in exploring policies that could improve program flexibility -- program efficiency, and state flexibility while ensuring program accountability, we'd like to take this opportunity to take a step back and consider these authorities and what opportunities there might be to streamline them.

I'll begin today with a broad overview of the Medicaid managed care rule, highlighting some of the key changes and discussing the implications of these changes for how states administer their managed care programs.

Then we'll review the authorities under which states administer Medicaid managed care, and I'll bring forward some options for you to consider to streamline managed care authority. Based on your feedback, we can move forward in developing some of these options into draft recommendations for you to consider at the December meeting.

Let's start with the Medicaid managed care rule. CMS updated Medicaid managed care regulations in 2016. The regulation applies requirements and standards to Medicaid managed care programs regardless of the authority under

which the program is operated. For example, the final rule standardized timely access and network adequacy standards across authorities. The rule also requires states to establish a monitoring system to assure access and quality of care for enrollees, which replaces separate monitoring requirements that varied by authority. It also establishes a process and requirements for rate review and contract review.

The revision provides states and the federal government with a mechanism to enforce managed care standards, ensuring certain consumer protections for beneficiaries. And because it makes these requirements standard across all authorities, it raises some questions about the purpose and rationale for each of these authorities.

Section 1115 waivers are the oldest authority under which states can implement Medicaid managed care. Many states implement managed care under these waivers today because under budget neutrality requirements, states can use the budget savings generated by managed care to finance other program changes. For example, states have used some of the savings generated by managed care to

finance additional payments to providers, such as payments made under uncompensated care pools or delivery system reform incentive payment programs, or DSRIP programs.

Some of the savings generated under budget neutrality can be carried forward in future waiver renewal applications. Twenty-two states implement Medicaid managed care programs under Section 1115 waiver authority today. So Section 1115 waivers are the waivers that we like to talk about the most. They provide a lot of flexibility to states, and states have experimented with a lot of program changes under this authority. But for today's discussion, I'd like to set these aside and think more about the 1915(b) authority.

States generally use 1915(b) authority to waive beneficiaries' freedom of choice, either to mandate enrollment in a restricted network or to enroll traditionally exempt individuals in managed care, or to limit choice to a single managed care plan. States can also waive statewideness and comparability under Section 1915(b) waiver authority.

Currently there are 64 active Section 1915(b) waivers, and they generally fall into one of three buckets.

There are 13 waivers that implement comprehensive Medicaid managed care programs. There are 30 waivers that implement a specialized program, such as a behavioral health carve-out or a non-emergency medical transportation program. Under these programs, states use 1915(b) authority to limit beneficiaries' provider choice and enroll them into a specialized network. And I should note here that we have counted South Carolina under both of these programs. You'll notice that the numbers probably don't add up. South Carolina operates a 1915(b) waiver that provides prenatal care and postpartum care to pregnant women and also uses that waiver authority to mandate their enrollment in managed care, a comprehensive managed care plan.

Finally, states use 1915(b) waivers in conjunction with 1915(c) home and community-based waivers. States use the 1915(c) waiver authority to create the program, that is, establishing eligibility criteria and some of the program benefits, the array of services the beneficiaries can receive. And they use the 1915(b) authority to waive freedom of choice to mandate enrollment into these programs. We'll come back to the topic of states' use of 1915(b) authority in these situations and

home and community-based waivers.

It's worth noting that Section 1915(c) waiver programs are substantially different than comprehensive managed care. These programs are generally designed for beneficiaries with complex needs and feature their own array of services, eligibility criteria, and so on. So while we'll talk today about states' use of 1915(b) waiver authority in conjunction with 1915(c) waivers, the scope and design of 1915(c) waivers is beyond the analysis that I'll present today.

After years of implementation under Section 1115 and Section 1915(b) authority, Congress added a managed care state plan option under the Balanced Budget Act of 1997. Under this option, states can manage managed care enrollment for all beneficiaries except individuals dually eligible for Medicaid and Medicare, American Indians/Alaska Natives, and children with special health care needs, which we include foster care children under this category. In 2014, 15 states operated managed care programs under Section 1932 state plan authority.

I apologize the print on this slide is pretty small on the screen there. I think in your notes and

materials it should be a little bit larger.

These authorities vary in a number of different ways. For example, the application process and approval periods vary. CMS is required to respond to 1915(b) applications and state plan amendment applications within 90 days, while no such requirement exists under the 1115 application process.

1915(b) waivers can only be approved for two years, or five years if they include dually eligible individuals. Section 1115 waivers can be approved for up to five years, and state plan authority, they're approved indefinitely and renewals are generally not required.

The financial requirements are also different among each authority. Section 1115 waivers must be budget neutral, which means that federal spending under the waiver cannot exceed what it would have otherwise been without the waiver. 1915(b) waivers must be determined to be cost-effective, and state plans, states must submit a statement estimating the fiscal impact along with state plan amendments.

Another key difference is who can be enrolled. Section 1115 and 1915(b) waivers can be used to mandate

managed care enrollment for all beneficiaries; whereas, there are some exempt populations which I previously mentioned under state plan authority. And as I mentioned earlier, managed care standards and requirements are similar across managed care authorities.

I noted earlier that today's presentation is intended to build on the conversation we started in March. During the March meeting, we raised some policy questions, and you expressed interest in learning more about how states use 1915(b) waiver authority.

Based on your feedback, we've begun to develop some potential policy options for you to consider. These are really straw man options for you to consider and to refine or perhaps reject. As you begin to think about them, I hope you'll think about: Are these the right options that we should be considering? If so, is our rationale solid or could it be strengthened? And are there other options that we should be considering? So let's turn to Option 1.

Option 1 allows states to mandate enrollment in comprehensive managed care for all beneficiaries under state plan authority. Under this option, states would no

longer be required to seek waiver authority to mandate managed care enrollment for traditionally exempt populations. The option would reduce burden associated with 1915(b) waivers and would ensure that beneficiaries have sufficient protections under Medicaid managed care.

This option would be particularly helpful to states like New Hampshire, which operates a single managed care program for all beneficiaries under separate authorities. In New Hampshire, they have a 1915(b) waiver for those who are traditionally exempt from managed care, and they manage the rest of their program under Section 1932 state plan authority.

Including New Hampshire, there are 13 states that operate comprehensive managed care programs under 1915(b) authority. These populations typically have complex health needs that require coordination across payers, providers, and other settings. And while managed care was in its infancy, there was little experience providing for these needs under managed care. And there were some concerns about whether managed care could provide sufficient care for these populations. But Medicaid has matured in ways that might mitigate some of these historical concerns.

First, states and the federal government have more experience covering these populations in managed care. For example, seven of the 13 states that administer comprehensive managed care under 1915(b) waiver authority allow at least one of these populations to enroll in their program.

And, secondly, the Medicaid managed care rule standardized the requirements across authorities. So whereas the federal government may have historically relied on the waiver application and the special terms and conditions of each waiver, to extract assurances from states, for example, around timely access or network adequacy requirements, grievances, and appeals, these assurances are now required regardless of the authority under which the state implements managed care.

And when we reviewed the 1915(b) waivers, we found that coverage available under the comprehensive 1915(b) waivers is generally the same as coverage available under the state plan in those states.

Policy Option 2 is to extend waiver approval periods for Section 1915(b) waivers. Under this option, states would be allowed to seek approval to implement a

program under 1915(b) authority for up to five years. This would reduce the administrative burden for states and the federal government associated with the renewal process. Currently, 24 of the 64 active waivers are approved for two-year periods. I mentioned earlier that waivers that include dually eligible individuals can be approved for up to five, so there are about 40 waivers now that are approved for more than a two-year period.

This option would align Section 1915(b) approval periods with other authorities, such as Section 1115 waiver and some of the duals demonstrations. And I mentioned before that the 1915(b) waivers that include dually eligible individuals can be approved for up to five years. This authority was added during the Affordable Care Act really to align those periods with some of the demonstrations available under the Duals Office that was also created in the Affordable Care Act.

So Option 3: For circumstances in which states now use 1915(b)/(c) waivers to administer a program, freedom of choice and selective contracting should be moved to 1915(c) authority.

To be clear, there are a whole set of issues

around 1915(c) waivers that were beyond the scope of our analysis and beyond the scope of our discussion today. What I'm really trying to talk about here is allowing states to waive freedom of choice under Section 1915(c) waivers so that when a state wants to establish a home and community-based services program, they could do so under a single waiver authority rather than two separate waiver authorities. This would reduce the burden associated with applying for two waivers, including completing two separate applications, having separate reporting requirements and separate monitoring requirements.

The option would also create a more predictable application process than the Section 1115 waiver process because the 90-day clock also applies to 1915(c) waivers and the federal budget requirements are a little more straightforward.

So, with that, I will close. I look forward to your feedback and discussion today.

CHAIR THOMPSON: Okay. Marsha, do you want to kick us off? Thank you very much, Ben.

VICE CHAIR GOLD: Yeah, I think this is really helpful. I think that there's a little tweaking of the

rationale for why we're getting into this that actually is implicit in your head and behind the recommendations, but might make it a little less geeky for readers and maybe supported a little more.

CHAIR THOMPSON: Not that we object to geeky.

[Laughter.]

VICE CHAIR GOLD: But our readers probably have limited capacity of interest.

Anyway, you know, I don't remember all the details, but, you know, there was a big -- in the beginning there's only been 1115 waiver authority, and I don't know if that started at the very beginning or some other point. But, basically, there was a lot of trouble at the very beginning of the Medicaid program with managed care, and a lot of concern. There was much less experience then, and so there was reluctance to it.

So that had two implications. One is anyone who wanted to do anything had to do it on 1115, and that is one extreme, I think Arizona even getting into Medicaid, and at another the freedom of -- the demonstrations of managed care which happened under President Reagan in 1982 to '85 were authorized under 1115.

But then, as people got more comfortable with it, then you ended up with some of these different waiver authorities that have come more recently, and the reason you have so many mixtures of people doing things, it depended when they did it, it depended whether they were trying to do something else in addition to the managed care, and so you ended up with this.

I think what you're asking us to think about -- and I'll leave it to others to comment on it -- is whether, in fact, with some of the more narrowly defined just managed care waiver authorities that were enacted, we now know enough and are comfortable enough with them that they can sort of become regular program features that go into the state plan and don't have to go through these separate waivers because they're more steady state.

And so I don't think there's a lot of change, but some tweaking at the beginning in your chapter where you talk about 1115 and then move into this, I think that would help it, because that really does set it up logically for what we're looking at and, you know, seems like there could be some tweaking that would be appropriate.

CHAIR THOMPSON: Alan, Bill, Chuck, Kit.

COMMISSIONER WEIL: I found this very helpful, and I also find it hard to offer guidance on what to do, so I'm going to offer just a framework that I'm trying to use, maybe will be helpful that also can move us forward.

A little bit with Marsha, I'm trying to figure out sort of what's the issue, and I see three, and I may -- I see three, whether it's right or not. One is sort of the burden, you know, lining up dates, how many people, duration, two waivers versus one, sort of the hassle factor.

The second, which is related, but I mean it in a pretty different way, is approval terms. So, you know, the whole concept of the waiver is we want to do something, we need permission. In order to get permission, you get to ask us a whole bunch of questions and tell us to change a whole bunch of things that we were thinking of doing. What's the added value of that and what's the approval term difference between a waiver and a state plan amendment? Sort of this whole sense of what's the federal value add in reviewing this, and I think that's where the evolution of managed care, when it was seen as particularly scary and new, there were a whole lot of questions, and, frankly,

states weren't often asking the questions and the federal government felt that it needed to. I think there are populations now where I would still say that's true. I'd say there are populations where that's not true. So it's sort of that.

And then the third is the monitoring element, which is that, by definition, to achieve certain endpoints to sustain approval of the waiver into the future, you have to do certain kinds of monitoring that are different than what you would just do for your routine program.

So when I'm thinking about whether or not we should have a recommendation, I'm trying to figure out in some respect which of these three are we trying to solve. Where do we think the problem is? How much of this is just burden? How much of it is where oversight's value, which I think is in some respect the toughest.

Some of these I think I could see us moving in a place where we said robust monitoring sort of supersedes the need for waiver, but then the question is: What happens to that monitoring?

So as I say, I'm still not sure where to go with it, but this is a little bit the way I think about what's

on the table.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: This relates somewhat to what Alan has just said. I think if we look at a lot of policy areas -- and we've watched sort of how things get added over time, when you step back, it's just sort of an incredible number of arbitrary sort of conflicting, sort of contradictory messes. I mean, and you think about why shouldn't we rationalize this, and this is maybe sort of an area where there it calls out for something like that.

But I feel like in our discussion there's a dimension missing, and that is, while we may have requirements and assurances, we don't know about compliance. And having sort of spent a fair amount of time looking at compliance, I know the difficulties there. Part of it is we don't have the resources to really look and see whether or not there has been compliance. And so sometimes those lack of resources are dealt with both at the CMS level and at the state level by trying to set priorities and targeting those resources. And even then, it doesn't always work out that we can be guaranteed and assured that there has been sort of compliance.

So there is a question in my mind that, given that some of the waiver authority was meant to protect some groups, the issue would be, if we try to simplify this process, sort of what happens in terms of special oversight for people that may be at higher risk, may be sort of more vulnerable? And I don't think that -- I mean, I would like to say I would not want to have these remarks interpreted as something about managed care. It's not about managed care. It's about some entities that might be joining your program. There is a failure, I think, or shortcomings sort of in policy discussions. We tend to focus on concepts and averages, and we don't spend enough time thinking about the distribution. And a lot of what we need to think about in terms of protecting sort of individuals are the tails of distributions. And we don't want, to use the term, the tail to wag the dog and become this huge burden for everyone, but we have to make sure that when the process of making things efficient, sort of making things less burdensome, we don't ignore what that tail might be doing and that we have and institute sort of proper protections for those that are vulnerable.

CHAIR THOMPSON: Chuck, Kit, Stacy, Toby.

COMMISSIONER MILLIGAN: Thank you. Thank you, Ben.

I want to align myself to a couple of things Alan said. I think part of, you know, what's the problem we're trying to solve, if we're trying to solve it, I think part of it is just administrative costs on both sides, both the state and the federal government, and administrative opportunity costs, too, of spending time on the waivers that could have been spent on some other things.

So then I go to is the solution kind of -- does it address the problem and is it worth addressing the problem? And I guess I'm less certain about that. What I see is really a trend toward 1115s. I think, you know, the first time I was a part of managed care, it was New Mexico, we were bringing up managed care in 1996-97. We went to a 1915(b) approach because an 1115 was very indeterminate in terms of the federal government's review process, approval process, timeline, and a 1915(b) created more accountability. But I think that that has changed quite a bit over the intervening years, and I think in 1115 CMS has demonstrated that they work on, you know, with all due kind of focus.

I want to make a couple of comments. I see a trend toward 1115s. I see a trend away from 1915(b) and 1915(c)s to the extent that they're part of kind of a managed care approach for duals or otherwise. I guess part of what I want to offer though is I don't think that -- I think that there will c1ontinue to be a need for 1115s and a growing need for 1115s because of the other reasons that states are pursuing them. And I don't think that administratively simplifying this to a state plan type approach is going to diminish the amount of the waiver activity around the 1115s. I think states pursue them because they're also seeking to waive things that are unrelated to managed care, whether it's cost-sharing rules or in lieu of service or paying for aspects of social determinants of health, which ties back to how budget neutrality funds are used. If everything was a state plan and you don't get credit for savings to apply toward non-Medicaid-covered things, I think states will continue to look for 1115s for some of the benefit design issues, some of the eligibility implication issues, and some of the use of budget neutrality savings.

I think that one of the other elements that I

just want to put kind of a bow around is -- well, I guess two things, and I want to comment, I guess, Bill, on what you said about kind of the distributional aspect. I think that it's a valid point, but what always brings -- where I always go when I hear that kind of comment is we have that same distributional aspect in fee-for-service Medicaid. We have that same distributional aspect with low-quality providers in a freedom of choice, any willing provider, fee-for-service model. And I always worry when implicit is a view that the distributional aspect only affects managed care and doesn't affect state plan fee-for-service.

COMMISSIONER SCANLON: And, Chuck, I would never say that. I mean, I am as vigilant around the fee-for-service side about the distribution as I am here.

COMMISSIONER MILLIGAN: I was going to defend your honor in my next sentence.

COMMISSIONER SCANLON: Okay.

[Laughter.]

COMMISSIONER MILLIGAN: But it was a test, Bill.

To me, there is a laudatory element of an 1115 that is not available ot11herwise, which is the public comment part. And I think the local advocacy groups, the

local provider groups, the local state legislators would object to certain things going into what they would perceive to be a black box between state governments and the federal government. And so I do think that to me one of the benefits of the 1115 approach is that requirement of public comment and public feedback, which we're going through in New Mexico right now.

So I've rambled quite a bit. I guess where I want to wrap up is this: I think the main benefit is reducing the administrative costs and opportunity costs. But at the end of the day, I'm not sure that actually would result in fewer waivers, because I do think that the waivers are evolving in the direction that what states are seeking to waive isn't so much about managed care anymore itself.

CHAIR THOMPSON: Kit, Stacy, Toby.

COMMISSIONER GORTON: So in response to several comments that were made, I would add to Alan's list, and you may have assumed this under the heading of burden, but I think complexity in and of itself creates barriers and confusion and opacity that is worth addressing, even if it feels abstract. To Bill's point, it's easier to monitor

compliance with a simple construct than it is to monitor -- and cheaper -- to monitor compliance with a complex construct. And so I do think there is -- eliminating is a laudatory goal in and of itself.

I would push back on Bill's comment. I don't think anybody who's spent any time in a managed Medicaid program ever felt that there was a lack of compliance oversight. These are some of the most regulated programs on the planet, between EQRO and NCQA, which is required by many states, and all of the other certifications and reports and other things that go on -- corrective action plans and whatever, there's no shortage of compliance activities in the managed care world. Arguably, in states' attempt to deal with measuring the tail, they overmeasure the whole rest of the program. And so, you know, I think there is some fine-tuning that could go on in that.

I agree with Chuck that we're seeing the move toward 1115 waivers. I think that's in part because you can't do what you need to do in a 1915(b). And the biggest part of it is you can't mix conditions and populations in a 1915 -- or in a 1915(c) and 1915 -- the approach to who you can put in and what you can put in and how you can offset

within the program is much more rigorous in the individual 1915(b)s. And I think that the 1115s give you more flexibility. It could be -- and I wonder if we should sort of pose this question to ourselves and others -- that the streamlining might need to occur within the authorities. And one of the points I want to make is that 1115 is a demonstration authority. The vast majority of what goes on in a standard 11 -- it's sort of silly to talk about a standard 1115 waiver. But, in fact, they're pretty similar in many aspects. And so it would seem to me that there might be room within 1115 authority to say there are certain components which are sort of plug-and-play kinds of things. And let's have the states and the federal regulators focus on the stuff that's really different.

You know, I often find myself wondering what is of demonstration value in what we're currently doing and what is simply it's the only way to game the system in order to be able to do what we need to do. And so I think it might be worth looking at the individual authorities and what you can do within the individual authorities. Are there ways to streamline within the authorities? I would be interested in hearing from states and from the federal

regulators what they think are constraining because of the way the authorities are currently structured. Is there a way to improve that above and beyond the three options that Ben has laid out as straw models?

And I'll just finish by saying that I do think the straw model proposals have value in and of themselves. I would be supportive of them. I think that there's work to be done to get them ready to be baked into a full recommendation, but it seems to me we might have room between now and February or March to be able to get to a place where we have recommendations that we could put forward about this in one of those reports. And I would be supportive of doing that because I think that there is value in this exercise.

CHAIR THOMPSON: Stacey, then Toby.

COMMISSIONER LAMPKIN: I think I am a little bit out of sync, not because I disagree with anything I've heard, but I'm just -- everybody is way, very abstract up here, and I'm feeling very concrete with specific questions about the material that you presented. In the context of kind of what Kit was saying, this delivery system is not such a demonstration anymore in kind of what does it take

to package it.

But my specific kind of concrete questions and as they relate to the three straw options relates to managed long-term care programs, the full-risk very managed long-term care programs.

So I'm not sure whether this is a question for you, Ben, or maybe it's a Brian question. But do we know how those are authorized today, 1115s versus (b)/(c) combos? I mean, I've seen some of the -- I know I've seen each. I just don't have a sense of what the overall distribution is between those two.

And with the idea of shifting some of the (b) already into the (b), the option 3, is that necessary if we do option 1 and you can require duals to be in managed care under a state plan option? Does that make that option 3 less necessary? I don't understand how those might relate in the context of managed long-term care.

MR. FINDER: So I'll answer those in reverse order.

I think for option 1, we were thinking mostly for comprehensive managed care, which I -- and you can tell me if this is wrong, and I'm interested in your feedback. I

think we're thinking more about the hospital benefit, the physician benefit, less about a the managed long-term care services, long-term services and supports that are provided in those specialized programs, which are not entirely dually eligible individuals. They might be people with certain disabilities and other conditions.

The options we propose, then, are sort of separate and apart in that sense, that option 1 would be specifically for comprehensive managed care to allow states to enroll those populations of comprehensive managed care programs, and option 3 would just be more moving selective contracting or freedom of choice waivers into Section 1915(c) waivers.

Your first question was about the distribution of -- or how states are implementing MLTSS. I'm not sure off the top of my head. I think I'd have to come back to you with a little bit more research or phone-a-friend.

EXECUTIVE DIRECTOR SCHWARTZ: There's some mention of it in Kristal's materials for tomorrow, but it is across several authorities, depending upon the state circumstances.

COMMISSIONER BURWELL: I just want to -- we have

a report in to CMS that they're about to release, which is an update of the MLTSS program, which provides information about various characteristics of all the programs, and one is under what authority are they authorized. So that data is available. I don't know the answer.

CHAIR THOMPSON: Okay. We've got Toby, Kisha.

I want to say a few things, and then we're going to have to wrap up.

COMMISSIONER DOUGLAS: I definitely view that the problem here is just the administrative cost and the changing -- and that's coupled with the changing environment with the managed care rule really setting the framework for managed care, regardless of vehicle you use.

I guess one thought is just the framing of the paper. 1115s -- states are going to do 1115s, and that is not -- this is kind of separate from this, and they do it -- I would not agree with -- I think most states do 1115s because they're looking for some way to create, you know, budget neutrality and some additional programs rather than the flexibilities that they can't get in a B.

So to me, really this question is the issue of the (b) versus the SPA and why given the managed care

regulations, the framework, why would that be necessary to have a (b) framework.

So I don't know. It's just changing that, and I think it's putting more of the context, I would say, in the paper around the regulation. You have it interspersed in a lot more discussion of it under the option 1 SPA, but to me, that's kind of an underpinning of this problem being the administrative cost and the issue of the changing in the regulations. So it really gets to Bill's concern about the monitoring. Well, that's just inherent now. The regulation sets that framework, no matter what. You don't need a waiver to set that and say we're going to monitor -- we're going to double monitor you. It's in the regulation.

So a long-winded way to say try to, I think, reframe this paper in a couple different ways.

CHAIR THOMPSON: Kisha.

COMMISSIONER DAVIS: Sure. Thanks.

Just bringing into the conversation how the downstream effects of changing the administrative burden -- so certainly, there's significant administrative burden in cost that goes with all of this, and so how does these different proposals affect the state's ability to recruit

providers to the program and access to patients? Certainly, if things are changing all of the time, it makes it more difficult to create continuous access for patients, and so how do each of these options relate to downstream access for patients and providers staying in the programs.

CHAIR THOMPSON: So, Ben, you know that I was a reluctant come-along to this subject like, "Oh, do we really want to spend time on this?" Now I'm all in.

So I maybe want to press us a little bit further here, which is if we start with the proposition that managed care is just as legitimate a delivery system for at least the majority, if not all of the program's beneficiaries, as fee-for-service, and in many ways has more to offer, it seems to me that -- and that we have longtime experience with it as a delivery system and that, in effect, wherever you're landing in terms of using these authorities, you're still ultimately responsible for the same requirements -- we studied terms and conditions particularly over the last few years in 1115, so those terms and conditions are being completely lifted from the (b)/(c) world. They're intended to be uniform, so that there isn't a particular benefit of going under one

authority for the other in terms of meeting certain kinds of requirements.

And that we have states who have been operating under these waivers for years upon years upon years, the idea that you have to come in under a (b) a get renewed every two years is crazy.

The question of whether or not we have to -- I mean, this becomes kind of a thorny question in my mind about if you simply said to states -- and again, I think that there's some details here that matter a lot. We keep talking about the managed care regulations, but we also know that the administration is taking a look at that, and whether or not that exists in perpetuity, I'm not sure that we should like put all the chips in on the current regulatory environment. And we ought to think about if you wanted to simply and provide a unified authority for states to employ managed care, are there some cross-references or some other reinforcements to some of those kinds of monitoring requirements or beneficiary protections that you would want to be sure to insert there? And I don't think that we should lose that idea.

But cost effectiveness, like the idea that you

have to produce a cost-effectiveness test doesn't make it -- I mean, to some extent, I think some of these authorities are -- they're overtaken by events. We have experience now. We've been in the field. We should find ways to now convert this to an easier process for both the federal and the state governments, not going backwards, but taking advantage of all the forward direction and experience that people have accumulated and spend our time on monitoring or special populations where we think there needs to be some specific effort made.

I would like to find a way to make some recommendations in this area. I don't know that we have to decide that it is our Commission's job to delineate all of the details and the templates that would associate themselves with something as much as we have an option to potentially just articulate the proposition that managed care is an established delivery system mechanism, that it should not be treated at least in the main as something that requires steps and approvals without affecting any of the outcomes and outputs from any of this.

I'm not sure that states have ever -- there's a conversation about a back-and-forth between the federal and

the state governments. I'm not sure how many states have ever submitted any of these that changed demonstrably. I mean, there's a certain level of it's just almost a pro forma exercise with respect to some of this, but it does eat up resources on both sides. And I think if we can find a way to -- I mean, there may be a set of different things that we can identify as you should definitely do this, maybe you could do that, there might be some way to tier the recommendations in terms of where the opportunity lies.

I do like, Alan, your kind of construct about sort of separating out if we're doing something because it's just -- we're not trying to change anything in the environment. We're just trying to reduce the amount of burden involve, and I think we should at least -- and to me, the approval terms start to get there as well.

And then monitoring, I agree it's a completely different issue, and it is where more of the effort ought to be expended.

I think that we should look at it from the standpoint of the renewal periods I think on the (b)'s are absolutely -- I really don't know why they're not in perpetuity. That is the advantage of the state plan

amendment. The state plan amendment also assumes you're in compliance with all of the requirements that exist rather than you're having to say a whole lot about those things.

So I think we should sort through some of those kinds of questions and issues in terms of making a recommendation. I don't think we should hold ourselves up to figuring out the exact delineation between the authorities, and how they come together, maybe it's more a matter of establishing sort of where we think the Congress could take different kinds of actions.

The other point, on the 1115s, I'm not sure -- here's the question that I would ask about the 1115s and budget neutrality, which is if you put all of managed care and Medicaid under a state plan authority, could you claim any budget neutrality savings from it?

Now, there's a different question, I think, about whether states should be permitted to collect savings off of an established delivery system. I think we could have that conversation, but I'm not posing we have it right now. But if it was a state plan authority and there was nothing waived to implement it, does it mean that you could not capture a budget neutrality savings as a result of that?

Do you know the answer to that, Toby?

COMMISSIONER DOUGLAS: You said you don't want to concentrate --

CHAIR THOMPSON: No. I don't -- whether it's right or wrong, I just don't know if it would be permissible or not permissible.

COMMISSIONER DOUGLAS: [Speaking off microphone.]

CHAIR THOMPSON: You could do it. It's just I don't want to disturb something we don't intend to disturb by suggesting a particular direction.

COMMISSIONER DOUGLAS: Budget neutrality is more an art than a science, so it really is --

CHAIR THOMPSON: That is a true statement.

COMMISSIONER DOUGLAS: Yes.

MR. FINDER: I think the executive branch probably has a lot of discretion over that particular question.

In our DSRIP work, when we were talking to states, some of the states that had previously implemented managed care under 1915(b) told us that that was a barrier when they went to implement managed care under 1115s to generating that budget savings and had to look for it in

other places.

CHAIR THOMPSON: Mm-hmm.

MR. FINDER: So I think like everything in Medicaid, there are some examples where you can and some examples where you can't.

CHAIR THOMPSON: Mm-hmm, mm-hmm.

Okay. I think we have probably exhausted that topic.

And now we are very happy to welcome -- is she here? Have I not seen her? Karen?

We're going to hear an update about the CMS Medicaid Innovation Accelerator Program from Karen Llanos.

Welcome, Karen. It's nice to see you.

UPDATE FROM CMS MEDICAID INNOVATION ACCELERATOR PROGRAM

* MS. LLANOS: It's nice to see some friendly faces.

So I will start by just thanking everyone for the opportunity to talk about our program. It's been a labor of love at our center, but we're very excited to talk to you. Obviously, some of us are more familiar around the table with IAP than others. So I'll give a very high-level

overview, and then maybe during the Q&A, we can get into some of these different topics.

Let me just start off by saying a lot of the topics that we've identified were as part of a six-month stakeholder process where we talked to state Medicaid agencies and stakeholders. So our goal for IAP is to test the most effective way of providing technical assistance to state Medicaid agencies, to move them through their Medicaid delivery system reform goals, so not an easy task.

We are essentially a CMMI model. We are different than other CMMI models in that this is a Center for Medicaid and CHIP services-led model. It is not grant funding, so we can't provide grant funding to states.

So, as I said, the test that we're testing is what's the most effective way of moving states towards their Medicaid delivery system reform activities.

So we picked, and it's a four-year activity, started in fiscal '15. So we are a little bit more than halfway through the program. Our activities are currently stretched out through September 2019, so there's a lot -- ways to go.

Because we are a CMMI model, we have an

independent evaluation, and that is led by Abt Associates, and that is led out of the Center for Medicare and Medicaid Innovation. Our first public report, evaluation report, will be coming out in the next several months, so over the past year and a half since the evaluation has been up and running, we get rapid-cycle feedback. So a lot of our activities are really based on that refinement process, as what are we learning from our state Medicaid partners who are participating in these activities and how can we continue to refine and make these more effective.

To date, we have worked with 30 states, the District of Columbia, and three territories. So we've been able to grab a wide swath of the United States.

In addition to that, I'll say we are working within eight streams of work, so a lot of this is around program areas, and those program areas are some of the topics that you've discussed directly or indirectly today. So reducing substance use disorders is our very first program area, so we have the most to tell on that activity. And I know Nevena referenced some of our activities earlier this morning.

The second is improving care for beneficiaries

with complex care needs and high costs. The third is integrating physical and mental health integration, and the fourth is improving community integration through the use of home- and community-based waiver services.

In addition to that, we know that there are some hot-topic issues, and those are our program areas that I just noted. To move states towards their ongoing delivery system reform activities, we know that there are just some key levers that are also where they have technical support. So we are working on data analytics, quality measurement, performance improvement, and that's based on the health care improvement model or IHI model, Plan-Do-Study-Act, and then fourth is value-based payment and financial simulations.

So across these eight works of streams, we have independent projects that are working with all states, and it's voluntary for states to kind of raise their hand. There is a selection process.

In addition to our broader framework, we work individually with selected states, anywhere between 5 and 12. In addition to that, some of them are higher-level intensity. Some are lower-level intensity. We've heard

from our evaluators that that's exactly the type of options that states want and need.

The time frame ranges, and that's another thing that we're testing. We've tried high-level webinar, three series webinars, and had really good response to that. We've tied 6-month webinars to one-on-one individual support, and then we've had 12 months or longer in types of activities. When I run through them, I can tell you in terms of what are some of the feedbacks or differences.

Some of my goals are to be able to -- within each topic and program area, the level of maturity of the field is different. So, for example, when we think about value-based payment, we're 12 months working with states, and that's just going to help them move a little bit, depending on where they're starting down the continuum.

We've been working on creating partnerships between the Medicaid agency and their housing agencies, and those are nine-month programs and a little bit more intensive in nature.

So those are the types of time frames and parameters that we're testing.

One of the things that we get asked when folks

learn that we are working with state Medicaid agencies and are funded by the innovation center is how is the overlap with the state innovation model. So I will tell you that we are tucked in the budget of the SIM model program, but we operate completely separate from them.

We do overlap in terms of the types of states and the topics, so we work really closely with that team and that group to really make sure that when we're working with the state, we're using the opportunity to leverage the state moving further.

So a good example is we have a lot of states that we are overlapping with on our one-on-one data analytics support work. So we've got several states that had state innovation model funding. That has ended because they were a design state, and they now know and have models to test as part of their payment approaches.

But they want to be able to tie it to a data dashboard or some enhance data analytics. That's when IAP comes in, and through their data analytics support, you can see how we're leveraging where the state is in terms of the sophistication and knowledge learned from their payment approaches and to really being able to work more

sophisticated -- in a more sophisticated manner around building a portal, either internal or external, in order to push and use some of that data more effectively.

So within our substance use disorder work, I'll talk really briefly. We worked for a year with about six states in terms of really helping them understand what were some of the areas related to Medicaid delivery system reform around substance use disorders. So that was one track.

As part of that, topics like what is the right managed care language or procurement approaches to make sure that when purchasing substance use disorder benefits, you're thinking about how to do things and leverage existing work.

Value-based payment certainly came up, and we are -- just today, this afternoon, we're doing a value-based payment substance use disorder webinar that's national and open to all states.

So we worked intensively with six states for about a period of 12 months. In addition to that, we have a 15-part webinar learning series that hit a variety of different topics -- increasing provider capacity, screening

brief intervention referral to treatment and primary care settings, program integrity for substance use disorders. Our 42 Part 2 was certainly a theme that came up as well, and we partnered with SAMHSA and the Office of the National Coordinator in order to help clarify or to help states start to understand what's going on. CDC prescribing guidelines as well was one of our other partners, and the ever emerging theme of what are the right quality metrics in a substance use disorder delivery system reform program. So that's just a snapshot of the types of states -- the themes that we worked with.

In addition to that, we've developed different types of tools. You all talked about ASAM this morning. We have an ASAM guide that is on our webpage to help states understand how to think about ASAM, and we partnered with the ASAM developers in that guide.

We also worked with Vermont, which is a state that I heard you all mention as well, to -- Vermont and a couple of other innovative states around medication-assisted treatment rate design, so how do think about designing a rate around the MAT clinical pathway activities.

Then we partnered with SAMHSA, CDC on the opioid workshop where we had over 300 state officials join this summer.

In terms of what's coming up -- so I will say if you haven't visited our webpage and you're interested in substance use disorder, we have a phenomenal amount of information there. All of our webinars are archived. The two guides I talked about are also archived as well.

In addition to that, we are developing additional cohorts for states in this coming year. The big topics that we heard at the opioid workshop and that we want to continue to use as a follow-up are data analytics. So we worked with states around back-of-the-envelope data analytics, how to size the SUD population within the Medicaid program. This is potentially -- it's taking it a step further for states that are interested in really understanding what are the types of different service categories or provider capacity issues.

I mentioned metrics. So we're doing an affinity group around metrics for interested states, and then data dashboards are the other ones, so what are the quick and easy ways of thinking about what types of data should be

displayed, can you display, to really give you a sense of what your substance use disorder issues are at your state level.

In addition to that, we're developing new tools this coming year. One is going to be around a catalog of relevant substance use disorder-related managed care contracting language, so a little inventory. That's one of the things that states are asking for.

We're going to be looking at some best practices in MAT, and as part of the strategic design support that we have been working on with the states who are interested in submitting an 1115 for substance use disorder reform, we will be taking a look at the approved states that we've worked with and highlighting best practices and developing a series of one-pagers.

I think a lot of states are thinking about what can they point to and what can they be thinking about as they think about delivery system reform in that space, and those are one of the things that we want to make sure that we're pushing on and we are partnering with a lot of our groups that are center related to that.

In terms of our beneficiaries with complex care

needs, I'll note that we again worked with a group of states. Some of the topics there were data use agreements. So we have recently developed data use agreement templates from two states and an issue brief that we partner with the Office of the National Coordinator as well.

States are really hungry for really understanding how to identify and stratify their complex needs population and they define them in very different ways -- sometimes dual, sometimes individuals with substance use disorder, sometimes children with complex care needs. But that necessity of being able to share across sister agencies and other key partners, their data, to really understand what is their -- what the entirety of their population would -- looks like, has come up over and over again. So that issue brief was part of a national webinar series and now we're posting our findings on that.

In addition to that, we've developed what we call a roadmap to thinking about, again, where to start when you are defining and designing an initiative around a complex population, and that's -- we've tested it with several of our states that were participating in that initiative and they found it to be a really good checklist starting point

for how to think about these things.

And then risk stratification tools, which is another issue that came up. So what are the right tools or groupers to use? So what's an easy way of really understanding where to start? So these were issues that came up with our participating states and we're pulling them into public publications.

In terms of where we go next with this work, one of the key things that we kept hearing over and over again, when we pulled states, both participating and non-participating, was how do we narrow in on a particular population that's highly complex and has an opportunity to be impacted. And over and over again we kept hearing serious mental illness as a population to target.

So we will be -- we are in the process of developing an SMI tool to help states really think, again, in a more how to design and think about their SMI population by leveraging their existing Medicaid data. In some cases, we find that states do have contracting teams that can help them do that. In other cases, they want to be able to think through those issues on their own before engaging both the more data-heavy aspects of their agency

or even a contracting agency. So this helps them walk through how to define the SMI population, and we know that will vary from state to state, how to think about different types of stratification, again, to help size what it is that their SMI population looks like in order to target care and preventions more effectively.

For both our SUD and BCN work we found really positive results as part of our early evaluation reports. We've been able to track states, including particular value-based payment language into their managed care languages, into their contracts as part of direct results. As part of our complex care work we worked with states in designing some of their new health homes for chronic -- people with chronic conditions. So we are able to see, even though we are helping them, in some cases, make the case for why delivery system reform should occur. We are seeing some of those findings in our technical support translate into direct changes into their contract language, in how they structure their business cases around some of these activities.

The third area I wanted to just briefly mention is our work in building Medicaid agency and housing agency

partnerships, and this is an activity that we've worked with SAMHSA, HUD, the U.S. Council -- Interagency Council to End Homelessness. So we've gotten some wide variety of federal partners engaging on this. We are in our second cohort, so we work with pulling together groups of state Medicaid agency folks and health authorities in their state to really better understand how to speak each other's languages and how to think about cross-walking to better understand what some housing opportunities could look like.

I will say some of the biggest takeaways from our first cohort and the second cohort is some basic elementary connections and communications with each other. So we have heard from states that pulling them into these workgroups and into these meetings are the first times that they have ever even spoken directly to some of their housing partners.

The other thing is the language, so creating a common language. So we talked about 1915(a)'s and (b)'s, and 1115's, and our housing authority folks need to really get up to speed, and vice versa when you're part of some of the housing meetings. I know I have a hard time keeping up with the vernacular as well.

So there are opportunities to bring states together and have them learn from each other but to connect. And I will say we heard that under our substance use disorder work as well. One start in particular said that -- and I would pull them into a moderate-to-advanced state, and they said that some of their meetings were the first times that they've ever connected with their behavioral health agencies to that level. So they are really interacting in a way, through this work, that they hadn't seen before in the past.

In terms of our community integration work, some of the activities, in addition to our housing partnership, are two tracks on value-based payment, or the early steps to that, we call incentivizing quality and outcomes. So we've worked with a variety of different states around this topic, and we've learned several different things. This has been a high touch and a low touch activity as well.

And we've learned that when it comes to long-term services and supports, or home- and community-based services, thinking about value-based payment has to be very incremental, so no surprise to folks around the table. A lot of the questions that we get are what are the right

metrics that are going to be applicable for my population, do we have the data to populate the metrics, and then how do we think about creating a value-based payment approach that makes sense for this population, since it's so heterogeneous?

So we worked with states as part of a web-based learning series and then are just closing off more intensive implementation track. Again, we're seeing changes as part of the contracting language. I think a huge coup has been helping a group of states really understand their data sources and their quality measurement options in this area. And we are -- we should be implementing a brand new cohort in early 2018.

In terms of physical mental health integration, we worked with two groups of states. Some of the issues, again, very similar. So how do you align administrative requirements, what are the right metrics to use, how do you design value-based payment, and where is the locus of accountability, and where should incentivized payment be tied to that. We have been working on two issue briefs, thinking about where to start with the design of an integration activity or some key considerations, and then

the quality metrics approach. Again, reoccurring themes because these are the big building blocks to building system reform for states.

Next week we are holding a national webinar around quality metrics for physical mental health integration. We are highlighting both one of our SIM states, Oregon, and Harold Pincus, who is a thought leader in quality metrics for behavioral health.

And then in terms of data analytics -- so you've heard kind of themes of data analytics across all of our work around topical areas. We have standalone activities and they are divided into two areas. One is Medicare-Medicaid data integration. So very early on we partnered with the duals office. So they've been working with financial alignment states to offer data integration support to not only help them navigate the world of Medicare data but really increase their knowledge of Medicare data from a state perspective. So we have partnered with the duals office and are offering -- and have offered are working with five states around this topic. They are non-financial alignment states so that's the difference. But we are giving them the same access to

contractors and some of the same -- or all of the same activities as well, including development of use cases, both general and specific to the state.

I will say there are several states that have -- this is a long process, so we originally designed it as a 12-month project. We are now in our 24th month and are probably two-thirds of the way with most of the states. One of the biggest aha moments for me, as part of IAP, is the amount of work it takes, not only to complete a Medicare data request form accurately, but to really navigate it through, and getting access to Medicare is just the beginning. There's so much pre-work that needs to happen in order to get ready for it. But some of the states we've been working with have not just increased their knowledge base but are actually leveraging this as part of their design for MLTSS programs.

So that's our Medicare-Medicaid data integration work. In addition to that, we are working with 10 states on one-on-one data analytics support, and the topics range. I will say the biggest themes in the states that we're working with were how to build a data dashboard, how to think about behavioral health data as part of their

different types of programs, so how to pull in some of that work, how to think about data from other departments and integrating that into the Medicaid data.

In terms of other topics, we are running -- or we have run three national webinars, again, to leverage the states that we can't reach through this. One is data visualization, so how to really work and use data in a visualized way; building data dashboards, so we could reach more folks; and, most recently, how to improve managed care and counter data.

And in addition to that, we are working on building T-MSIS-based analytic tools around our key program areas. So how to use T-MSIS or leverage T-MSIS -- a T-MSIS-based tool to identify beneficiaries with complex care needs, how to think about physical mental health integration leveraging T-MSIS. So we are partnering with our data and systems group on that. All of those tools would be public-facing. There's also a material and infant child health tool as well.

Quality measurement I mentioned, across our other programs areas. Again, we've got standalone activities in this space as well. We partner with the National Quality

Forum to take a look at and nationally endorse metrics, understanding that it's just a starting point, so that states didn't have to keep reinventing the wheel in terms of a starting point for what are some good metrics to think about. So across substance use disorders, physical mental health, and our other four topics, they have leveraged our consensus-based work to help us understand what a good starting point is, and we won't be requiring them. It will be a resource for states that will be posting in early 2018.

In addition to that, we are proud to announce that we partner with the National Quality -- the Committee on Quality Assurance, or NCQA, to develop a Medicaid risk adjustor for their Plan All-Cause Readmissions Measure, which is a measure that our center has worked tirelessly to have states report, and I will say I worked on that metric set before IAP and the Medicaid risk adjustment piece was one of the areas that our state partners really, really needed and wanted, and it's recently been included in HEDIS 2018, so it will be available for the public.

We are also working with a couple of other activities on metric development in some key gap areas.

One is to explore how we might be able to tap into a Medicaid-focused hospital-wide readmissions measure, the one that's part of the CMS broader agency hospital compare and some of their other work, again, trying to test the feasibility of making sure that we try to get to a more multi-pair approach and that currently that measure lends itself.

There are a couple of other metrics that are under development in those key programmatic areas as well. We are trying to get to some key gaps, so we have been looking at an all-cause emergency department utilization rate for Medicaid beneficiaries with complex care needs, around substance use disorder we are looking at continuity of care for Medicaid beneficiaries after detox from alcohol and/or drugs, and then follow-up care for Medicaid beneficiaries who are prescribed an antipsychotic medication, and that's just a little starting point in terms of where we are. Not a lot of measures are going to come out of this work. We understand that states and our health plan partners are dealing with a lot of measures, so the intention here is to really try to carve out what are some key gap areas that we want to fill through this work.

And, finally, our last area is value-based payment and financial simulations, again, a recurring theme but has their own standalone activities. As part of this we are working with 10 states over a period of 12 months -- we are about halfway through -- around value-based payment in populations of their choosing. I will say some of the biggest area and aha moments have been states that have identified or have done previous work around value-based payment are taking a step back, particularly because there have been changes in governor and leadership at the state level, and really trying to build a case for why and how value-based payment, and the different types of approaches, the bundles, is it more advanced pay-for-performance, is it a different type of enhanced payment rate.

So we are -- I think, where we thought we might be developing all types of complex bundles and episodes and groupers are actually helping states think through more of a value-based roadmap, in some cases, or how to really build a case for where they want to go, so they can make the case more strongly to their leadership.

And one of the pieces that's also coming up is how to think about social determinants of health as part of

value-based payment, and certainly there are data limitations and state variation in that area.

We recently ran a value-based payment 101 webinar. It had about 500 participants join, so we know there's a need for some elementary topic areas, and this was Medicaid-specific.

In addition to our general value-based payment work we also have two other areas that are much smaller in nature but really targeted in the areas that we feel like there could be a nice improvement in our thinking and in our state partners' thinking. So children's oral health value-based payment has been an activity that we're trying to tackle. So how to think about -- so we are working with about three states to think about how to select, design, and test value-based payment approaches that can sustain children's oral health delivery models, and the states have come in with their own types of models they want to test.

In addition to that, maternity and infant health value-based payment technical support. Both of those activities will run two years, because of the complex nature of it. So we won't run additional cohorts at this time. They will just be the same states for a longer

period of time, because we're starting from, in some cases, the very early design through the financial simulations work if they would like it.

In terms of our evaluation, as I said, we are hearing some really good feedback in terms of are we supporting -- are we being effective in supporting states' efforts. So we are hearing very loud and clear that they are -- our participating states are learning new information, and that as we continue to incorporate more and more real-time work, we are hearing that states like both a high intensity and a lower intensity, depending on where they are in the staff bandwidth, because that's a big issue. Anecdotally, I will say that of our 30 states, or our 33 partners, we have had lots of repeat offenders, which I feel like speaks volumes. I would say a third of those states have participated in two or more activities, and sometimes it's the same state team members. Sometimes they're different. But seeing the same states come in over and over again is a really nice testament to the work in the value-added.

Peer-to-peer learning is a theme that I'm sure is not surprising but we hear that back over and over again,

is access to peer states, access to examples or highlights of best practices are some of the things in addition to direct coaching or direct access to technical support experts is what they need.

And I will say I think some of our biggest challenges are helping a state understand and helping ourselves understand where to tailor where a state is in terms of the work. So if we wanted more advanced data analytics, are states ready for that, or do they need more of just an understanding and helping with the learning curve is just as valuable, depending on the state. So we are flexible and that's why we are -- have decided to really engage states one-on-one, individually, and give them access to affinity groups or peer-to-peer learning opportunities. But we want to make sure we are tailoring each of these activities to where a particular state is.

In terms of looking forward, as I said, we will be rolling out two new activities this year, a second cohort of data analytics, a second cohort of value-based payment broadly. We will be rolling out a various set of tools, including our SMI identification tool and some of the other that I mentioned before, in addition to our T-

MSIS-based analytics. And then, finally, a second cohort on incentivizing quality and outcomes in our community-based LTSS work.

So we are continuing to evolve in terms of how we approach our technical support, but as I mentioned, have had great response in terms of the numbers of participating states. Certainly we have built our own capacity and knowledge base on terms of what states need in order to move towards their delivery system reform goals, and are starting to see, now that some of the cohorts are ending, and implementation is occurring, the effects of how states are taking us up on our technical assistance support as well.

So I'm happy to take questions. I know that was a whirlwind of work that I just outlined, but I'm happy to take questions or clarifications or dive into any of these areas.

CHAIR THOMPSON: First of all, thank you very much. I mean, that was a very impressive list of activities and accomplishments, so thank you for all that you're doing on behalf of the program.

Toby and then Marsha.

COMMISSIONER DOUGLAS: Hey, Karen. Good to see you.

The same, it's a wealth of information, and it's really good. I was just looking at the website.

A big question I'd have is how -- if you can -- observations of what you've seen in terms of state's ability to actually execute. I mean, it's clearly increased the level of resource and technical assistance that states now have in a venue, but the question always is, Do the states have the resources to actually then take that and --

MS. LLANOS: Yeah. I will say I think the limiting factor is our ability to give them funding. So we can give them access to technical assistance, coaches and resources, and help design tools and resources, but we'll always potentially be a bandwidth issue.

So I think I will say we're seeing -- it might be too early to be able to talk about execution in some of these areas, so we're pointing to under our substance use disorder work, approved 1115 waivers, so we have four states that have been approved as part of that work. That we've helped them through some of those activities.

As part of some of our other activities, what we're finding in the short term is what I had mentioned before, which is we can see and tie to some of their contract language, areas that we've helped them think through as it relates to thinking about the value-based payment framework for some of our community integration work, the types of measures that are included in their strategies.

So it's a little -- not a direct one-to-one at this point, but we're hoping to have a longer downstream evaluation to really help tie exactly what were some of the effects to the larger delivery system reform.

I will say some of the areas that we've seen or heard more repeatedly is that participation IAP has solidified their ability to go to leadership and make the case for why this reform should happen in this way.

In some cases, we're helping states prep for those kind of harder delivery stem reform activities.

In the case of the Medicaid agency and housing partnership, their participation in a partnership's activity has kind of created the rumors that a partnership is bound to happen, and because of that, partnerships are

happening. So some of this is a little bit like that in terms of informal uptakes of the types of work that we're helping them to do.

COMMISSIONER DOUGLAS: As we think recommendations, is the funding that -- could there be seed money that's given to states, or is that --

MS. LLANOS: I'm not sure enough about how CMMI funds this.

COMMISSIONER DOUGLAS: Yeah.

MS. LLANOS: I know that one of our constraints is that we -- because we are testing technical assistance, our ability to do grants is not possible under how we're currently designed.

COMMISSIONER DOUGLAS: Thanks.

CHAIR THOMPSON: Marsha, then Stacey.

VICE CHAIR GOLD: Yeah. I, too, was really impressed with the amount you're doing. I think both in work I've done with states and then as a Commission, what we've heard, is the ability to get technical support is really important. And in the past, I think some foundations have stepped in, but it's only been recently that maybe because of the CMMI, there's been support from

CMS to do more than it historically has done. So that's terrific to hear.

I was wondering if you could tell us a little more about the nature of the investment in those activities. I assume what you have is some funding for contractors who work with people or work with you. How long term is it? I mean, does the money have to be renewed at a certain point? Is there support for understanding that? Are there constraints?

Like I know one of the issues with states is they often don't have travel money. I don't know to what extent. Now you can almost do everything by conference call, but if there's ever a need to get together, do you have an ability to support that, or where do the dollars really help? And how much of an investment is there, and do you have a sense of how long a commitment there is to this investment?

MS. LLANOS: Sure. So the model was designed to be four years in length, so we are funded fiscally '15 through '18. Our activities run through at least September 2019.

In terms of what the money can be sent -- and

this isn't specific to this particular activity, but -- so we are not able to use this funding to pay for state travel. However, we've been creative, and for example, our partnerships work, because we're partnering with SAMHSA, so SAMHSA has had the ability to travel states to this. In some cases, we have tried -- and our other agencies have also tried leveraging philanthropic organizations to fund state travel over.

We are able to travel our experts to site visits, and that is a tool that we are increasingly using, mostly because it is really effective, and also it's because it's one thing that we can do pretty easily.

And in terms of in-person meetings, we -- in the first several years of IAP, we held several in-person meetings, and we're very up front to states in terms of our travel limitations and had really nice turnouts in both our substance use disorder in-person meetings, so much so that they asked for a second meeting that they would offer to fly themselves to. So we were like, "Sure. Why not?"

So we're happy to convene meetings. I think we're very cognizant that we are not a burden to states in terms of their budget and their time, so we do tend to do

more web-based virtual meetings than in-person meetings.

CHAIR THOMPSON: Stacey.

COMMISSIONER LAMPKIN: Thanks.

So this is -- I echo how impressive your breadth and depth of hitting really critical topics is and also the approach to meet states where they are and customize the technical assistance you provide.

Given that flexibility and those topics, do you have any insight as to what's holding back the states that haven't tapped into your --

MS. LLANOS: To the work?

COMMISSIONER LAMPKIN: -- to your work?

MS. LLANOS: I think it's been time, time constraints.

So we have -- I think we also tried thinking about -- I think the question was always if we overlapped the IAP participation map with the SIM map, would it be exactly the same or different? It actually covers everybody if you connect them.

So because these activities -- and I'm speculating -- came out around the same time and one has a very heavy focus on governor-level commitment, but not so

much necessarily on the Medicaid side -- we saw states gravitating towards one or the other.

Now that we are in year three, we see more of a convergence and sort of states leveraging, one and the other, so it's hard to tell.

I will say we have reached all states through our webinar platforms. It's the individualized one-on-one support that takes more of a time commitment, and honestly, I think what we're also finding is the timing of when we released these activities just don't necessary sync up with where a state is.

So we've had a couple of states say we would have loved to participate in that, but we just signed up for this other activity, also IAP sometimes, or we're going through some leadership changes or governmental changes, and we just can't commit to the time that it would take to commit to this. So it's been a variety of different areas.

It's voluntary in nature, so we're happy to work with the states that we have and understand that. I think we've tried to design a variety of different activities that could hit everyone's interest, but sometimes it's timing and bandwidth.

CHAIR THOMPSON: Kisha.

COMMISSIONER DAVIS: Thanks so much. You really have done a lot of work in a short amount of time.

I'm curious about value-based payments. You mentioned you thought that you would be further along and some states are actually starting to pull back. If you could just dig a little bit deeper into what some of those barriers might be and where those successes are?

MS. LLANOS: Yeah. So I will say I think probably pull back from what they had originally thought that they wanted to work on with us. So we asked for an expression of interest form, and some of those were probably due in late spring. So you can imagine six months into the project, things are changing in terms of kind of how they envisioned and how they thought about.

I will say because of some of the changes in their leadership, they just want to take a step back before fully committing to a particular payment approach, and that's been a handful of our states.

I think the other thing is once a state -- again, this is my perspective. It's different to put on paper what you want to do and execute in 12-month period once

you're in it and you realize that this does probably take a lot more time and effort. I think it is probably just natural to rethink or reassess what can be accomplished in the time that you've got, so that they can really leverage their opportunities with IAP.

CHAIR THOMPSON: Karen, thank you.

I'm not sure if you said this in answer to Marsha's question, but just to clarify, the total funding for IAP over the four is $100 million? Is that correct?

MS. LLANOS: It's a little over $100 million.

CHAIR THOMPSON: Okay.

MS. LLANOS: I'm sorry, Marsha. I forgot that was one of your questions.

So it is different than Know Your Money because it is part of a model, so I believe we may have access to anything that we haven't used. And that is the hope, but it's a little bit hard. It's not my center. So I'm still learning in terms of some of the budgetary activities and constraints related to that, but we do get our annual funding and have been using it since we were funded in FY15.

CHAIR THOMPSON: Okay. I think that we are at

time.

Thank you very much, Karen, for coming and joining us.

MS. LLANOS: Sure. Thank you.

CHAIR THOMPSON: This is very helpful, both for the substantive areas that you're involved in, which overlap with some of our interests, but also because tomorrow we're talking about multi-state collaboration and how to promote that, and so we also connect this with a number -- and our CMMI discussion about whether and how we're going to comment on the CMMI RFI.

MS. LLANOS: Oh, interesting.

CHAIR THOMPSON: So very helpful to have this --

MS. LLANOS: Yes.

CHAIR THOMPSON: -- injected into our consciousness as we consider those other topics.

MS. LLANOS: Great. Thank you.

CHAIR THOMPSON: So thank you very much.

We will now take any public comments on any of the topics and subjects this morning.

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Seeing none, we will close until the afternoon.

* [Whereupon, at 12:14 p.m., a meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION

[1:33 p.m.]

VICE CHAIR GOLD: Okay. Time is of the essence so let's get started. Penny will be in in a minute.

Kayla, I think you were going to introduce the panel and start us off on this topic.

PANEL: PAYMENT POLICY FOR FEDERALLY QUALIFIED HEALTH CENTERS

* MS. HOLGASH: Great. Thank you. So good afternoon again. The Commission decided to make FQHCs and the payment policy part of the MACPAC analytic agenda, due to some of the implications of these payment policies, including states arguing for more flexibility in setting payments and health center advocates arguing that certain policies may need technical fixes but are appropriate to recognize the wide-ranging costs of providing care to Medicaid beneficiaries while ensuring the financial stability of key safety net providers.

Today we have a panel of distinguished guests joining us to discuss these issues, so staff will be listening to your discussion to identify your areas of interest to develop for subsequent meetings.

There is a draft descriptive brief in your materials. The brief discusses the role of FQHCs in Medicaid and the policies governing the Medicaid payments to these centers. Some of the background highlights are that FQHCs provide critical primary, and preventive care, including services not often found in physician offices, such as translation and transportation, and Medicaid is the largest source of revenue for FQHC, accounting for 44 percent of their funding. The federal policy governing these payments is prescribed in that Medicaid must use the prospective payment system or an alternative payment methodology that pays at least what the PPS would have. FQHCs that are part of managed care networks must also be paid a minimum of the PPS rate, although not necessarily from the MCO.

Lastly, FQHCs are included in a number of value-based payment efforts and other innovative payment initiatives across the country, but payment rules can complicate that participation.

Thus, I am happy to introduce our panel today who have various points of expertise in this arena.

Dr. Nadereh Pourat is the Director of Research at

the UCLA Center for Health Policy Research, and a Professor of Health Policy and Management in the Fielding School of Public Health. Her research focuses on the role of the health care delivery system in addressing disparities and health care outcomes, among other things, and she holds particular expertise in examining challenges and outcomes in current primary care redesign efforts.

Ralph Silber is the CEO of the Community Health Center Network, a nonprofit Medicaid MCO that provides business administrative support to community health centers in California. He is also the Executive Director of the Alameda Health Consortium, which is a private, nonprofit, regional association of federally qualified community health centers that provide primary medical, behavioral health, dental care, and supportive services to more than 350,000 patients in more than 90 clinic sites.

And finally you will hear from Claudia Schlosberg who is the Senior Deputy and State Medicaid Director for the Department of Health Care Finance in Washington, D.C. And D.C. was recently approved for a state plan amendment enacting an APM for certain FQHCs, so we are excited to hear about that program.

We are very privileged to have all three of the panelists joining us, and now I am going to get out of the way and let them share their expertise. Thank you.

* DR. POURAT: Good afternoon. So in this presentation you will hear -- let me make sure I can work this -- you will hear a number of terms. I will be using community health centers primarily and in some of the slides you will see HRSA-funded health centers, and my fellow panelists will be using the term "federally qualified health centers or look-alikes." For the purposes of this presentation we are essentially talking about the same types of organizations.

So community health centers are often called the backbone of the safety net. They are critical safety net providers. They provide services to nearly 26 million individuals in the United States, 1 in 12 of the population. Other information about these organization: about 1,300 of them are often called grantees because they have multiple sites, so they are sometimes quite large organizations. There are a total of 10,000 sites operating in the United States, in all of the states as well as the territories and some of the other Pacific Rim island

states.

There are about 23,000 primary care providers operating or working in these organizations, another 15,000 dentists and behavioral health and substance use providers. So you get a sense of the magnitude.

There are a number of specific characteristics that characterize these organizations. Many of them receive Section 330 grants under the Public Health Service Act, federal grants from HRSA. They provide care to low-income, uninsured populations, regardless of the ability to pay -- this is part of their mission -- and that care has to be comprehensive and culturally competent primary care and enabling services. An example of some of these services are primary care services, dental, behavioral health and substance abuse, pharmacy, vision, and what's called enabling services, typically care coordination, care management, translation, transportation, and some other services.

Here's a little bit of a glimpse of the characteristics of the patients that are seen by community health centers. They provide health care to all ages, but as you can see in the slide, the majority of the

population, or a greater proportion of it, are those young, under 17, 17 and younger, as well as 18 to 44, in contrast with the populations that are seen by private physicians. When it comes to poverty, a much higher proportion of individuals at the poverty level, 100 percent or lower, that are seen by community health centers, in contrast with private sector. There are also another 22 percent that are seen -- that are between 100 and 200 percent of the poverty level, and that also is a much higher proportion than the private sector.

A little view of the race and ethnicity breakdown of the population. You can see that there's a very diverse population group that is being taken care of by community health centers, and if you were to look at the private sector, the main difference is the number of population that's white. More of the white population is seen in the private sector.

Community health centers take care of patients that have a higher burden of disease. More patients have one or more chronic conditions, and here are some of the chronic conditions that are highly prevalent among the health care population, including high cholesterol,

hypertension, asthma, diabetes, as well as about a third of the population that reports fair or poor health and about 22 percent that report needing mental health services. And when you do ask the population, though, how much unmet need they have, that rate is much lower than the population that is receiving care in the private sector.

Looking at the third-party revenues, you can see also a difference between community health centers and private physicians. About half of the revenues for -- third-party revenues for community health centers is from Medicaid, another 9 percent from Medicare, and about 23 percent of the population is uninsured -- their revenue sources are from uninsured patients, which includes primarily self-pay, out-of-pocket payments. A little bit more about that in a minute. In contrast, the private physicians are reporting about 60 percent of their revenues are from private insurance, and only about 13 percent from Medicaid.

A little bit more about the revenue sources overall. Community health centers, as mentioned earlier, receive Section 330 grants. They also get other kinds of federal and private sector grants. They might receive

donations and charities. The higher the share of the other grants and donations and charities, that speaks to the ability of these organizations to do other forms of improvements in care delivery.

Medicare and Medicaid both pay the PPS rate to community health centers, but they could also be in the form of managed care of fee for service. So some of the contracts under managed care could also be fee for service, but there's also capitation. Private insurance, the same picture, and in terms of self-pay, the amount of money that community health center patients are paying is on a sliding fee schedule. The lower the income, the lower that sliding fee, the higher income populations -- up to 200 percent, of course; that's what the sliding fee applies -- 200 percent of poverty could be somewhere around 80 percent of the fee.

The reason we are talking about the revenue source is because they drive incentives and impact service delivery in these organizations, like elsewhere. Section 330 grants are primarily there to support delivery of care to the uninsured population. Other grants and donations, as I just mentioned, could support infrastructure development and expand some of the other services, such as

enabling services.

Medicare and Medicaid pay the per-encounter bundled fee at the PPS rate. I think my fellow panelists will talk about that at much more detail. We talked about the managed care contracts. The significance of these kind of contracts is the fact that they could impose specific performance standards or have stipulations in the contracts for the health care delivery and oversight.

In terms of private insurance, one of the key factors to watch out for is the proportion of the low-income populations that might have high deductible plans, which means that they typically don't have the income to make the deductible, to pay the deductible, and so the health centers will be faced with patients that can't afford to pay the deductible and might have to pay on a sliding fee or not pay.

A little bit more about the PPS, which is essentially a bundled fee for service, or per-encounter rate. The goal of this form of payment is to provide comprehensive patient care at a given encounter. When the patient walks in, whatever services they need on that day will be covered under that encounter rate. But the reality

is that the incentives of the PPS rate are similar to the fee for service form of payment.

There are a number of challenges, though. Even the PPS rate may not -- may have some -- still be a barrier to providing comprehensives services to the patients. For example, patients that have complex conditions require a lot of services, and some services that cannot be delivered by the health center. So the ability of the health centers to deliver that care, even under the PPS rate, has to be considered.

Uninsured patients that walk in, because of their uninsurance, could have significant pent-up demand. They need a lot of services that need to be addressed, and that's a challenge because of the sliding scale fee and the ability of the patient to pay the health center for the services that they need.

The enabling services are not billable, even though the PPS rate is supposed to take that into account. It's still the reality that if you want to provide comprehensive services, apart from the medical services, you still have to figure out how to come up with the money to pay for those types of services.

And, of course, the ability of the health centers to secure the kinds of care that patients need outside the walls of the health center is another important challenge and consideration. Health centers may have formal and informal arrangement with providers outside, but that's not always foolproof.

So there are many things happening in the broader health care delivery system that are impacting health care delivery and motivating the consideration of alternative payment models for the health centers. The increased market consolidation and system integration means that a lot of the private sector providers, at least, are consolidating. For example, in the Los Angeles County area, there are several providers that are buying a lot of private practices. And so, as you can imagine, the market power of those organizations is changing. It's a different balance.

The demand by payers and stakeholders for efficiency, high-quality care, and improved population health means that there are new pressures for the providers to deal with, particular health centers. Health centers may excel in many different factors, but these pressure are

still part of the consideration of how payment is made.

The perennial challenges of workforce recruitment and retention are factors that are very real to the ability of the health centers to deal with alternative payment models, and it should be part of the consideration. And, of course, the ability of the health centers to sustain and maintain financial well-being to continue to operate. Payment obviously has a direct impact on that and other considerations, whether there is any changes in the funding levels that might lead to reduced funding for health centers -- those are all part of the bigger picture.

So APM requires payment that is tied to value, and, of course, there are several models. You will hear more about that in a minute. There are the accountable care organizations where some health centers have started to participate in. There are other forms of payment. The patient-centered medical home has payment implications, and pay-for-performance, paying for delivery of higher-quality care and perhaps better outcomes.

A few factors that speak to the ability of the health centers to participate in alternative payment methodologies, the fact that 68 percent of the health

centers currently report to have patient-centered medical home recognition or certification is important. Because of the requirements of those kinds of certification or recognition, they have to be reorganizing their care to be more patient-centered, more team-based, which means you have to have several types of providers that can do different functions and other considerations.

About 95 percent are reporting to have an electronic health record at all of their sites. Another 3 percent report they have it at some sites. This is an important infrastructure issue. It means that if you have an electronic health system that is functional you actually can respond to some of these requirements of alternative payment methodologies, show improvement recorded. There are also 90 percent that are reporting that their providers are participating in CMS's "meaningful use" criteria, which is also -- it means that those providers are actually -- not only you have a functional EHR but your providers are actually able to use that EHR meaningfully.

CHCs have already reporting capacity for several quality metrics. They report these quality metrics to HRSA, including some preventive measures, for example Pap

smears and mammograms, as well as some chronic disease management measures, such as A1C levels for patients with diabetes, as well as cholesterol levels for patients with heart disease.

The fact that many of the health centers have capitated contracts is important. As I mentioned, they have to be able to abide by the requirements of those contracts, but also it means that they have the capacity to negotiate and contract successfully.

That is the end of my presentation.

* MR. SILBER: Am I just going to push this, and mine is magically going to come up? It's magic.

Good afternoon. I am very pleased to be here. I was just reflecting I have been in the community health center field for about 35 years, and 20 years ago, we started out our Medicaid managed care organization. So being here is sort of bringing all the parts of my professional life together, so I want to thank Toby for suggesting that you invite me today.

The first couple of slides, I'm going to go through quickly because Dr. Pourat spoke to most of these issues about sort of what makes a community health center

or a federally qualified health center different than our partners in the primary care world.

She mentioned the notion that we do see all patients, regardless of their ability to pay, and even in California, which is a Medicaid expansion state, we still have millions of people without insurance. So that continues to be an important part of our mission.

I think one thing I'm not sure Dr. Pourat mentioned is consumer majority board requirement. So one of the Section 330 requirements is that a majority of the board of directors have to be patients of the health center.

And actually, just last week, I had the chance to go to a board meeting at one of our health centers to discuss our plans for electronic health record, and the patients on the board, I have to tell you -- and don't tell my bosses -- understood what value it can be to have a highly functional electronic health record, in some ways more than the administrators. And it was a nice reminder for me that it really does make a difference that the majority of our board members are actually patients of the health center.

I do want to point out because I think sometimes people -- sometimes people think the health centers are only in rural America, or sometimes they think they're only in urban America. One of the really wonderful things that I'm proud of about the community health centers is they are in all 50 states, are important providers both in urban and rural America.

And in many rural communities -- this is certainly true in California and I think around the country -- in many rural communities, the community health center is the sole provider not only for Medicaid but for all the other payers as well.

And Dr. Pourat mentioned that there are extensive requirements from the federal government from your partners at HRSA to be a federally funded grantee. One of the ones that I am also proud of is the quality reporting. So for many, many years, our health centers have been doing the kind of quality reporting that now Medicaid providers are being required to do across the country, so that's something we have a lot of experience with.

This is just another view of how important health centers are as primary care providers across the country.

You can see that we serve one in three uninsured Americans, one in three poor Americans, and as I just mentioned, 25 percent of all rural Americans, regardless of their insurance and income status, are, in fact, served by community health centers.

I thought it was important to spend a second about how I see the importance of Medicaid -- health centers -- excuse me -- particularly to the Medicaid program. One in six Medicaid patients across the country has a community health center as their primary care provider.

I can tell you in California, a huge part of the geography, the whole northern part of our state, which is pretty rural, community health centers are virtually the only Medicaid primary care providers. We have counties where the community health centers have 80, 90 percent of all the Medicaid recipients, and unfortunately, in California -- and I don't know how much this is happening in the rest of the country -- a lot of the traditional solo and small-group primary care practice providers who have served Medicaid patients, as they are aging out of the system, they're not being replaced by young people coming

out of training. Unfortunately, people who are coming out of training now with 100-, 200-, 300-, $400,000 worth of debt are not opening up practices in low-income communities. So this is another place where health centers are stepping in, is to maintain those access points in low-income communities.

Just an anecdote, I saw a primary care provider who has been practicing in Oakland for 50 years, 100 percent Medicaid population. We had the privilege to maintain that access point by one of our health centers taking over the practice.

I ran into Dr. Davis at a restaurant Monday night. He is 73 years old. He spent 50 years of his life practicing in East Oakland, and I said, "So, Dr. Davis, what are you doing now?" And he basically said, "I'm catching up on the sleep that I didn't have for the last 50 years." And I think he has graciously gone into retirement having the peace of mind that a health center is maintaining that primary care access site in the lowest-income community in Alameda County.

I want us to talk a second about the cost effectiveness. I know there are sometimes concerns about

our PPS rates. I want to suggest that the cost effectiveness really should be viewed in what the total cost of care is for Medicaid recipients, and we now have a fair amount of research that says if we compare Medicaid recipients served by community health centers to Medicaid recipients going to other primary care providers, the total cost of care to the Medicaid program is significantly less.

Most recently, a group of researchers at the University of Chicago did a study looking at 13 states with this paradigm: What's the total cost of care to the Medicaid program? It was published in the American Journal of Public Health, and in all of the 13 states, the total cost of care for Medicaid recipients served at health centers was less than it was for other primary care providers.

There's been a lot of studies done over the year, but I made a joke. I actually read this journal article front to back. It's a very well-done study. They used the most current methodology for accounting for any differences in patient characteristics. Across all 13 states, total cost of care was lower for health center patients, and across all of the expense categories -- outpatient,

inpatient, pharmacy -- the total cost of care was less for health center patients. So that's something that I'm very proud of.

I think folks probably know the way we get paid is a prospective payment system. The rate is set prospectively. I am old enough that when this program started, it actually used to be a true cost-based program. In the old days, we had retrospective cost reports, where we were actually trued up. That has not been true since '99, 2000.

And as Dr. Pourat mentioned, we are an environment, at least in California, where -- and ordered to hire primary care providers. I had a health center that had to increase their primary care provider salaries twice in one year. So in a prospective payment system, you're never picking up that kind of dramatic cost increase. But our mission is to provide access to care, so one way -- other way, we suck that up. But it is a significant difference from the old -- the good old days when we actually had retrospective cost-based reimbursement.

I think one of the major points I wanted to make today is that the existing alternative payment methodology

and the existing sort of rules of the road in Medicaid are allowing an enormous amount of innovation across the country, and I'm going to give you a little bit of a national overview and what we're doing in our particular community. And I know Claudia is going to talk about what they're doing here in D.C.

But I think when you look across the country, there's an amazing amount of value-based payment innovation going on in Medicaid, and FQHCs are enthusiastic participants in it.

I think staff told me that you all have looked at this framework about moving to more of a value-based payment system, and I would say in California, we are in the 2 to 3 category. So, for example, because we run as a risk-bearing managed care organization, we live in Category 3. Several health centers in California have upside saving sharing arrangements with their health plan, so lots of health centers across the country in Category 2 and at least some of us dipping our toes into Category 3.

These are a couple of maps just to show you that within the current framework, we have health centers participating in all of the major Medicaid value-based

payment innovations that are going on around the country. So these are Medicaid ACOs.

The three states on the left -- three, four, five -- five, those are states where FQHCs are actually participating as leaders in provider-operated Medicaid ACOs.

That's too fancy for me.

This is Section 2703 health homes. Claudia just mentioned to me in the hallway that we should add D.C. to this slide, so lots of states taking up the 2703 option in ACA and health centers participating in those efforts.

And this is patient-centered medical home, which Nadereh mentioned. Again, many states are paying some kind of premium for providers who are certified as patient-centered medical homes.

So lots of innovation going on and health centers, I think mostly enthusiastically, stepping into this innovation.

I was going to take a couple seconds to talk about our local situation. So I am with Community Health Center Network, which is the eight health centers represented with the logos at the bottom. We're in and

around Oakland, California, so we have eight corporations, about 90 delivery sites now across 5 countries, about -- more than 400 primary care providers.

We operate as an IPA, for those of you familiar with the terminology. We take full professional risk from our Medicaid health plan partners and manage the care and cost for about 143,000 Medicaid managed care members at this point.

So being in this arrangement gives us the opportunity not only to participate in sort of the system-wide Medicaid value-based payment arrangements that are going on in California, but it really gives us the opportunity to do some really exciting things.

So today, we have at least three different value-based payment programs that we are participating in. We have pay-for-performance agreements with both of our two Medicaid health plan partners, under which we are able to earn additional revenue for improving HEDIS scores.

We have savings-sharing arrangements. These are upside savings-sharing arrangements with our health plans, and in anticipation of 2703, which California is not yet doing, both of our health plan partners are funding us for

-- Care Neighborhood is sort of our branded name, but it's an intensive outpatient care program.

So we're fortunate that we've had a lot of these opportunities, and I just want to share with you a little bit of the results of what we've been able to achieve.

So do you guys have a hard copy of this?

We just got our 2016 HEDIS results, and I took a leap of faith and actually gave you our results. But what I'm really proud of is the two columns on the right. So you can see for all of these HEDIS measures that we're -- financially incented to improve. Our rates exceeded the overall average rate for our plan partner in this case, but probably more importantly is the right-hand column, which when you compare our results to the NCQA Medicaid 90th percentile, with one exception, we're now exceeding the 90th percentile.

In the big scheme of things, this is a few million dollars. We've earned about $5 million last year, but it's just sort of enough to get people revved up at the health center level.

We are now using our electronic health record system. Every night, we're running a report, every

measure, every clinic. When they come to work the next morning, they get a list of which of their Medicaid managed care members are due for these particular services, so really using the infrastructure of electronic health records, patient-centered medical home, to drive these kinds of improvements.

The only one we didn't exceed the 90th percentile is diabetic retinal screening, which is a reporting issue, and we are going to solve that because we do the screens. We just haven't yet gotten them into a form that NCQA will accept.

The total cost of care. So we have this program where we are targeting, using a predictive modeling algorithm, our most expensive, highest-need Medi-Cal managed care members. It's a community health worker model, where we're working both on the social determinants of health and helping people make sure they use their clinical services correctly.

We just ran our second total cost of care analysis, and you can see we're showing a 35 percent reduction in the total cost of care. Now, you can see these are PMPM numbers, so these are really expensive

patients, but in terms of saving money for the Medicaid program, as you all know, the biggest bang for the buck is in targeting these really expensive patients.

We just got some grant funding. We're now adding a medical-legal partnership to this program, helping people get all of the public benefits that they're entitled to, so a lot of really exciting value-based payment stuff that we're able to do under the current rules of the road.

And then just a couple of key takeaways before I finish up. I think it's clear that health centers are really important to the Medicaid program. We're really proud to be part of the success of the Medicaid program, and at this point, because of some of the market forces and the payer forces that Dr. Pourat referred to, I feel like we're really taking the infrastructure that we've created in community health center land and really marshalling it to be part of the solution to make Medicaid an even better program for the people we serve.

* MS. SCHLOSBERG: Good afternoon. It doesn't look like that first slide is readable. There, we'll go to that one. Thank you.

My name is Claudia Schlosberg. I am the Medicaid

Director for Washington, D.C., and serve as the Senior Deputy in the Department of Health Care Finance, which is our Medicaid single-state agency.

First of all, thank you so much for inviting me to speak. I am going to represent the view of the payer. I want to start by giving you a little bit of an overview of Medicaid in the District.

Some of you may or may not be familiar with the Medicaid program here. We are a relatively small Medicaid program. About $3 billion is our budget, but we're not the smallest Medicaid program. There are six states that cover fewer people.

And in the District of Columbia, we were very aggressive and very committed to Medicaid expansion and our state-based exchange, and as a result, in fact, we were an early adopter with respect to the Medicaid expansion. And so we now are, I think, ranked third or tied for third in the nation in terms of number of people with insurance. We have a 96.2 percent insurance rate in the District, so we're very, very proud of that.

While we have fantastic coverage and virtually everyone is insured -- and I will also note we have a state

or locally funded program called the Alliance that covers about 15,000 individuals who are not eligible for Medicaid. While we have great insurance coverage, some of the data on health outcomes is not as favorable.

About 12.9 percent of District adults reported their health was fair or poor. We have had very high emergency room utilization, almost twice the national rate and very high readmission rates in our hospitals.

We are addressing that in Medicaid now, and in the last three years, we have embarked on pretty ambitious efforts around value-based purchasing and have developed new payment rate methodologies for our -- well, we've added some provisions in our MCO contracts, but again, we've recently completed or are about to complete a nursing home rate methodology change. And a major piece of this is the work that we have done with our federally qualified health centers and the D.C. Primary Care Association to infuse a new rate methodology with principles of value-based purchasing to drive quality and reduce those numbers.

In D.C., we cover 260,000--approximately 260,000 residents are covered by Medicaid. That's nearly 40 percent of the District's residents, and 70 percent of

children are covered by Medicaid. And we have very high participation rates in the Medicaid program for children who are eligible.

As I mentioned earlier, we were an early adoption state. We expanded Medicaid before the end of 2010 for childless adults, and I believe now we're covering about 70,000 childless adults.

And 70 percent of all Medicaid beneficiaries are covered by managed care. We still have both fee-for-service and managed care delivery.

So I included this slide just to give you a bit of a snapshot. Like Ralph, we're somewhere between LAN Category 2 and 3 with respect to value-based purchasing. We have worked very hard in the last several years to develop -- we have two health homes now in the District, one focused on people with serious mental illness, the second health home launched in July, which focuses on individuals with multiple chronic conditions. Our FQHCs are participants in that second health home as well as other primary care practices.

And we have developed rate methodologies, including adding provisions in our MCO contracts to address

the low-acuity ER admissions, readmissions, and preventable, avoidable hospital admissions.

We very much want to get to Categories 3 and eventually to 4, and so part of that's this payment methodology that we developed with our FQHCs, and in collaboration with our D.C. Primary Care Association, we think helps us move us down the road.

Let's see. Oops, I didn't know that that did that.

[Laughter.]

MR. SILBER: I had one of those, too.

MS. SCHLOSBERG: Sort of surprised me.

MR. SILBER: Some younger person put it in there.

MS. SCHLOSBERG: So this is kind of a snapshot of our federally qualified health centers, and I will say that D.C. is probably somewhat unique. We are about 10-by-10 square miles, and we have fairly high penetration of federally qualified health centers within the District. We have eight federally qualified health centers and one look-alike. There are -- 52 or 56 approved service delivery sites are located in the District, so we have a couple of FQHCs who have sites outside of the District. And the

FQHCs are serving about 178,000, a little more than 178,000 patients. That's across all of their payers. About 36 percent of our beneficiaries are served by FQHCs, and you can see in the map they largely -- I don't know how familiar you are with the District, but we have coverage in Wards 7 and 8, which tend to be -- this is the area where we have most of our Medicaid recipients, but also throughout the District.

So we started working on our FQHC payment methodology, our APM, probably in 2015. This was a very collaborative effort. We invited the D.C. Primary Care Association and our FQHCs to partner with us in the development of this rate methodology, and I think that was ultimately extremely important in our success. But these were our goals.

First of all, the historical PPS, I can't even tell you when it was set or what it was based on. I don't think I'm unique with respect to that. But we had not -- I don't think it had been touched since 2001, and so one impetus for developing the new rate methodology, we heard a lot of complaints from FQHCs letting us know that our PPS rate was not covering their costs, that it was out of date

and it needed to be updated.

So, again, we embarked on this goal of putting the reimbursement methodology on a sound legal and regulatory footing. We also did not have much in the way of language to define what was actually included in the PPS rate. You know, there was just not a lot of structure around it, if you will. We wanted to provide a fair and adequate reimbursement rate for the FQHCs, improve health outcomes, and reduce health disparities for patients, allow for a person-centered holistic and integrated approach, both so that care meets patients where they are, both literally and figuratively, and allow for same-day reimbursement for different types of encounters. Particularly of interest, we heard a lot about the need to allow for an encounter for physical health as well as behavioral health on the same day. And we wanted to lay the groundwork for value-based purchasing by developing a fair and sustainable approach to performance measurement.

So the new APM rate methodology, I will say this. I did not want to highlight it too much, but the actual effective date for this rate is October 1, 2016. We just got approval from CMS last month. So we are in --

MR. SILBER: [off microphone] have that experience.

MS. SCHLOSBERG: There was quite a lot of negotiation with CMS back and forth over various aspects of this, and we did finally get approval in September. But that now means that we are going to implement this retrospectively, which is something we seem to be doing quite a bit of.

So the new APM clearly defines services included in an encounter, services that remain in our fee-for-service system. That is those things that are paid outside of the PPS rate or the APM rate. And it also clearly defines allowable costs. Again, prior to this, we did not have those definitions clearly laid out in any rule or in any SPA.

It also establishes the alternative payment methodology that includes four separate encounter rates -- one for a medical visit, one for behavioral health, and then two separate rates for dental: preventive and diagnostic, and comprehensive. And those also are very clearly defined in our rules.

The APM allows for same-day reimbursement for

visits for one of each encounter type -- medical, behavioral health, and dental -- and we have capped administrative costs, but we allow for -- but this is how we develop or create the pool from which performance bonus payments can be paid. So we have also developed a pool of funding that will allow us to pay for performance based on mandated measures.

The other thing that we have done is we have defined the wrap payment process. We've also automated that process. That has been somewhat of a challenge, but what we are attempting to do or are doing in that process is making sure that we are matching an actual MCO encounter with a wrap claim. We have had some technical challenges with that, but we are working through them. And we also established an appeals process for MCO denied claims.

One of the things -- I thought that I had put this in here -- is that we are now requiring FQHCs, when they submit their claims to us, to include on those claims CPT codes so that we have a better understanding and more visibility into what is included in that encounter. Previously, the claims were simply -- there was a single code, and we would pay the encounter based on that. So we

are very much looking forward to having that additional information about the services provided at the FQHCs.

The APM rates are based on audited cost reports from FY13, and we will be rebasing them every three years. I think that has been an issue for FQHCs, that these payment rates don't keep up and don't ever go back to capture new costs. And we expand the list of billable providers that are allowed for behavioral health services.

In addition, an important feature of the new APM -- and this is only for those providers, those FQHCs that elect to participate in the APM -- is that we have designed a new program that pays for performance. And so FQHCs are now required to report to us the various quality measures that they also report to HRSA, and this was very much, again, a collaborative effort with the D.C. Primary Care Association and with FQHCs to design this quality performance program.

We included measures connected to meaningful outcomes, again, identified by providers and by DHCF, by D.C. Medicaid. Some of those measures, there's nine measures. Three of them address patient-centered access issues, like providing 24-hour access, after-hours care.

Another three look at transitions of care. And then another three look at those clinical outcomes that I spoke about earlier, reducing low-acuity ER visits, preventable hospital admissions, and 30-day readmissions. So these measures align with our other value-based initiatives to reduce again the reporting burden and confusion that can come when a provider has to report on multiple sets of measures.

So challenges that we have had. From the payer perspective, while we understand the importance of the PPS rate, the payments are notably higher than payments to our other primary care providers. And, again, in an area, a rural area or somewhere where there's only an FQHC, it's maybe not an issue. But in the District of Columbia, where we have other primary care practices that are not FQHCs, there is truly -- there is the perception that the PPS rate is not necessarily fair to those who are not FQHCs.

In addition, it can incentivize the non-FQHC primary care practices to become FQHCs through the application to HRSA, which can increase budget pressure on the state.

There's also a conflict between PPS and value-

based purchasing. Again, I think we have more flexibility with the APM, but the reimbursement primarily remains cost-based and volume-driven. We are creating a PPS rate, but it is based on costs, historical costs, and we pay that rate based on how many encounters. There have been problems. I'm not saying this happens in D.C., but there are problems in some states where FQHCs unbundle services so that they can increase encounters and have more revenue.

The PPS rate, again, unless updated -- and I think D.C. was in this position -- doesn't keep pace -- if you don't update it, you're not keeping pace with costs. While the alternative payment methods provide us with more flexibility and allow us to tie payments to quality, the key feature here is an APM is only feasible if an FQHC agrees to it. So in designing our alternative payment methodology, we wanted to make it attractive to the FQHCs because we wanted them to participate in that program. But we also cannot pay less than the PPS rate, so that is a restriction that doesn't necessarily exist when we're dealing with other providers.

Then reconciliation back to PPS means that FQHCs effectively do not take on downside risk, even when the APM

is structured as a PMPM. So there is a reconciliation process at the end of the -- annually.

There are some concerns and it has been raised that the normal MCO levers are less effective given wrap payment guarantee. That is our FQHC -- our MCOs will have a negotiated rate with an FQHC, but we then have to come at the back end and pay that wrap payment up to the APM rate or the PPS rate.

It's also difficult to move from -- to LAN level three in terms of value-based purchasing because of the difficulty -- it's not impossible, but the difficulty of sharing risk. And I think as we look at where we are right now -- and I think you've heard it from all the panelists, and our FQHCs and D.C. Primary Care Association actually share in this vision. We definitely want to move forward together around -- to move toward value-based purchasing and shared risk. We've been working with them on our ACO models. But in a world where we're moving away from paying for value -- I'm sorry -- volume and payment based on costs, the historic PPS payment methodology is not necessarily supportive of those efforts. It does pose challenges.

And I think with that, that is my last slide.

CHAIR THOMPSON: Thank you. Extremely informative. This is a very important subject and something that we were very eager to get into. I know we have a number of questions. Let's just start them out.

[Comment off microphone.]

CHAIR THOMPSON: All right. Martha's -- she's holding her fire. All right. Toby.

COMMISSIONER DOUGLAS: Thank you all for being here, and definitely thank you to my colleagues from California. So I thought one place maybe to start, I would love to get Ralph's perspective and reaction to some of the points that Claudia made at the end, especially in kind of thinking through the attempts in California to move to almost -- you know, try to create a capitated rate structure, and just from an FQHC perspective, the pros and cons of doing that and what prevents the movement to going to a full kind of risk-based arrangement where there is true flexibility in the provider types that can deliver the services the way it's delivered and the upside/downside risk and total cost of care opportunities, especially within a changing delivery system, as you mentioned, with

EHRs and everything, away care, your population, and the generation and the use of technology is changing visits. So I'll be quiet there because Ralph knows, at one point I wanted to take -- did not receive my approach lightly.

MR. SILBER: You know, in preparation for today, I talked to my colleagues around California largely, a little bit around the country, and sort of took a step back from my daily grind. I think what's striking to me over the last couple years is how much movement across the board in Medicaid there has been to value-based payment and how much health centers -- and I'm obviously most familiar with California -- are really in the forefront of that.

In California, 80 percent of the Medicaid MCOs now have pay-for-performance programs, so really just every day the field is moving in that direction, and health centers are fully participating in those programs.

The other thing that's true for us in the Oakland area and for most of the clinics in Los Angeles is health centers are coming together to create risk-bearing organizations. You know, I would argue that you don't really want to have a lot of downside risk at an individual primary care provider level. I really don't think --

that's not the model in the industry generally, right? You want to aggregate groups of providers, hand them responsibility, and give them a financial incentive upside and downside. So, in our case, our health centers have downside risk. Almost all the health centers in Los Angeles are organized into a collective risk-bearing organization where they have downside risk. There are health centers across the country that are partners in Medicaid HMOs, full-fledged plans where they have downside risk.

So I think what's really striking is that within the current environment, there is lots of interesting innovation going on, which may -- I was pleasantly surprised when I looked across the board. So I think this notion that the problem is we can't put these primary care providers way down here at downside risk, I don't think that's right.

Now, I do think through ACOs and lots of other entities you see providers coming together, but you really want to aggregate bigger groups of providers. And I also don't think downside risk is the only lever to achieve changes. You know, when we got these HEDIS pay-for-

performance, it was really just a year ago, and I got my team together and I said like let's really focus on this for a year. I wasn't 100 percent sure what the results were going to be, but I don't think you should underestimate the impact of upside risk in really motivating the changes.

The last thing I would say is if you look across the health care system, not just in the Medicaid space, I think there's a pretty broad consensus that the problem is not that we're overinvesting in primary care. Right? I mean, I think there's a pretty good consensus we've underinvested in primary care and we've overinvested in a lot of high-end things.

COMMISSIONER DOUGLAS: [off microphone] group based, how the model allows you to have group-based email, other approaches, and how you --

MR. SILBER: Yeah, so for better or worse, and sometimes over the objections of our chief financial officers, we're doing it. So one of our health centers now has a clinic that is run by medical assistants. So the CFO was a little hysterical because those are not billable visits. We don't generate PPS rates. But, A, it's the

right thing for the system. It actually makes better use of the physician time because they're really practicing at the top of the license. So on the same day in California we cannot bill for a medical visit and a behavioral care visit the same day. The doctor is walking the patient down the hallway to meet with the LCSW. Nobody is standing there saying, "Well, you know, we're not going to do it because we're not going to get our second rate."

So I would argue because of those market forces and because of the upside financial incentives we have, there's a lot of innovation going on, and I just think we're overstating being tied to the visit. We're doing email. We're now doing electronic e-consults. It's not a billable service, but instead of unnecessarily sending our poor patient who has no transportation, who's going to lose a day's pay, to the hospital, we now have a system where a primary care provider is consulting with an endocrinologist through an electronic email. Do I really need to send the patient? There's no revenue associated with that. But, again, in our situation, because we have downside risk at the collective level, we get some financial reward if we avoid that unnecessary endocrinology visit.

CHAIR THOMPSON: Sheldon. I've also got Chuck and Fred. Martha's going to stay last.

[Laughter.]

CHAIR THOMPSON: Okay. Thank you.

COMMISSIONER RETCHIN: Batting clean-up.

Well, thanks for those presentations. I've spent my career in safety nets as a provider and been a big fan of FQHCs from the beginning. That said, I just -- I wonder. My experience with FQHCs has been that there's a seam between FQHCs, community health centers, and safety net systems, like hospitals in the region. And it's almost as if we're watching -- to stay on the movie theme -- we're both watching the same movie and we're in different theaters. That's the best I could do.

I wonder if it's time -- I guess my role is to be provocative, but just to revisit the governance structure and opportunities, I don't think it's only going to be through taking risk together. But I've even been to conferences where they're meeting in the same hotels and they're -- it just seems like there's a gulf there. And I even wonder why is HRSA the supervising agency for FQHCs. It seems like these all create some sort of a separation

and gulf, and to be able to move to more vertical integration, there seems to be a barrier.

MR. SILBER: Are you talking about this sort of FQ versus hospital system? Is that what you're asking about? I'm not sure I understand the question. Yeah?

COMMISSIONER RETCHIN: [off microphone] question, but -- okay. Why?

[Laughter.]

COMMISSIONER RETCHIN: I just made it a question.

MR. SILBER: The world is changing. I'll tell you -- I tell stories.

COMMISSIONER RETCHIN: We'll hear from California.

MR. SILBER: I am from California where we've had a huge amount of consolidation in the hospital sector. For example, the Medicare readmission financial hit has made a huge difference. I had another health center, the CEO came up to me about a year ago at a meeting, Christine Noguera. Do you remember Christine? She came up to me and she whispered in my ear, "Something's changed, Ralph. After all these years of the hospital execs never wanted to talk to us, now all the hospital system guys are knocking down

our doors because they understand the contribution we can make to reducing readmissions." Now with the Medicaid expansion, you know, hospitals in California are happy they're getting paid from Medicaid, but they have more and more Medicaid patients in their emergency rooms and in their inpatient beds. So it's been a big change over the last couple years.

Our major hospital system is funding us for care transition. They're paying the salaries of our employees in our health centers to receive patients who are being discharged to reduce --

COMMISSIONER RETCHIN: Electronic health records and --

MR. SILBER: Funny you should ask that. We are embarking on changing our electronic health record, which would be my swan song, but exactly for this reason. And our hospital systems are paying for it because they understand the value of us being on the same system that they're on.

CHAIR THOMPSON: Chuck.

MS. SCHLOSBERG: I would just add that I think it's the space that we're all in right now, which is that

we have a kind of non-system of health care, where we have separate and different providers with different payment methodologies and different payers, and as Ralph has said, the world is changing. We're not there totally yet. We haven't gotten 100 percent, but I think we're all looking for those levers and incentives that will allow us to have more integration and more coordination among the various players that we have to interact with and that patients and people have to interact with.

So I agree with you. There are historic reasons why HRSA is the agency -- and it's because of the Public Health Service Act that -- and funds FQHCs, but now Medicaid is the payer. So how do you put those two things together?

But there are historic and political reasons why our health system looks the way it does today.

CHAIR THOMPSON: Chuck, then Fred.

COMMISSIONER MILLIGAN: Thank you.

I've got three questions. The first one, speaking of HRSA, one of the barriers that I've observed is health centers are still reporting HRSA-based quality measures, which are not always the same or aligned to HEDIS

measures. Prenatal care is a good example, the kind of engagement of prenatal care. It's different measures.

So maybe Ralph, the first question, or, Claudia, to you. Is HRSA adapting to HEDIS? Because HRSA needs to adapt to HEDIS because the world is going to HEDIS for cross-payers. So that's question number one.

MR. SILBER: I can't believe I'm going to speak for HRSA, but HRSA is doing a relook at the UDS system, which is how we report, and this issue is front and center. It's got its complications, because they have arguments about what's better about the way they report, but this issue of how clinical outcomes are reported in UDS and how they're reported in HEDIS is absolutely on the list of things that they're looking at carefully.

COMMISSIONER MILLIGAN: Because, I mean, the health -- I'm sorry.

DR. POURAT: If I can add to that, I think in 2016, about nine of the measures were changed to be more consistent with other nationally recognized metrics.

COMMISSIONER MILLIGAN: Great.

My second question is going to the Level 4 value-based contracting. I think the question I have is, What do

you consider to be the minimum membership threshold if -- because you were talking about -- and, Ralph, again to your comments about scale and organizational at that level, sometimes some FQHCs are pretty big by themselves, and so I'm curious about scale to take downside risk without being part of a consortium or collaboration. What membership scale do you think is minimum to take downside risk?

Anybody? Anybody for the obvious?

MR. SILBER: I don't feel qualified.

COMMISSIONER MILLIGAN: It's an actuarial question.

MR. SILBER: I don't --

COMMISSIONER MILLIGAN: Okay.

MR. SILBER: I don't have an answer.

COMMISSIONER MILLIGAN: Okay.

Yeah. No, I -- well, it's probably less than 130,000, but I just -- I don't know kind of -- it was really -- it wasn't a trick question. Just curious.

I guess -- and, Claudia, I think the last question I have is really about the D.C. One of the things that I've observed in my past life is that some health centers are further along and more willing to progress, but

among the Primary Care Association, then it becomes like all in or all out, how many is enough, because then it becomes local association politics about how supportive to be of APMs and all of that.

And I'm curious from a political science point of view how you would evaluate the association versus or including the health center component when there are varying stages of readiness for those kinds of changes.

MS. SCHLOSBERG: So again, I think probably not unique to D.C., in any state Medicaid program, providers are going to be at different stages of readiness, and we certainly see that.

But I will say that the D.C. Primary Care Association has had great leadership and continues to have great leadership, and they -- I think since you've been around, Chuck, they have really progressed in terms of bringing the members together. They're doing a lot of innovative things, particularly around electronic health records, population health management, and also, we are working with them, sort of trying to raise the level of practice and a lot of technical assistance.

But I'd also say this. When every FQHC, when we

finally got this payment methodology off the ground, was given the choice of whether to stick with PPS or APM, every one of them signed up for the APM.

So we think we're moving forward together, and I think a lot of that has to do with a lot of the work that we have done to work with them to make this happen.

COMMISSIONER MILLIGAN: And just one closing comment. That's great to hear. My observation actually is that the state primary care associations are much more advanced than NACHC nationally, and I think that that's a different kind of issue because I do think that -- and I contextualize it within the D.C. conversation. I do think that there is a lot more appetite for evolution or progression out at the state primary care associations than you often hear in the federal discussion about this issue.

CHAIR THOMPSON: Fred. Then I'm going to ask a few questions, and then Martha is going to take us out of this section.

COMMISSIONER CERISE: Okay. Thanks.

Two questions. The first one has to do with the Medicaid expansion. It seems like this particular area would be one of the more dramatic -- dramatically impacted

from expansion states compared to non-expansion states in terms of the practice model. Maybe you could comment on sort of what that impact has been between the two states and what that says about the reimbursement model and the sufficiency of that model.

So the impact between Medicaid expansion states and non-expansion states in the reimbursement model and the experience of the community health centers in those two very different kind of environments.

DR. POURAT: [Speaking off microphone.]

CHAIR THOMPSON: Can you put your mic on, please?

DR. POURAT: Quite a bit of literature emerging on the impact of Medicaid expansion. I think some of the research we've also done shows that the community health centers in the Medicaid expansion states had an increase in the number of patients. Obviously, they also had some -- sort of changes in their structure, ability to grow and provide more services. So Medicaid expansion definitely had a positive impact in those states on community health centers.

COMMISSIONER CERISE: Ralph, maybe this is for you. But would you -- when you talk about the ability to

do more services that are not reimbursed, I would imagine that that Medicaid rate is sufficient that allows you to do some of that other business? I mean, is that a fair assumption, or what is the support that allows you to do some of that other work?

Then in a related comment, can you comment on Claudia's observation that when there's been a shift to the primary care providers in D.C. who want to become FQHCs because of cost-based volume-driven services, kind of how that sort of contradicts a little bit with your earlier statements about your overall impact on the Medicaid program of reduced cost?

MR. SILBER: So, as Dr. Pourat said, the Medicaid expansion makes a big difference. So even if your margin is 2 pennies per visit, we have clinics that went from 40 and 50 percent of their patients being on Medicaid to 80 or 90 percent of their Medicaid. So there's just -- there is more financial wherewithal to do these kinds of innovations.

And for some of our health centers, their value-based payments are not insignificant, and we have been very strategic. And I work for the health center CEO, so I've

had to be a little careful about this. But we have been very strategic about now requiring that some of those upside dollars are strategically invested in the things that we want to incentivize, which are improving access, improving quality, and improving outcomes.

So the Medicaid expansion puts more money on the table, and I have to say at this point, there is enough money in our system out of the upside P4P payments that it really is a source of innovation funding.

In terms of the private docs, in our case, the only private practices we have maintained and incorporated into our systems are people who were retiring. We literally have cases where a private provider came to us and said, "I'm about to die." We literally had one where when we closed, Dr. Jenkins died six months after we closed. So they're all cases where we're maintaining practices of people who are aging out.

In many cases, older -- these are mostly older African American doctors who have been practicing in the community for 50 years. They cannot find new graduates to take over their practices.

On the other hand, we have in California,

community clinics who don't want to be FQHCs because of the reporting requirements and meeting all of the federal requirements.

I have zero cases of mid-career private-practice Medicaid doctors knocking on our door saying they want to be part of our system. They're unhappy with the amount of paperwork they have to do in just regular Medicaid, let alone -- you know, our health centers have these audits by HRSA. They spend an entire year preparing for a three-day on-site audit. The private docs are not -- they're not interested in that level of scrutiny.

CHAIR THOMPSON: Let me ask a couple of quick questions, Claudia, to you about the road not taken.

So you mentioned administering the wrap. Did you think about requiring the plans to pay at the APM, and what were your pros and cons of doing it that way versus the way that you chose?

MS. SCHLOSBERG: Yes, we did actually consider having the MCOs pay the full PPS or APM rate. The problem with that is it would have increased our cost because of the way we reimburse MCOs for their administrative cost. It's -- I forgot -- 10 percent, and so that would have been

a significant increase in our payments to the MCOs. So we did not incorporate the wrap into the MCO payment.

Our struggles with the -- the new APM does require the FQHCs to actually submit claims to us. This has been a bit of a heavy lift for them. The MCOs had to reconfigure their systems, and we've had some challenges, but we're working through them.

The goal and the way this is -- when it does work, and it has been working with some exceptions -- is that we will be able to process the wrap payments and match these claims up and pay on a weekly basis, so they're not going to be waiting every quarter to get these wrap payments. It will be in the regular cycle of payments.

CHAIR THOMPSON: So I'm trying to square a few points that you made, one which was that the original PPS rates based on the 1999-2000 costs were not keeping up with actual costs. And so you re-based, but the old rates would have been also inflated forward using an index. And the delta between what that was and what you're now paying could have been chosen to be an incentive payment or a value-based payment add-on.

So I'm just curious. So you chose to make the

PPS rates more accurate to today's costs rather than fill the gap between the prior payment and today's payment with something that was more characteristic of a value-based payment. And I'm just wondering if you could say a little bit more about why you didn't choose to keep the base rates and supplement it with a different kind of payment arrangement rather than updating the base rates.

MS. SCHLOSBERG: I'm not sure I -- I'm struggling to answer that because the FQHCs clearly took the position that we were -- that our rates, which again have not been touched for some time. We're not keeping up with costs, and so I think we started out from that basis looking at their cost reports and move from there, so --

CHAIR THOMPSON: So first wanting to recognize the cost --

MS. SCHLOSBERG: Right.

CHAIR THOMPSON: -- and then thinking about how to make that a ladder up to a value-based payment arrangement.

MS. SCHLOSBERG: Yeah. I'm just struggling to -- you know, why we didn't choose that route versus another, but these things kind of happen organically and move

forward in various ways. This is where we ended up.

MS. SCHLOSBERG: It seems to me that as states are looking at this question, that issue of rebasing the rates often comes up, and certainly, as established, they are based on pretty outdated costs, so it's an interesting dynamic to think about reinvesting in that methodology to bring it to today versus leaving it where it is and making up that difference with some other approach.

Toby, did you want to jump in on that point?

COMMISSIONER DOUGLAS: [Speaking off microphone.]

COMMISSIONER CARTER: One thing, one point that I think is implicit in what you all said and is in our reading material, but the original cost-based rate was put in place because the feds didn't want our grant funds to be supporting the Medicaid program cost at the visit level. So that's the underlying philosophy behind how that all happened. There's a different mechanism to pay. They're just two different mechanisms. They didn't want the federal grant --

CHAIR THOMPSON: To supplement --

COMMISSIONER CARTER: Exactly.

VICE CHAIR GOLD: And it may be -- I don't know

your situation -- that you were out of compliance with the HRSA rules, with the FQHC payment rules if you hadn't updated at all, so you didn't really have the option to continue it? I'm guessing.

CHAIR THOMPSON: I'm sure D.C. was in compliance. It's just that the methodology --

[Laughter.]

COMMISSIONER CARTER: Always in compliance.

SO given the wide range of health center organizations -- large and small and rural and urban -- unless we think that a readiness to participate in value-based payment is just an East and West Coast phenomenon, can you talk a little bit more about what you see?

You talked a little bit, but I'd like maybe a little bit more about the health centers' readiness across the country to engage in alternative payment models and the readiness of the state Medicaid programs to partner with them or the MCOs, whichever.

MR. SILBER: Yeah. I'm a little bit humbled to talk about the rest of the country.

I'll say a little bit about our experience in California. I was just reflecting. We have had a huge

challenge in attracting enough primary care providers over the last couple years because we're competing with all the big systems. I cannot prove this, but I think our increased focus on HEDIS scores and reducing readmissions and addressing the social determinants of health and integrating behavioral care, I believe these are things that are actually helping us attract and retain our primary care providers. I think we are creating a more professionally fulfilling situation and environment for our doctors.

So I think we're at this place where there's a lot of natural positive reinforcement. I see this also with our top talent, not just our providers, but we are increasing our quality improvement, our data analysts, our health informaticists. I think we are getting the talent we need and keeping them in part because we are more and more oriented towards these kinds of outcomes that the Medicaid payers want us to be focused on. So I would share that.

You know, in terms of the Medicaid plans, in California over the last couple of years, we have started a collaborative of the plans and the providers and the

Medicaid agency to work on collectively advancing the value-based payment work. So I'm less familiar with what's happening in the rest of the country, but in California, we now have a statewide collaborative in the Medicaid space, focused specifically on how to advance value-based payment work and how to standardize the way it's measured, because we have counties -- as Toby knows, we have counties where there's six or seven managed care Medicaid plans. We're trying to figure out ways that they're measuring and rewarding performance using the same metrics. So at least in California, there is a lot of progress.

I will say the way you phrased the question is appropriate because there were questions about readiness by the plans as well as readiness by us as providers and other providers.

MS. SCHLOSBERG: I would just like to add that we have benefitted greatly by getting technical assistance from various consultants, organizations -- NASHP, Robert Wood Johnson -- participating in collaboratives. We were a SIM grant state. We had money for planning but not for implementation, and I think when we look at the map as to what states have been able to progress most quickly and get

as far down that -- or up that ladder of value-based purchasing approaches, having that additional funding and technical assistance is critically important.

We are challenged every day in trying to literally run the program on a daily basis and then looking ahead or looking forward and thinking about how we move forward.

We struggle. We know our health plans struggle, and the FQHCs also struggle. So I think the ability -- there is a need to think about how we support this work on an ongoing basis.

COMMISSIONER CARTER: In the impressive quality results that the health centers achieve, a lot of the work is done by non-clinician staff, as you mentioned. We all know that there's a shortage of primary care clinicians, but in addition, nurses, social workers, community health workers. Are there any regulatory and reimbursement barriers that this Commission maybe should hear about in more detail that are impeding the work that you're doing?

MR. SILBER: Well, Toby and I fought for years about us being able to bill for behavioral care visit the same day as medical visit, but I think that happens in some

-- you do that, right? You pay -- yeah. So I think a lot of my wish list is state based, not federally based.

COMMISSIONER DOUGLAS: I don't have --

[Laughter.]

CHAIR THOMPSON: Toby, did you have one last question that you wanted to ask? And then we're going to just have to --

COMMISSIONER DOUGLAS: Yeah. I'm sorry.

CHAIR THOMPSON: We've blasted through our time here.

COMMISSIONER DOUGLAS: Again, not to be the last word, on social determinants, I'd love to hear a little bit more, given -- and we're exploring that. You mentioned, Ralph, the work you all are doing, and it would be good to understand a little of the financing. Can that be -- so where does that fit within the PPS? Did it trigger --

COMMISSIONER CARTER: That's kind of like my workforce question.

COMMISSIONER DOUGLAS: I'm sorry?

COMMISSIONER CARTER: That's kind of like my workforce question.

COMMISSIONER DOUGLAS: Yeah.

COMMISSIONER CARTER: It's the same question, really.

COMMISSIONER DOUGLAS: Yeah. Where does like those types of housing and other types of food assistance support fit in, and are you able to actually incorporate that into a PPS?

MR. SILBER: So right now, we're very fortunate that our health plans are essentially funding that on top of the payments for medical services on a pilot basis, and we are hoping that because we're generating such significant savings to them, primarily on the hospital side, that they will provide that funding on an ongoing basis.

We are hoping that California will soon join the other states with 2703, so that would create another revenue stream, hopefully.

Also, California is using a program under the 1115 waiver to address a lot of those issues, including the housing thing as far as we can push it. So it's a combination of the health plans using some of their capital, hopefully things like 2703 where there's a federal Medicaid stream. And I'm sure California is not alone in

using some 1115 waiver opportunities to do that as well.

CHAIR THOMPSON: Okay. Well, great session. We really appreciate the time that you've given us. You can see there's a tremendous amount of interest among the Commissioners on a variety of subjects relating to FQHCs. We thank you both for your service to the program, and we will take a quick 10-minute -- no longer -- break, and then we'll pick up with DSH at 3:05.

* [Recess.]

CHAIR THOMPSON: Okay. I know that wasn't much of a break but we're trying to get back a little bit on schedule, so if everybody could come in and take their seats.

[Pause.]

CHAIR THOMPSON: Hi, Rob. We are glad to hear from you and thank you for being patient with us, running a little bit behind. But you have some updates for us on DSH.

THEMES FROM EXPERT ROUNDTABLE ON DISPROPORTIONATE SHARE HOSPITAL PAYMENT AND NEXT STEPS FOR MACPAC WORK

* MR. NELB: I do, thanks. I'm not so sure about

the slides but I'll just go ahead and get started since I know we're short on time.

So I'm going to share some themes today from an expert roundtable that we held about the future of DSH payments, to help prompt a discussion with you all about next steps for MACPAC's work in this area.

I'll begin with some brief background on DSH payments and the reason why we decided to hold this roundtable, and then I'll share some of the themes that we heard about the role of DSH today and opportunities to improve DSH policy in the future. Finally, I will conclude by talking about some next steps for MACPAC's work, particularly our plans for the March report.

And since we're running a little late on time, I'm going to try to skip over some points as I go through, but if you have questions or want me to elaborate just feel free to ask questions as I go along.

First some brief background. States are statutorily required to make DSH payments to hospitals that serve a high share of Medicaid and low-income patients. However, states have broad flexibility to distribute DSH payments to virtually any hospital in their state.

DSH payments to an individual hospital cannot exceed the hospital's uncompensated care cost for Medicaid and uninsured patients, and total DSH payments within a state cannot exceed federal DSH allotments.

The Affordable Care Act added reductions to state DSH allotments under the assumption that increased coverage would reduce hospitals' uncompensated care costs. However, these DSH allotment reductions have been delayed several times. The first round of reductions actually took effect earlier this month, in FY 2018, with a $2 billion reduction in DSH allotments, which is about 17 percent of states' unreduced DSH allotment amounts. Under current law, the amount of DSH reductions increases each year, and so by 2025, DSH allotments will be reduced by more than half.

CMS is required to develop a methodology for distributing DSH allotment reductions among states. CMS issued a proposed rule this summer and MACPAC submitted comments on the rule. However, CMS has not yet finalized this rule and so even though reductions have taken effect, we do not yet know exactly how they're going to be distributed among states.

So a key theme of MACPAC's ongoing work on DSH

payments has been that DSH payments should be better targeted to the states and hospitals that need them most. But perhaps one of the biggest challenges with this work has been the fact that states and hospitals use DSH payments differently. For example, in some cases, DSH funding is used to pay for hospitals' unpaid costs of care for the uninsured, while in other cases states and hospitals use DSH payments to offset Medicaid shortfall, which is the difference between a hospital's cost for serving Medicaid patients and the total amount of Medicaid payments that it receives for those services.

And finally, MACPAC's work has also identified cases where DSH funds are really used to support the overall financial stability of safety net hospitals more generally, including rural hospitals and other institutions that are struggling for reasons other than their uncompensated care costs.

Another complicating factor in all of our targeting work has been the fact that DSH is not the only source of funding that helps to address these roles. In Medicaid, for example, states also set base payment rates to hospitals, which help address -- which are related to

the Medicaid shortfall that the hospitals have. In addition, states also make large non-DSH supplemental payments, which are lump-sum payments to hospitals very similar to DSH, but they're made under different rules, the upper payment limit rules for fee for service.

In 2016, states actually made twice as much non-DSH supplemental payments as they made DSH payments, so it's another big source of funding to be aware of.

To help us better understand the roles of DSH in the context of some of these other sources of funding, we convened an expert roundtable last month. We gathered states, providers and other stakeholders to discuss why different types of states and hospitals use DSH funding differently, and also to ask about how DSH funding should be structured in the future. We contracted with Health Management Associates to organize and moderate the roundtable, and we really tried to gather a diverse group of stakeholders, including representatives from expansion and non-expansion states, representatives from a variety of hospital types listed on this slide, a CMS representative, a consumer representative, and we were really fortunate to have two MACPAC commissioners, Dr. Retchin and Dr. Cerise,

join us. So they can let you know how well I do in summarizing the discussion.

All right. So let me first start with some of the themes that we heard about the roles of DSH today. First, participants noted how the role of DSH payments has evolved over time in different states alongside other state Medicaid payment policies. States and hospitals, at the roundtable really valued the ability to use DSH as a flexible stream of funding and many felt that DSH funding was sort of more flexible than some of the other Medicaid funding sources that they have.

For example, some participants noted how DSH payments can be targeted to specific hospitals for reasons other than their Medicaid patient volume, which is a little bit different from increases to base payment rates, which are typically applied across a class of hospitals and aren't targeted -- are a little more difficult to target to specific institutions.

States noted that they have often used DSH and non-DSH payments interchangeably, but they valued the ability to use DSH to provide supplemental payments in managed care. Upper payment limits supplemental payments

which are made under fee-for-service Medicaid, are not allowed in fee-for-service.

So although states have broad flexibility to decide how they use the DSH funds that they are allotted, participants did note that the size of state DSH allotments varies widely by state, and so this affects how DSH funding is used. And so in some states that have very large DSH allotments, because they had large historic DSH spending, they are able to use DSH funding to support a wide variety of hospitals in their state, while other states with historically small DSH allotments cannot distribute DSH funds as broadly and have had to use other Medicaid payment policies to help support some of these institutions.

And, the sort of flexibility that's provided by states is appreciated by some of the state stakeholders, but we also heard differences of opinion about whether, in some cases, DSH funds are being distributed too broadly and are not being as well targeted as they could be to the institutions that need them most.

Another theme that we heard was about the effects of the ways that states finance DSH payments on the ways that DSH funding is used in different states. So just as

some background, compared to other Medicaid expenditures, states are much more likely to finance DSH payments with contributions from providers and local governments. These include provider taxes and intergovernmental transfers, or IGTs, often from public hospitals. And at the roundtable we heard a number of examples about how state targeting policies were related to the source of non-federal share.

So, for example, some states choose to distribute DSH payments broadly in their state, to make sure that they go to all providers that are contributing to a provider tax. In other cases where states fund DSH payments with intergovernmental transfers, they may choose to target their DSH payments more explicitly on the public hospitals, which are often providing those IGTs.

We heard some similar themes in terms of DSH funding to state-owned institutions, such as institutions for mental diseases, and participants noted that, you know, if states didn't provide DSH payments to those institutions they'd have to use other state funds to support these state-owned institutions.

So even though we heard a lot about the role of financing in DSH policy, we also heard concerns among

roundtable participants about the effects of potentially federalizing DSH payments. That is what if states didn't have to provide a source of non-federal share and just sort of drew it down as a grant program? There were concerns, in general, with federalizing, that states may lose their ability to target funds, based on local needs, and there were also concerns about what might happen to the sources of non-federal share that states have been previously providing for DSH payments.

On one hand, some of the states that did provide state general funds for DSH may no longer use those payments for Medicaid purposes, which could reduce the amount of funding that hospitals could receive. And then, on the other hand, states that may be generating the non-federal share with provider taxes or IGTs may use that non-federal share to draw down other Medicaid funds, which could increase federal spending. So it's a real thorny issue, for sure.

The last theme I want to highlight is just about the consequences of uncertainty. We held the roundtable right before DSH allotment reductions took effect, and participants noted that the uncertainty that has

accompanied these DSH cuts was affecting their ability to plan for the future. The states represented at the roundtable had not yet developed their plans for how they were going to distribute DSH allotment reductions to providers, and part of this is because they don't know exactly the amount of DSH allotment reductions that they are going to receive.

And the providers were also uncertain about the future, but some reported that they were kind of planning for the worst-case scenario and sort of looking at services they may have to cut if their DSH funding were cut in the future.

All right. So now that I've sort of talked about how complicated DSH policy is, I want to share some ideas that we heard about the future of DSH policy and sort of long-term approaches to better align DSH with its original goals. I want to emphasize, at the outset, that there wasn't consensus among the participants about any particular approach, and that wasn't the point, but we heard a lot about the pros and cons of different approaches and how it might affect different institutions. And the idea of presenting this today is to sort of jump-start a

discussion with you all about where you would like to take our work on DSH policy, going forward.

First, there was interest in better targeting DSH payments to the hospitals that need them most by raising the minimum eligibility criteria for DSH from the current 1 percent Medicaid utilization threshold to a higher standard. Participants talked about different thresholds that could be used, but, by and large, the discussion sort of followed a lot of the same themes that you all have raised in our previous discussions of these issues. There is a sense that, you know, there was opportunity to better target DSH payments but there's also concern from states that they may lose flexibility with new federal standards, and there's also concerns that some types of hospitals might be a little bit different from the rest, particularly rural hospitals and institutions for mental diseases.

A second idea that we discussed was about tying DSH payments to quality rather than cost, to help encourage -- to help better use DSH funds to support access to care for low-income patients. Currently, as I mentioned, the total amount of DSH funding that a hospital can receive is based on the hospital's cost of uncompensated care for

Medicaid and uninsured patients, which has a couple of limitations that the roundtable discussed.

First, not all costs are included, so particularly these costs of care outside the hospital setting. A lot of the primary care and physician services that hospitals provide aren't included. And second, there's sort of this conundrum that some hospitals are in, where if they are receiving DSH payments up to their DSH limit, they are actually disincentive for improving efficiency. So if you're receiving payments up to the limit and you become more efficient, you receive lower DSH payments, even if you're providing the same amount of care to Medicaid and uninsured patients.

To help tie DSH payments to quality rather than costs, participants were particularly interested in a new approach that's being tested in California called the Global Payment Program, which was approved as a Section 1115 demonstration in December of 2015. The Global Payment Program combines DSH and other supplemental payments in the state into a new global payment for safety-net hospitals that's tied to quality goals. The costs of care outside the hospital setting are included in this global payment,

and over time hospitals are incentivized to reduce avoidable hospital use.

While the Commission has talked briefly about the California approach before, I think we heard a lot more at the roundtable about some of the underlying circumstances that enabled California to pursue this approach, which I think is worthwhile for considering if you're thinking about whether or not this approach might make sense in other states. So bear with me as I go through a little of the history.

So, first, about 10 years ago, California decided to target its DSH payments more narrowly to a small group of public hospitals, and it was able to do this, in part, because it increased non-DSH supplemental payments to some of the private hospitals that were previously receiving DSH funding. And so then, for this group of public hospitals, the state also made a change to increase its payment rates using what's called a certified public expenditure approach, and the net effect of this on paper is that it effectively eliminates the Medicaid shortfall for some of these hospitals. And so, for DSH purposes, it meant that the DSH funds were really being focused on care for the

uninsured, you know, and weren't being used to pay for Medicaid shortfall.

And then, finally, I think part of the impetus to convert payments for the uninsured from a cost-based payment to a value-based method came about as a result of the Medicaid expansion, which reduce the total amount of uninsured in the state to sort of a more manageable group of folks, and also the result of a variety of quality initiatives, such as the DSRIP programs that we've talked about before, which have really incentivized these public hospital systems to expand care outside the hospital setting and try to reduce avoidable hospital use.

And Toby and others can provide more background about the context. You know, each state is unique, but I think it's interesting to see how these pieces come together.

Although there was interest in the California approach, roundtable participants noted a variety of implementation challenges that are worthwhile to consider if this approach were expanded more broadly. Two, I just want to highlight: first, if you are going to include some of the costs outside of the hospital setting, you need to

figure out how you're going to actually account for those costs, and so not currently in a lot of these hospital cost reports. And second, to help tie payments to quality, you need to figure out how you're going to measure quality, which is a particular challenge for the uninsured since you don't have claims and other things that you might have for the Medicaid population.

A third big idea that we discussed was rebasing DSH allotments based on current measures of need rather than historical DSH spending. Roundtable participants discussed a variety of measures that could be used to rebase DSH allotments, such as the number of Medicaid and uninsured individuals in the state, and also where the state levels of hospital uncompensated care, either for all hospitals or for some subset of hospitals, such as the deemed DSH hospitals, which are required to receive DSH payments.

While most participants agreed that the current DSH allotments were not well distributed -- I mean, they're based on state spending 25 years ago -- there was concern about making changes to current allotments, in part because states have developed their existing payment policies

around existing funding level, and so any change sort of upsets that balance.

For all of these policies discussed, there were a few themes that kept coming up. First, participants noted the importance of phasing in any policy changes to minimize disruption for states and hospitals. This could be done by testing out new policies incrementally, such as the new demonstration in California, before requiring all states to adopt a new approach. And on the allotment level, participants discussed changing DSH allotments incrementally by phasing in rebase DSH allotments through the DSH allotment reduction formula, rather than changing state DSH allotments all at once.

And a final consideration, as I mentioned before, is the importance of considering DSH policy in the context of other Medicaid payment policies, particularly non-DSH supplemental payments, which we have mentioned, have sort of been used interchangeably with DSH in many states.

So that concludes some of the themes from the roundtable. In terms of next steps, we are required to report on DSH in our March 2018 report, and I plan to present some of our statutorily required analyses at our

next meeting. If there's interest, I can also prepare another report chapter that elaborates on some of the themes raised at the roundtable, particularly as they relate to some of these long-term DSH policy design issues.

To help facilitate your discussion today about the future of DSH and long-term goals for DSH policy, here are some considerations to think about. In the interest of time I won't go through each of them, but I'm really looking forward to hearing your feedback today and I look forward to incorporating it into our ongoing work in this area.

CHAIR THOMPSON: Thank you, Rob. Terrific presentation, as always. It sounds like it was a really fun roundtable.

Sheldon, Fred, do you want to jump in here first?

COMMISSIONER RETCHIN: Yeah, it was a great session, no food fights, and just some reflections and then I do want to bring Toby in as part of the discussion.

One quick reflection was the statement made by several, and actually in the note, I believe, Rob, was that the providers who were taxed might not like the fact if we were retargeting. And so I thought to myself, wait a

minute, highly taxed special interest groups should have determination in terms of the allocation of resources? And then I thought, God, it's America, Sheldon. Go easy. So, yeah, I think there unfortunately is a barrier, but I don't think it's something that should prohibit changes in policy.

Part of the roundtable and I think here at the Commission meetings we have spent a lot of time talking about targeting, and I think we should -- we're going to continue to do that.

That said, states are going to bite, scratch, and kick to continue to have the flexibility to allocate DSH on their own. We might as well face that. I don't know -- I still think we should be able to influence it. So far, the measures don't seem to have an absolute delineation. I think 1 percent is a little -- that's a pretty low bar to jump.

But one of the things that we did talk about was the commercial percentage, that is, that would maybe delineate some of these hospitals. And, Rob, we don't have a complete data set, but there might be some opportunity to look at that.

But let me just transition to a different theme and then bring Toby in, and that is the discussion around is this a time to take stock on policy around funding for vulnerable populations. DSH is an entry card for that, but it then wraps in all the supplemental funding, not to mention the funding comes from local counties, 340B. So there's a lot of sources for funding that we can't get our hands around.

But as a Commission, perhaps we ought to take stock and determine where we're going. Anne had a conversation with me earlier in the week about thinking bold.

[Comment off microphone.]

COMMISSIONER RETCHIN: I know, but you pumped me up. In fact, the next-door neighbor was playing really loud music, and I went -- I actually pounded on their door, which I hadn't done. So I appreciated the coaching.

But to look at some of the things that MedPAC has also done in terms of some principles around integration, and I think that the discussion we just had is apropos to be able to encourage transformation of the system from what we currently have, which is very fragmented, not to mention

fee-for-service based, to something that would be more coordinated, that would improve access to care, and also integrate the clinical fragmentation that we have between hospitals and provider groups.

So I do think there was a lot of interest in the global payment program, which was absolutely brilliant and insightful and a progressive vision of the governor -- no, so, Toby, maybe you could help transition that and tell us a little bit more about --

COMMISSIONER DOUGLAS: Yeah, sure, and Mari Cantwell, the Medicaid director, this is her -- she's the one who really gets the credit for this.

It does fit into, you know, the previous discussion on FQHCs. I think in California, Medicaid has been the push really trying to move -- look at all the different supplementals and how do we move it more to a value-based approach and try to get better incentives between where the services are and the broader total cost of care.

You know, Rob had it right around the reasons we did it, so I think first it is important to just put the context of -- similar to what you just said, Sheldon, it's

the taxing entity. So these are public hospitals only, and it was a way for them to retain the dollars in their system. So there was a lot of incentives on how to reshape the DSH because they're uncompensated care was going down in a way that it stayed in there.

That being said, it was done with the right policy goals in mind of, okay, let's reshape it, but incent for care to be provided in the right place and the right setting. So moving it from this idea that only could be uncompensated in the inpatient to use it across inpatient and outpatient and really forge broader system delivery reform with over time more ability to be paid for providing services that are outpatient, that are targeted on interventions, rather than ending up in an emergency room and inpatient.

COMMISSIONER RETCHIN: So it's a point system.

COMMISSIONER DOUGLAS: And it's a point system for that, so they're rewarded, and the values of the points are more heavily weighted to where we as a policy want care to be provided. And it gets more weighted over time, over the five years in that direction.

So I think it really is, you know, as hard as it

is to redistribute, I think from a policy standpoint, it's where we need to think about DSH like any other of the conversations we're having on PPS or any -- how do you create the right incentives for the delivery system to forge the relationships? And, in fact, Ralph was talking -- when he was talking about the EHR, that's because of the intersection between the GPP, this program, and the outpatient clinics and the hospital wanting to work and figure out how to bring in a broader delivery system. So the more that the financing can do that I think would help do it.

COMMISSIONER RETCHIN: I'll just jump in. As a result of the payment program, have -- I know you've left, but do you know, have there been changes in structures or is it just the way the payment flows? Have providers come together with hospitals in a different structure or do you know?

COMMISSIONER DOUGLAS: Well, definitely, I mean, at the delivery system, for example -- and Rob -- I can't remember which of the staff highlighted Santa Clara Valley Health and Hospital System and the changes that have gone on there, the same going on, you know, new ambulatory

outpatient clinics presenting in Alameda, the L.A. County system continues to evolve and create more outpatient and building out their e-consult structure, so ways to do services differently.

Now, some would have happened organically, so I don't -- you know, I don't want to say it's all because of -- but it's an intersect between the DSRIP and GPP, the global payment, and all of these moving away from cost-based to more of a value-based approach.

COMMISSIONER CERISE: Yeah, so a couple of observations. One, when Rob was talking about federalization, that was part of a discussion I hadn't really heard a lot about in the past, and that is, you know, do you maybe take the state share out of the formula? And the reason -- he gave all the reasons why that probably won't happen, but the reason it comes up is because it's a program with federal dollars and largely local or some other source of dollars, non-state dollars, where then the state's directing that. And, generally, it is probably one of the least strategic payments that you can imagine. And, yeah, it's evolved over time -- or maybe it hasn't evolved over time. You know, it was established -- what? -- in the

early '80s and where the rest of health care has kind of moved along to much more outpatient, preventive services, integrated services across a continuum. This has stayed there. That's kind of a plug number for hospitals and states use it very non-strategically to satisfy providers and kind of boost up insufficient base payments in a lot of regard.

So it's not -- I think there's plenty of room -- I've read the Commission's previous work, and there's plenty of room to target these payments better, and I think, you know, as Sheldon said, 1 percent is a pretty low bar on Medicaid to say, you know, you're really hitting hospitals that have disproportionate share of Medicaid or low-income individuals. So I imagine we could come up with some recommendation that did target better.

And with that, though, I wouldn't just pay attention to the percentage of low-income or Medicaid, but also how you use the payments, and that's the discussion that these guys were just having, because I don't think it's too much to ask that you're using the payments in a way that furthers a strategic goal, and you can expect -- hospitals have integrated and formed ACOs. They've

coordinated with other providers outside of the hospital to get better outcomes. And you can do the same thing with the uninsured, and you can have those expectations with the uninsured. You can enroll them in a program. You can track them. You can track outcomes. And so you can move away from these blind payments to something with outcomes and expectations, but I would just be careful that those outcomes are really tied to not only quality but to real access and to -- when I say real access, not just, you know, a number on a page but really be able to show they're connected to primary care, they're connected to specialists, they can get diagnostics, they can get services that are not just default ED drop-in service but they're really part of a system of care.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: I totally agree with what you said, Fred, but we can start at a real basic level and say that only -- recommend that only hospitals that are participating in Medicaid, whether it's with health plans and/or on the fee-for-service side, are eligible to get DSH. I mean, we could put the bar -- I mean, that's just a very low bar, in my opinion. I think we should go further,

like you said, but not all states even have that requirement. That was the one thing we did, and it allowed us to have --

[Comment off microphone.]

COMMISSIONER GORDON: In order for a hospital to get paid, they had to be participating in the networks of our health plans. And so that's why we have all hospitals participating in our network. So we didn't have an access issue there.

But I totally agree, I think there's some basic steps we can take to progress to something -- I mean, if we're moving to value-based purchasing in other areas, this should also be looked at through that lens as well.

CHAIR THOMPSON: I was struck in reading -- I mean, I think, first of all, the roundtable results and some of the issues that you raised about, like if you're trying to think more globally about this, what issues arise for you, I think it's very helpful. It also -- I mean, it really is a roundtable because it just keeps making you kind of run around in circles. And I was just struck by how the roundtable participants all acknowledging the places where it doesn't really do this and it really isn't

that and probably needs this, but don't touch anything, because we've created this huge hardened system, and if you -- there's a game, right, that you pull out the --

PARTICIPANT: Jenga.

CHAIR THOMPSON: Jenga, right, that it felt like they saw that as a big risk. And so while -- you know, in thinking about what this Commission can do, I can appreciate the point about maybe we should spend a little bit of time trying to design in rather than design out, right? So like what are we trying to accomplish and what are the goals? And how does DSH fit into that along with these other things? That might be a useful thing.

You know, I'm also conscious of this is -- you know, that starts to expand the world and expand the things that you get into and the complexities and the complications and the degree to which states have made different decisions and how they've taken some of these different streams and put them together and so forth. So I'm a little worried also that taking that approach sort of causes us to get confounded by all of those variations and complexities, especially if we don't have a really strong evidence basis for a different model that we think is, you

know, objectively correct. So I just put it out that that's a worry.

I also think that, you know, the California experiment is very interesting, and sort of some of what we have talked about in terms of the ability of states to innovate and experiment and then to evaluate and determine what worked and didn't work also suggests perhaps letting California work a little bit and seeing how that starts to play out and thinking about how that gets picked up or transported to other states or not.

So that generated some interest. So Stacey, Sheldon, and then Marsha.

COMMISSIONER LAMPKIN: Yeah, I would just say I would like to see us consider a two-track on two different timelines investigation here where maybe there's something that we can suggest on a shorter time frame that relates to targeting, still leaving states flexibility in distribution, which I think is important, but maybe there's a little bit of improvement there, but longer term not necessarily to get there in a year, but over the course of a two- or three-year work plan where we really look at hospital financing and the distortions or the crazy stuff

that's developed over something like locking states in at their spending level in 1992, or whatever the year was, and how that's created this other system of crazy payments to kind of pack around that really doesn't make any sense. It's not something that we're going to have a recommendation for in six months, but can we start to unpack those pieces, learn more about the supplemental -- the non-DSH supplementals at the facility level as we can get data on that to really complete the picture and try to work towards a bigger, bolder recommendation here.

CHAIR THOMPSON: Can I just pulse the rest of the Commissioners on that characterization of sort of the shorter term and then a longer term and the level of interest in that kind of a dual-track approach?

COMMISSIONER CARTER: I think with the -- there's so much at play right now. I mean, we've got CHIP and Medicaid and Medicaid expansion. By the way, the FQHC funding hasn't been reauthorized. So there's so much at play that I think there's not much appetite for big changes, and it's really risky for big changes.

CHAIR THOMPSON: Go ahead, Marsha.

VICE CHAIR GOLD: I was going to say I think we -

- I'd benefit by a little more discussion before we decided it was short term/long term. I mean, I resonated very much with the way you were describing the situation, because I was thinking that, too, and I had a couple of thoughts, which I'll say after Sheldon, you know, says his. But I don't know if that -- I don't know how that fits into a short-term/long-term scenario, but I very much -- I kept thinking this is crazy, and then they keep saying, well, we can't change it because it's crazy. And then it will be crazier. And I say, well, what if we just say it should do what it says it was going to do and phase it in and make it do what it says it was going to do? It said it's supposed to be disproportionate share, so, okay, maybe it should be disproportionate share because that's what it says, and we know it's going to screw things up if we make it change, so we'll give it time.

But then I am a little -- there was a very subtle difference, Sheldon, between the way you were talking about California and the way, Fred, you were talking about hospitals. I'm very reluctant to make things even more complicated than they are already by putting quality on top of DSH when it really should be part of payment. But there

are ways, if it's dealing with the uninsured or things like that, that may work, because I'm kind of afraid that we may fix it by making it even more complicated than it started out. And maybe I already said what I said I would say after you said it.

[Laughter.]

VICE CHAIR GOLD: But, anyway, I don't know how that fits into a short-term/long-term scenario. I clearly see the need for a phase-in of any change, and part of me is just, dammit, if the law says it's supposed to do X, maybe we should say, well, then I guess it should do X, even if it's disruptive.

CHAIR THOMPSON: Sheldon, then Chuck.

COMMISSIONER RETCHIN: Yeah, Marsha yields her time.

[Laughter.]

COMMISSIONER RETCHIN: So, you know, I don't disagree that we ought to let California play out. That said, I mean, we just had a discussion about this, that there is one thing we know that works, and this is not true of where the DSH payments are going, but that is people do much better in the health care system if they have a

physician, and there are a number of DSH hospitals that are getting DSH funding all it goes for is for that care that comes through the emergency room. Others are creating a system of care with providers. And so just the identification of a physician and the encouragement, and all the things that that leads to -- I don't disagree that going to a provider community that already was receiving and is short on reimbursement, 50 percent of Medicare, and to say, hey, we want to throw in some quality metrics, can be problematic, but I think creating a system where people have doctors is worth -- and that may be complicated but it's worth the complication.

CHAIR THOMPSON: Chuck and then Bill.

COMMISSIONER MILLIGAN: I just want to go back to Stacey's comment for a second. I think, in some ways, the short-term and long-term naturally comes from the fact that there's a DSH report due every year and there are expectations that we say something when it's delivered every year. And maybe it would be helpful, just -- so we're going to have to do something when the DSH report is delivered in March, and it might be just a helpful reminder about the expectations and requirements around the delivery

of that report.

EXECUTIVE DIRECTOR SCHWARTZ: The requirement is not to have policy recommendations of any type. The requirement is do a certain set of analyses on the relationship between the DSH payments and allotments and different other metrics -- uninsured, hospital's delivery of essential services. So we can do that without your having decided too much, and we can also do that in March, and do another policy chapter in March. We can do another policy chapter in June. We could do March and not do another policy chapter until the next March. So you have a lot of flexibility.

COMMISSIONER MILLIGAN: And thank you for the reminder, Anne. And so I guess, Penny, what I would suggest is we should work backwards and not necessarily in this conversation but work backwards and determine if we want to say something more than just "here's the report" in March and a subsequent March, and sort of to think about the short-term, long-term around when the DSH report itself is delivered.

CHAIR THOMPSON: What are the -- Bill, jump in.

COMMISSIONER SCANLON: I mean, this relates, in

part, to what Marsha was saying about sort of original intent and to, Sheldon, what you just said about sort of where a good investment could be made. I mean, I think we go back to original intent. I mean, the reality was that hospitals were then, and continue to be the provider of last resort, and because of EMTALA, they have no choice. And so the idea is, I think, that we recognize we have a segment of the population that's uninsured, we're not willing to kind of bring them into some full insurance program, but we want to at least compensate sort of these hospitals that disproportionately serve them, and we know that there's going to be disproportionate service because poor people that don't have insurance are going to be located probably in areas -- concentrated in certain areas, and so, therefore, certain hospitals are going to have a bigger role.

But this whole issue is a lot -- I mean, like the waiver discussion this morning was almost an introduction here. We have created something that is so complicated over time, every one of the additions that -- and complications that were talked about, there may have been a good purpose for that, at the moment, and either it, you

know, when added in kind of complicates things, or it's been distorted as we've gone forward.

So this idea of how to disentangle it to go back to sort of an original purpose -- and we have to think, is there a need for that original purpose? You know, compensate hospitals for disproportionate share since they remain providers of last resort. That, I think, needs to be addressed, and then we can think about moving forward and saying, okay, other investments -- how do we do sort of well with them, in terms of meeting other goals? And this idea of sort of improving health, improving quality may be sort of other goals that are not conceivable to accomplish within the DSH funding.

CHAIR THOMPSON: Fred.

COMMISSIONER CERISE: So just to that point, I think what you'll find is that those hospitals that are disproportionately caring for this population, most of them have already developed those programs that Sheldon's talking about, because, practically, you've had to do that. And so those two things will go together naturally. When you start selecting out ones that have higher percentages of low-income, uninsured, and Medicaid, they're going to

have built those connections, which is why, when you spread this, like you said, peanut butter, I think, in one of your reports, you're picking up a lot of hospitals that have very low percentages and therefore haven't built the infrastructure to deal with it. And so you're paying ineffectively because you're not getting to the problem.

COMMISSIONER SCANLON: And in doing that and spreading the money too thin you may actually not be accomplishing your original goal. I mean, that, I think, should be part of it. And what the hospital does with the funds after they've gotten them, I think, is another issue.

COMMISSIONER RETCHIN: Well, and, Bill, like we've said on many occasions here, I mean, in a lot of the funding there are perverse incentives. There are no incentives to create -- I mean, many systems have -- Denver Health, Parkland -- but many haven't. There are perverse incentives to bring them through the ER, to not set up those, because you can't get reimbursed.

CHAIR THOMPSON: So I think that the idea of bringing some of the larger considerations or the complications of larger changes around DSH into focus, whether we do -- whether we pick that up and decide to

continue on with that work or not could be helpful to people. I think I also hear that there is some appetite for trying to grapple with some of these more, let's call them -- I mean, they're not to the affected hospitals, but micro level improvements that would ensure that the DSH funding is going to, you know, particular hospitals that are bringing the biggest benefit to the program.

Though I remind ourselves that as we've looked at this data over the last year, we have not coalesced around some obvious methodology. And so, you know, I think that if we want to take one more run at that, that's okay, but, again, part of our discussion has been, do we have a significant argument for a different method that would take away some of the current structure that people have built around, that would take away state flexibility, and I think we ought to be careful and conscious about that.

Any other final -- Alan.

COMMISSIONER WEIL: Yeah. I worry about going after you because I think you said that just right.

If I remember right, the DSH statute says states shall set up -- shall make supplemental payments, so it gets all to the federalism stuff. Yes, it's messy. So is

everything else.

I'm -- my -- I like, I think it was Chuck's point that, you know, the short-term is set by the statute that requires the report. Frankly, I think we might not comment on DSH every year if we didn't have to. But I'm not sure what the long-term is, and I guess I want to at least weigh in to say without a little clearer picture of the what the long-term, given everything you just said about how we don't really have a gravitational pull towards some fix to this, I think if we want to get into bigger issues of quality incentives, of integration -- but I wouldn't do long-term on DSH, because I don't think DSH, by itself, is amenable to a long-term discussion.

CHAIR THOMPSON: Although I think that Stacey's argument was DSH in the context of a larger conversation about hospital.

COMMISSIONER LAMPKIN: Absolutely. It was total hospital financing through Medicaid.

CHAIR THOMPSON: Right. So just with that clarification. Okay.

Okay. Great. Thank you, Bob. We can just not get enough about DSH. I think we're okay.

All right. So we have our final session. Moira is going to come talk to us about the RFI from CMMI.

REVIEW OF REQUEST FOR INFORMATION ON FUTURE OF CENTER FOR MEDICARE AND MEDICAID INNOVATION

* MS. FORBES: Thanks, Penny. So I'll quickly give a little bit of background on the Center for Medicare and Medicaid Innovation -- I know Karen talked about it a little bit this morning -- walk through some of the provisions in the Request for Information that they sent out a few weeks ago, and then ask you to talk about whether MACPAC wants to provide a response to that RFI.

So the Center for Medicare and Medicaid Innovation, which they also call the Innovation Center or CMMI, was created by the Affordable Care Act to test innovative payment and delivery system models to maintain or improve quality while slowing the rate of cost growth. The ACA specified a number of specific models for CMMI to test, which included medical homes, all-payer payment reform, and payment models that transitioned the system from fee for service to global payments.

Some of the ones you may have heard of, some of the big models that come out of CMMI include the Financial

Alignment Initiative for Medicare-Medicaid dually eligible enrollees, the duals demos. There's the Medicare Quality Payment Program, which is replacing the Medicare Sustainable Growth Rate formula. CMMI has sponsored a number of major payment and delivery reform demonstrations, including all the big ACO demonstrations, the State Innovation Models--the SIM grants--the Comprehensive Primary Care Initiative.

Medicaid initiatives have included the Medicaid Incentives for the Prevention of Chronic Diseases model program, the Strong Start for Mothers and Newborns initiative, and, of course, the Medicaid Innovation Accelerator Program, that Karen Llanos talked about this morning.

On September 20th, CMMI announced that it's considering a new direction, including more focus on patient-centered care and market-focused reforms, and they requested stakeholder input on several specific models under consideration, and they issued this RFI, you know, sort of broadly to the entire health policy community. A copy of the RFI is in your materials. Stakeholders have been asked to submit comments by November 20th. MACPAC is

not required to provide comments or response to Requests for Information, but it, of course, may do so.

The RFI announcement stated that, as I said, CMMI is considering a new direction for models that are sponsored specifically by the Innovation Center. They did list six guiding principles that they have indicated they will be using to assess their new models, and this -- these are what they have said are their guiding principles. You know, it's sort of unclear at this point. This was an early sort of vision for the new direction, but this is the kinds of things that they're thinking of.

The RFI also asks for input on eight specific potential models that cover a range of different health care delivery areas. Most of these are general areas, again, that they've indicated their interest in. These aren't so much specific models, like ACOs. But, they're interested increasing opportunities for eligible providers to participate in value-based purchasing arrangements, which are referred to as advanced alternative payment models in Medicare now and for increasing the number of payment reforms that involved specialty providers. They are interested in facilitating and encouraging price and

quality transparency; in testing new models for drug payments in Medicare and in Medicaid, providing Medicare Advantage plans and states more flexibility to innovate; for enhancing physical and behavioral health integration, particularly through payment reform; and developing new program integrity approaches that balance burden and effectiveness.

They have asked respondents to provide feedback on design issues such as how these guiding principles can be applied to different models, options that CMS could consider for reform beyond fee for service and Medicare Advantage, and how CMS can involve beneficiaries more. They have also asked for input on technical issues such as potential challenges and risks in the different models, and what waivers might be needed.

So while the Commission could choose not to respond, if you want to submit something we've drafted some potential areas that you could choose to include in your materials. While much of the focus of the RFI is on Medicare payment and delivery system reform, they've included some questions about Medicaid payment reform, and MACPAC has, you know, through a number of prior projects,

identified a number of findings relevant to the potential models described in the RFI.

So we prepared a summary of some of these findings as they relate to four of the specific models listed in the RFI, and the Commission could submit something like that, just to share that work and get it in front of CMMI, since they've sort of put this RFI out there and they're broadly soliciting input, and since they may be putting more grant opportunities out there for states.

You could also comment generally on the Commission's views of the role of future federal support for Medicaid delivery system reform. This could include support such as federal investment in Medicaid delivery system innovation, including direct support, such as more grant programs -- you know, the SIM grants have ended. A lot of the prior Medicaid grant programs have ended but they may be thinking about future ones. It could include future technical assistance, more things like the Innovation Accelerator Program. It could include Medicaid participation in multipayer reform models or opportunities for Medicaid stakeholder involvement in the development of new models.

So that's it. I will turn it over to you. If the Commission decides to submit comments, staff can draft something based on your discussion today.

CHAIR THOMPSON: Okay. Marsha, if you want to jump in.

VICE CHAIR GOLD: Yeah. I generally like the approach that you're sort of laying out. There's one additional thing that I think we may want to say, which is sort of to reinforce the fact that a lot of the things going on right now have taken a lot of energy on the part of the provider community and the public sector and states, and that we know, from a lot of evaluations of all these innovations, that this takes time and it's hard. And I think it also is fair to say that a lot of the innovations that are moving along are, at least in Medicaid, pretty consistent with some of the goals that they have, especially patient-centered care, the emphasis on primary care, the emphasis on multi-payer collaboration and work with states.

And that in whatever they're doing to redo things, it's important to make sure that they're -- that the current activity, to the extent it's -- it matches

future goals, is important to avoid disrupting it too much, because it changes things.

So I'd hate for them, for example, just to retitle something to put it under a new box, and people have to get together again and call it that, if what the people are doing in the field, where all this happens, still make sense. And I think a lot of it probably does, to emphasize primary care, value-based payment, and things like that.

So I don't quite know how we say that, but it's a pretty strong finding, in every evaluation I've done, of how hard it is to get people to move in a direction, and what's happened through CMMI is that slowly people have. And I recognize that there are some things, especially in Medicare, which isn't our purview, that are pretty controversial. I think a lot of what's going on, either in Medicaid or in a multi-payer perspective, is still very much consistent with what they want to happen here, and it needs to keep being supported so that people don't get jerked around, actually.

CHAIR THOMPSON: I wanted to comment on the idea of encouraging CMMI to seek input from Medicaid

stakeholders on payment and system delivery reforms, focused on Medicare, because of the overlap in provider networks, and I think we ought to be stronger about that. I don't think it is just helpful. I think there are actually some opportunities for states to move along inside the wake of what Medicare is doing in a payment innovation, relating to certain provider groups. I think it's also possible that Medicare can follow along in the wake of Medicaid, in some cases.

And so I think I would just want to strengthen the characterization of that idea about it might be helpful to consult, to, you know, we think that it is an important element of the success of the model to ensure that, to the fullest extent possible, where Medicare and Medicaid can be working together, that they're doing so. And that requires some conversation in those cases where even if it's not, as you say, a Medicaid-specific model, it's still a model that's going to exist inside of a state affecting a lot of providers, and I think that the state having a view into that and an opportunity to participate in that can only strengthen that potential innovation and experiment.

Okay. We've got Toby, Sheldon.

COMMISSIONER DOUGLAS: So a couple of points. Just on the dual eligibility, I think it's really important for us to call out the importance of the duals office, and that it's not -- that it has been very effective in influencing both, you know, new approaches, and rather we'd want to see that to be -- continue to build off of that, rather than to go in backwards. I think, just partly, make sure it's clear, the importance of that office. I'll just leave it at that.

The IAP, again, I think we should really strongly support that, because of all the different initiatives underneath it are a lot of the ones that we're focusing on.

But I would add, I think this is an area where we need to be -- recognize that the state capacity and that there could be investments building off of the IAP structure to support states in actually being able to execute and to build these systems in partnership, and it could be more, you know, CMMI or SIM-like grants for those who are participating in IAP.

CHAIR THOMPSON: Mm-hmm. Okay. Let's see. I've got Sheldon, Chuck, Alan.

COMMISSIONER RETCHIN: This may be a little off

kilter but just maybe, in one of the comments, looking at CMMI, some of the models of care that they promote, is it worthwhile to make at least some effort at differentiating Medicaid? And I'll just do it in one area, which is the idea of -- which I think it catching a fair amount of enthusiasm -- is consumer-directed care. And I think it's moving in a, at least from a Medicaid standpoint, the whole notion of HSAs, and some other incentives. But where transparency is really probably not going to do as much as it will with other payers.

And I think just in, for what the "A" stands for in MedPAC versus MACPAC, is very different. Our concern is really access. So I just make that point of the consumer-directed care model and market-based innovations is difficult when you have such a thin provider community.

CHAIR THOMPSON: So just to be clear about what you're suggesting there, are you suggesting just placing a warning about “let's be careful there with these populations?”

The one thing I'll say is that, you know, it's not an area that we have spent a lot of time on, so I'm a little concerned about getting out in front of our skis on

that.

COMMISSIONER RETCHIN: So, yeah, and you don't want to lean back too much on the skis either. But I think you're right. We haven't spent a lot of time on it, and maybe that's just, in itself, a notation. We haven't spent a lot of time on it. These are models that are being promoted, and I think for the Medicaid population we ought to look very carefully at them. I think it's a good thing to do.

CHAIR THOMPSON: All right. I think I've lost track. My notes are scribbled over. Chuck and Alan. Thank you. I can tell it's the end of the day, with my little list.

COMMISSIONER MILLIGAN: It's okay. Me and Alan were tracking for you.

So I support sending comments. I support sending comments like you've outlined, Moira. Thank you for doing this. With Toby, amendment to maybe the second bullet. The way I would frame it is, consideration for Medicaid participation and support with infrastructure-building, where necessary, for multipayer reform models, because participation only gets you so far if CMMI isn't also

giving some consideration to whether the states have the capacity and have resources to do it. So to me it's a way of tying in the IAP conversation earlier. But I like what you've laid out here and I think we ought to send comments.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: A simple comment and then one that's probably not doable in the timeline that we have. You know, we do have, as part of our CHIP recommendation, this integration notion, and I think we thought of that mostly as an eligibility, which wouldn't quite be a CMMI thing. But I have to think there are also delivery system elements to it, and to the extent that we could sort of refer back to our own sense that this is a priority, that seems doable.

The one that's more complicated, that I haven't really thought about until I saw the materials, Moira, CMMI has this unique provision where if the chief actuary determines that something is cost-effective, it can be expanded and extended. To my knowledge, that's not been used yet on anything related to Medicaid. And I would just wonder -- as I say, this is probably too complicated for a letter to be prepared quickly, but I wonder how that might

work and whether we might be helpful in thinking about that, because it's obviously very different to change Medicare payment, you know, extend an ACO model, than it is a demo that's being done in a state to other states. I'm just throwing it out there.

CHAIR THOMPSON: That's a good question. To my knowledge, actually, only one model, in Medicare --

COMMISSIONER WEIL: Right. That's to my knowledge as well.

CHAIR THOMPSON: Yeah, yeah. But that is a good question, that issue about, and then what in terms of diffusion and decision-making about elsewhere.

Brian.

COMMISSIONER BURWELL: I'm just throwing this out. I'm not sure it's a good idea but I'm interested in what other people think. Might this be an area where we combine forces with other groups interested in new Medicaid models, like NAMD or NASHP or NASUAD? I mean, I'd be interested in making calls and seeing what they're thinking is around this, and whether they intend to propose some Medicaid-oriented models in response to this RFI. I'd just be curious.

EXECUTIVE DIRECTOR SCHWARTZ: We can call around. I'm not aware but, I mean, that's a simple thing to do.

CHAIR THOMPSON: Just remind me, Moira, on the date. When is this due?

MS. FORBES: November 20th.

CHAIR THOMPSON: Okay. So just in terms of being able to take any other thoughts or perspective into account while we formulate something, we wouldn't have another chance to come back and do that. But I think certainly as a point of information to Commissioners.

DR. SCHWARTZ: Yeah, and also, if you have ideas that other organizations are sort of -- if what you're saying here is similar to what other organizations are saying, then that is a point that is easy to --

CHAIR THOMPSON: You can reinforce it, yeah.

DR. SCHWARTZ: -- to reinforce.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: I agree with what's been said. On the IAP, I just would not want it to be that that's the only pathway, you know, you've got to go through that door to be able to get that. But, I mean, I think it's a -- there's a nice relationship there between those,

but you don't have to go through the IAP to do that, because some states are further along than others, as she was describing, that can still use some support to go to the next level.

On the consumer direction point, I'm a little leery about going down that path because I think if you look at it -- it depends what you're thinking here and what that looks like, versus a lot of different things that states can come up with that might actually think differently about. And I just say that because I've heard a lot of different variations within that, that actually help promote some of the things that folks, from a quality perspective, a better understanding of how the system will work later but also cognizant of where people are on the income scale, and that it's a way to potentially, you know, use those, like an HSA-like account to avoid out-of-pocket cost for certain things.

So I don't think it's -- I think you just have to be thoughtful about it, and so I'm a little leery of saying you take that whole thing off the table, because I think there are things that can -- okay. I just want to be clear.

CHAIR THOMPSON: Okay. Any final thoughts? Comments?

[No audible response.]

CHAIR THOMPSON: Thank you very much. Okay, we'll now open up for any public comments on any of the afternoon's proceedings or of the day's proceedings.

PUBLIC COMMENT

* [No audible response.]

VICE CHAIR GOLD: What we doing wrong? No one's commenting.

CHAIR THOMPSON: Okay. Thank you very much. We are adjourned.

[Whereupon, at 4:12 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Friday, October 27, 2017.]

PUBLIC MEETING

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

Friday, October 27, 2017
10:07 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
MARSHA GOLD, ScD, Vice Chair
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
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:07 a.m.]

CHAIR THOMPSON: Okay. I think we're ready to get started, if everybody could take their seats.

We have a panel on state experiences with managed long-term services and supports. Kristal is going to introduce our guests, so, Kristal.

PANEL: STATE EXPERIENCES WITH MANAGED LONG-TERM SERVICES AND SUPPORTS

* MS. VARDAMAN: Good morning, Commissioners. Today I'm pleased to be able to introduce a panel of distinguished guests with a wealth of experience in the administration of managed long-term services and supports, or MLTSS, programs. Over the past several years, the Commission has engaged in issues surrounding states' increased adoption of MLTSS on several occasions. In 2014, MACPAC staff and contractors conducted site visits to five states to better understand MLTSS program design, implementation, and evolution. This past April, the Commission heard a summary of research conducted on network adequacy standards for home and community-based services and contracts between states and plans.

In addition, we have incorporated considerations unique to MLTSS into much of the Commission's work on long-term services and supports, including research on functional assessments and access to residential care settings.

Finally, the Commission has work underway exploring the unique needs of individuals with intellectual and developmental disabilities, or IDD, enrolled in MLTSS.

In today's session, Commissioners will have an opportunity to continue this discussion by hearing directly from experts on states' successes and challenges with MLTSS.

Our first panelist is Michelle Herman Soper, Director of Integrated Care at the Center for Health Care Strategies, or CHCS, where she works with states, federal agencies, and health plans to improve care delivery and financing for dually eligible beneficiaries and those in need of long-term services and supports. Ms. Soper directs CHCS' efforts in the Integrated Care Resource Center, a technical assistance resource for states, and the Promoting Integrated Care for Dual Eligibles and Advancing Value in MLTSS initiatives.

Next you'll hear from Curtis Cunningham, the Assistant Administrator of Long-Term Care Benefits and Programs at the Wisconsin Department of Health Services. Mr. Cunningham is responsible for long-term services and supports programs for the elderly and people with disabilities in Wisconsin's Medicaid program. He administers the Family Care managed care program, the Include, Respect, I Self-Direct program, several community-based waivers, and support services for children with disabilities.

Our final panelist is Sue Kvendru, coordinator of Senior Managed Care Programs at the Minnesota Department of Human Services. Ms. Kvendru helped design and implement Minnesota's integrated care programs and has served as a coordinator of the Minnesota Senior Health Options Program, an integrated care program that has been in operation since 1997. She also leads the Minnesota Senior Care Plus MLTSS Program.

Each panelist has been asked to make brief remarks, followed by some time for Commissioners to ask questions and engage in discussion. The panelists' remarks will center on several areas, including: states' use of

MLTSS as a tool to integrate care for dually eligible beneficiaries, the needs of individuals with IDD in these programs, and how states are assessing program outcomes.

In addition to this dialogue with panelists on these themes, Commissioners may also wish to use the discussion time to set priorities for new staff work to build upon its existing body of work.

And with that, I will turn it over to our first panelist.

* MS. SOPER: Good morning. My name is Michelle Soper, and I'm the Director of Integrated Care at CHCS, and I just want to say I'm really, really honored to be here. I used to work on the MACPAC staff and was one of the first members, so it is just a real honor to be back here to present to you all today.

So I'm going to talk about, just give you a very brief overview of CHCS, and then tell you about two projects and related findings that we have done recently that look at understanding value of MLTSS, and then quickly I'll talk a little bit about one of the predominant ways that states are using MLTSS platforms to integrate care for dually eligible beneficiaries, and then turn it over to our

state panelists.

So, very quickly, CHCS is a nonprofit health policy resource center, and we work with a wide variety of stakeholders, primarily state Medicaid agencies, to help improve health care for low-income individuals. We also work with the federal government, some health plans, and providers, and the team that I lead focuses on projects related to Medicare-Medicaid integration and long-term services and supports delivery.

So just very quickly, again, why are we looking at MLTSS? This type of program is expanding rapidly throughout states. In 2004, eight states had MLTSS programs. Now we count 21 states with programs and two more that are launching in 2018 -- or, actually, I should say Virginia just recently launched its MLTSS program in its first region a couple of months ago, but they will be completing their transition in 2018, bringing the state total up to 23.

I wanted to take a minute to review some goals for the program. So why would a state want to implement an MLTSS program? One of the two projects related to value that I'll tell you about in a moment was a state survey and

issue brief that we did in partnership with NASUAD. We hypothesized what some of the goals would be for implementing an MLTSS program and then surveyed states to confirm whether or not those goals were right and also to determine how they were meeting those goals. And these are the four predominant reasons that states decided to launch these programs, either to meet all of these goals or some of them. So rebalancing services towards the community was number one across the board; improving how members reported their quality of life; also influencing health outcomes with the assumption that improved LTSS would increase clinical outcomes.

A few states wanted to launch these programs to reduce waiver lists and increase access to services across the board; and then also to improve budget predictability with a capitation rate to better rein in the costs that they had for MLTSS programs.

This is sort of an aside, but this also underscores the importance of setting accurate rates for these programs, given the high needs of this population.

So we focused on trying to understand the value of these programs in two recent projects that we've done.

Given the broad expansion of these programs, we really thought it was important to understand, you know, what are the goals that they're actually meeting? Are they actually meeting these goals? And how can we continue to drive value in programs that are expanding rapidly for a high-need population?

There's not a lot of evidence out there right now that these programs are working, and there is a lot of anecdotal evidence, but there is limited objective published research that actually has formal success stories at these programs. There's also limited comparison across states, so we did the project with NASUAD to try and collect some of the research that might be out there in states to try to bring it to the forefront and put it all together in one place.

In addition to focusing on MLTSS programs at CHCS, we also do a lot of work on value-based payment initiatives, which is, as I'm sure many of you know, another trend that has really taken off in health care and in Medicaid generally. Most of the value-based payment work, though, happens on the primary and acute-care side and is less targeted towards higher-need populations.

So we decided to work with some states on another project, which is the state learning collaborative on the slide below, to try and assess whether or not states are interested and are implementing value-based payment models to help improve paying for value in these programs, and, again, to understand what are the challenges of implementing these models in MLTSS and what can states actually do with these. So those are the two areas that we've been focused on.

And so what we've found so far, for general findings related to the study that we did with NASUAD, we found that eight states out of the 12 that we surveyed reported that they were able to promote rebalancing in their programs. More than half of the states collected information on individual and family satisfaction. Some of this is anecdotal, but several states, more than half, were able to collect evidence that these programs improved physical health outcomes.

We also found that just over half of the states had some evidence that these programs were reducing the cost growth in these programs as well.

So that project concluded in May. The value-

based payment project is still underway. In fact, we just started a couple of months ago. But we were able to do a scan, an environmental scan of some leading MLTSS states, some health plans, and other health policy experts to try to understand the landscape of value-based payment efforts in MLTSS programs right now. We found that they're limited, not surprisingly, that most state efforts are tied to broad contract requirements. So there are a few states out there that have, you know, some contract requirements for their plans that they have to have a certain percentage of payments to providers in alternative payment models or they have to have a certain number of programs that advance alternative payment models.

There's some limited activity, a little bit more activity but it's still limited in the plans, and that most of these activities are focused in nursing facilities. But there is great interest to expand these models to the community, which is where we decided to focus the rest of our project, which will be underway over the next year, to really understand how to put these models in community-based settings.

One consideration that we found that I think is

really interesting and something that we'll continue to explore is really defining "high value." There's such a wide array of ways that you can define quality in MLTSS. Is it clinical outcomes? Is it functional outcomes? You know, is it a more subjective understanding of whether or not an individual is satisfied with their services? It's really difficult, and there's not a lot of agreement even on the quality measurement side. So not having that standardization makes it difficult. Also determining whether -- how to define program efficiency when an MLTSS program is supposed to be person-centered, and somebody might see less services as less efficient. So those are some of the challenges we're working through right now.

And then a couple more challenges we found. Generally with states' ability to demonstrate the value of their MLTSS programs, the lack of standardized quality measures across programs is challenging. State resources are limited, and collecting this data is very resource intensive, so that is definitely a challenge. Attributing health outcomes or other outcomes specifically to MLTSS programs is also quite difficult.

Lastly, there's not many states that have

collected some baseline information before program launch, so there's limited ability to compare a pre and a post to, to determine what impacts the program did relative to where beneficiaries were before.

On the value-based payment side, the biggest issue is getting providers up to speed, especially HCBS providers, and getting them prepared to participate in different models that have different reporting and quality and potentially risk-sharing responsibilities.

Some considerations for states is to make sure you have enough resources, whether you are launching a broad-based program, like launching MLTSS, or a relatively smaller endeavor, like a payment reform. Making sure that it's staffed sufficiently throughout the entire process is really important. Having that baseline measurement is important to incorporating stakeholder feedback throughout the whole process, can really make or break a program. Then understanding the system and provider landscape, and this is, again, something we're really interested in exploring in this value-based payment project.

We got a lot of comments particularly from plans and providers that there's a lot of squeeze going on in the

system. There's a lot of different initiatives, and states, when they're implementing these programs, should be very, very clear about what their few most important goals are and really dedicate the resources of all stakeholders to meeting those goals, because there's just a lot of competition for resources right now.

And then, lastly, including Medicare in the value equation is really important considering the high percentage of dually eligible beneficiaries in these MLTSS programs, and when you're investing heavily in LTSS and most of the savings are potentially accruing to the acute-care side, that can be a challenge for states, too.

So I'll quickly just go through the next point, which is how states are using MLTSS programs to integrate with Medicare. I know that you are familiar with financial alignment demonstrations because I believe Tim was here a couple of months ago to talk to you all. So I'm just going to focus on another model that is becoming a predominant model, which is using a Medicare Advantage Special Needs Plan as a step towards greater integration.

All D-SNPs, Medicare Advantage Special Needs Duals Plans, must sign a contract with a state agency in

order to do business in the state. So states can have an opportunity there to set requirements that a D-SNP has to offer a Medicaid MLTSS companion plan, or they can require Medicaid plans, before signing a contract with them, to offer a companion D-SNP plan. So even though states can't mandate enrollment on the Medicare side, because you can't do that for Medicare, they have the opportunity to create a situation in which a plan offers both a companion Medicare and Medicaid product and can facilitate enrollment into the same product.

This is a very broad generalization, but we look at integration through this platform as a trajectory. Starting with an MLTSS plan only, this is a potential way to improve access to HCBS and promote rebalancing, like we talked about, but there is no real connection to Medicare or the services that individuals who are enrolled in these plans receive through Medicare.

Then there's basic D-SNP contracting, so D-SNPs are in 40-plus states, and all of them have contracts with the state. These contracts must include eight minimum requirements, but, frankly, the requirements don't go very far. They're very, very basic, and they just have, you

know, very rudimentary integration requirements, and they don't do a lot to facilitate coordination across the plans.

The extent to which a state decides to include requirements in the contract in addition to the minimum requirements can really pave the way for integration. D-SNP alignment and MLTSS alignment is what I just mentioned before. When a state requires that plans that do business in their state to offer both a Medicare and Medicaid product in the same plan to provide the opportunity for an individual to enroll in both products would be the next step. And then a fully integrated D-SNP, or FIDE-SNP, is what we consider to be the most integrated. This is a special designation that plans have to apply to CMS to receive. States can require that D-SNPs in their states become FIDE-SNPs. New Jersey, for example, requires that. And this ensures a higher degree of administrative alignment and also requires that these plans provide LTSS and have a single care plan across Medicare and Medicaid.

It's possible for a D-SNP, an MLTSS-aligned plan to reach that amount of integration without the FIDE-SNP integration, but that's just a way to help ensure it.

And I think now I'll turn it over to the states

who can talk about their experiences with that.

* MR. CUNNINGHAM: Hello, and thank you for having me today. My name is Curtis Cunningham, and I oversee the long-term care programs. I've been doing this for about four years, but what I'm presenting is a much larger initiative that has been going on with multiple very talented people before me creating the system in Wisconsin that is probably -- when we talk about MLTSS in the new states going forward, we've been doing MLTSS for about 17 years. So I wanted to give you some highlights of that and what our model looks like and talk about some of the systems with IDD, and then some of the barriers we are still facing in regards to getting to a fully integrated plan and my thoughts on integration versus alignment.

Family Care and Partnership are both capitated models. They were established in 1998 as a result of -- with two goals in mind: to increase -- and you mentioned this -- to increase the people moving into the community out of institutions, and then also to increase the number of people we can serve by taking the savings that we achieve through MLTSS and moving them out of the institutions and reinvesting that savings into the

community-based services to serve more individuals.

A long-term-care system design is a prescriptive model. When you read our contract, we do have a methodology that we expect our plans to use in assessing the needs for our individuals. And a big key and organizational component is we have our ADRCs, our Aging and Disability Resource Centers. They are responsible for the intake and counseling and enrollment counseling for all individuals that are going to come into our long-term-care system. In addition, they do the initial functional screen.

One part of our long-term-care system is, first off, let's try and mitigate people coming to the Medicaid system first by giving them options counseling, making sure that if they can get their needs met through the community, through other resources, that they do do that. And then you have a functional screen, and you have to be functionally and financially eligible for Medicaid.

MCOs started as quasi-public entities. Actually, what we did in '98 was started five pilots that the county-based waiver agencies, we then created districts which were quasi-public and capitated those districts. And then as of

last year, all those districts now have converted to nonprofits. So, again, it takes 17 years to do that stuff, so I just want to caution this is not a quick thing to do.

Inclusion of the state plan services, we include all long-term care services in our waiver, 28 benefits, so very comprehensive HCBS services, and then we include the 15 associated state plan services like therapy, DME, and other things that a long-term care member might need.

Strong encounter system, submission, quality management, obviously this is important for any system, but we do have a very good encounter system and very good infrastructure to support our programs.

I think the other thing is a vision that all people can live in the community.

There are no opt-outs for our MCO. Any individual that enrolls in our MCO has to be served by our MCOs. They can be in a nursing home, but it's very few, and really, the MCOs are required to move those people into the community.

And I say this because when you get into IDD and other situations where you have potentially sexually violent predators, aggressive behaviors, violent behaviors,

we still require MCOs to take those individuals and help them live in the community.

Emphasis on natural supports. This is really important when you have a system in Medicaid. We want to make sure that the first thing they're doing is natural supports or unpaid supports.

So our system and our resource allocation tool first looks at natural supports and how those can be used to support the person. Then only after that does it look at what paid supports are needed to wrap around that. I'd mention later I have some concerns with eroding that.

And the big key for the counties in this model, the big selling point, was if the counties move to this, their obligation for the long-term care population and the expenditures would be borne by the state, and their county would move towards entitlement for all target groups, frail elders, DD, and physically disabled. So they were already contributing a lot of money. So the tradeoff was the state takes it on, and then they don't have that obligation.

Our model includes strong contracting and quality expectations. It includes a functional screen, and that functional screen is key not only to assessing need but

also setting our rates. Our rate model has a high R-squared value relative to other MLTSS rate models.

It has a resource allocation decision tool. That's that process that I was talking about how to determine a person's needs.

It is based on the outcomes of what the individual needs, not on the services the individual needs.

Person-centered approach. That focuses on outcomes. There's a high-risk funding pool. We found with the IDD population that there's an uneven distribution of people, and we had some individuals that are over $250,000, so we establish a high-risk pool to mitigate the negative financial consequences for taking on those individuals.

Strong oversight model including -- well, we have a contract monitoring team and a quality oversight team and a best practices integration, and collaboration with MCOs and advocates obviously is key to make sure this model works.

So what are the results of our MLTSS model since 1998? In 2000, 49 percent of Wisconsin long-term care population was in the community. Now in 2015, 80.2 percent live in the community.

In 1998, there are 11,000 individuals on the wait list. By July 2018, the last two counties will be eliminated -- well, it won't eliminate counties.

[Laughter.]

MR. CUNNINGHAM: But it will eliminate their wait list to reach entitlement for all target groups. So I think I can probably say Wisconsin will be one of the few states that will cover anybody with developmental disability. Frail elders or physically disabled adults will all have access to HCBS services if they qualify for Medicaid.

In addition, we're eliminating our children's wait list. That's another presentation for some other time.

In 2015, 65 percent, Wisconsin ranked tenth in the nation for Medicaid HCBS expenditures as an percentage of all long-term care expenditures. I think nationally CMS, they just had a tipping point where they got past 50 percent nationally.

And then lastly, the AARP scorecard, we ranked sixth overall in the nation and received the Pacesetter Award for choice of setting of providers, and that's really

because as we roll out our long-term care system, people have access to HCBS providers as opposed to institutions.

I will say Minnesota, I think you're -- yeah, dang it. Well, we got a little competition, a healthy competition.

So MLTSS final thoughts. It provides a great service delivery model, but there are some concerns. And there are some concerns I think people need to really think about. Two of them are when you have an RFP and you procure for an MCO and then your incumbent MCO loses or there's a failure of an MCO, these are highly vulnerable people, and what happens is, all of a sudden, once that RFP is announced, that MCO that's there starts to collapse. And so you need to understand that long-term care people are receiving services every day, and so those methodologies of how you manage transitions are very important.

Same with contract compliance. You must understand how there is an escalation process and a termination process that is smooth and can make sure it's member-centered, so that there's no break in coverage.

And then move slow to go fast. Like I said, this

took us 17 years. This is not something that was done overnight. It was a progressive thing, and advocate and member buy-in is key.

I wanted to speak a little bit about the IDD population target groups. Since we include all target groups, it spreads the financial risk. By far, IDD is the highest cost, about $4,000 per member per month, and so having it all together spreads risk for the MCOs.

Focus on meeting their needs. Our model is person-centered, and the RAD, it basically says if the person needs it to meet their outcome, you've got to provide it. So you get away from, well, is it a covered service, or is it not? You need to provide it.

And so you need to make sure that those services to meet the different target group needs are incorporated and being promoted. Supported employment, community integration are very important for the IDD population.

Best practices team, where you've got movement on community-integrated employment.

Complex behavior workshop with counties and others, police and law enforcement.

High-risk pool, I mentioned, and then behavioral

health screening, we just recently added. And that will allow us to look at the attributes of the behavioral health screen.

Our attribute model for rate setting, we actually correlate the cost to the functional attributes of the individual. So with this behavioral health screen, we can use that data to be more accurate.

Quality strategy on the next slide here. We're currently under the development of a large quality strategy. Now that we've reached enrollment, it's the question of how do we really go down the road of making sure there's high-quality care, and so this just illustrates that at every level of our process, we are looking at the whole person and looking at measures that address each level, the MCO, the statewide, our contractors, and our programs. And then we want to also do a consumer dashboard reporting.

We have a scorecard. It's available online, looks at the whole system. We are implementing Pay for Performance for customer satisfaction in our 2018 contract.

We have a Coalition for Collaborative Excellence in Assisted Living. Assisted living is a huge spend. It's

about half our spend in our long-term care system, and actually, we're starting to get close to spending just as much in assisted living in HCBS as we do in hospitals in our Medicaid program, and it's very -- how do we quantify quality of that system? Just another little step. Forty-one percent of our Medicaid budget goes towards long-term care services, and I really think that's why people are waking up to looking at MLTSS.

We used National Core Indicators. We have a customer survey, consumer dashboard, and EQRO.

So the quality strategy here is that we want to have a list. We went through and did a scan of all the measures we collect on individuals in MLTSS -- or long-term care, and there are 406 measures. That includes Medicare measures. That includes our oversight of our residential. It includes our Medicaid measures, the CMS 372s.

I guarantee you that it's not a problem with having enough measures -- or data, okay? We've got the data. The question is, How do we put that together in a comprehensive organized strategy?

So this is what we're looking at here. We have the behavior drivers, and then you have the goals. For

example, we want to increase customer satisfaction. So we're introducing the concept of leading indicators, which a lot of our measures are. They're all process counts and things, looking at grievances, appeals, complaints, and then moving up through doing P4P, NCI surveys, customer satisfaction. And then you get there.

Barriers to integrating Medicare and Medicaid. Savings again, Medicaid investments accrue to Medicare. I will say partnership is a great model. We want to go there, but it is an aligned model. It is not an integrated model in the truest sense because the buckets of funding are still different, the contractual obligations are still different. So I think it still could be more integrated.

Medicare's lack of funding and administrative flexibility, I think we've seen some of that in the demos.

Medicaid must still maintain alternative long-term care models. Voluntary enrollment in Medicare. Partnerships already exists. Medicare and Medicaid models -- is a medical model -- Medicare is a medical model. MLTSS is a community model. No shared vision between Medicare and Medicaid.

I think one of the things, we're trying to push

these two programs together, but maybe we should step back and say what is the right model and then go from there for looking at some of this stuff, the thoughts I have.

Long-term care services affect medical care, and medical care affects long-term care services. It's obvious.

Data exist to understand the benefits of integration. We have started to receive the Medicare data. We've done some analysis combining our data. I think it's there for people to look at, and I think some big brains can go and look at what are the potentially preventable readmissions, what are the complications that you're seeing across, and at least start to look at that.

I'm concerned about some of the regulations that potentially could inhibit the flexibilities of managed care, EVV, and a lot of this is also with workforce. We have a big workforce issue, but in lieu of requirements now, for example, have to be specified in the contract prior to the year. That's a problem for if you want to just be there to meet the needs of the person.

Problems with room and board and affordable housing. If the member can't pay the room and board

portion, then it's a threat to keeping them in the community.

And then commoditizing natural supports. You need to keep natural supports.

Member-centered approach is key to sustainable cost-effective model. This includes integration of natural supports, long-term services, medical services, housing, et cetera. This is a member with a whole bunch of needs, and how do we wrap around to make that happen?

Again, probably more of a personal statement, but we're currently building systems in silos top down, and we need to be refocusing to build the systems from the member's perspective up, so I'll leave it at that.

And if you ever have any questions, feel free to contact me, and feel free to give me a call because my email is a mess.

So thank you again for having me.

* MS. KVENDRU: Good morning, and thank you for inviting me to participate today. I am excited to be here. My name is Sue Kvendru, and I coordinate our Senior Managed Care Programs at Minnesota.

I am going to attempt to give over 20 years of

history in 10 minutes on 10 slides of Minnesota's integrated programs, and so I've had to kind of pick and choose of what to tell or talk to you about. But I'm always excited to talk about what we've done in Minnesota.

It's been helpful to have Michelle and Curtis give some preliminary information that actually applies to Minnesota. We've participated in all the studies and information that Michelle did present.

I'm concentrating on our senior programs. That is where we've done our integration in Minnesota. Our Medicaid managed care program does require our seniors to enroll in Medicaid managed care, but they can opt out of the Medicaid-only program and enroll in our integrated MSHO, Minnesota Senior Health Options Program.

Our Medicaid-only program is called the Minnesota Senior Care Plus, just for references.

The services that are provided through MSHO include all of the Medicare, Medicare primary and acute care, dental, behavior, long-term care supports, HCBS waiver services for seniors, and 180 days of nursing facility care. So if you see that list, we are a fully integrated dual eligible SNP program.

The services that are provided through our MSC+, which is our Medicaid-only program, include all the Medicaid-covered services but also include our LTSS and waiver services and that 180 days of nursing facility care. We started with our integrated program and putting the MLTSS services in that and then moved it to our Medicaid-only program after its success, and seniors in all settings of care are included in our program.

Now, interestingly, even though our MSHO, which is the integrated program, is the voluntary program, 74 percent of seniors in Minnesota have chosen that as their program to receive their services, and 26 percent of those eligible are on the MSC+, which is the Medicaid-only program.

Just talking a little bit more about our MSHO program, we have been operating that integrated program since 1997. It was the first -- one of the first, I guess, Wisconsin, and Massachusetts, I think started similar programs around the same time.

We actually achieve our integration through Medicare through the MIPPA contracts and coordinating benefits, all those Medicare benefits in one program. We

have a Medicaid contract that tries to incorporate and build on the Medicare program.

We are actually operating under a demonstration. That's a fancy title to “Align Administrative Systems for Improvement in Beneficiary Experience” with CMS. We signed that demonstration authority in September of 2013. It was extended again, and we are waiting for a second extension, which will extend our demonstration through 2020.

It is a unique demonstration in that we are working on administrative alignment. Some of the problems that Curtis talked about with Medicare and Medicaid and integration, we continue to work with CMS on some of those ways of overcoming some of those alignment problems.

We've worked hard and long on one set of materials, one enrollment form, one enrollment date, carrying one card. I've always laughed about putting that in one little paragraph like that, but I tell you I've spent over 20 years doing just that one paragraph. And it's never, never ending, and as I said, I could talk for hours just about one set of member materials. So it's funny to see it just written as one little phrase on there.

We do a state assessment, which is required

within 30 days, which incorporates the health risk assessment. It has been long our goal to have a single assessment for our members, not having a Medicare assessment and a Medicaid assessment, and so that in and of itself has been a struggle as well.

And the cornerstone of our program has been a care coordinator and care coordination. Back in the '90s when we were starting our program, nobody used the term "care coordinator" and "care coordination." I always laugh. We should have trademarked the term or something. We could be wealthy. Not that you could, but really designing flexible care coordination delivery models, and it's really that that pulls together the LTSS in the acute care services, is through that care coordination. And our health plans have worked really long and hard in doing that.

A little bit about that assessment. Early on in our health plans, we have that concept of doing a health risk assessment before it became a requirement on the Medicare side, D-SNP side, and our plans came to us and said, "We're finding so many people who need these services. Can we just use the state's LTSS assessment as

our health risk assessment?" So that idea actually was born before any of this came to fruition, and so Minnesota was actually able to lend some ideas to what that health risk assessment should include and how to incorporate some of those into one, one assessment.

So taking what's making the most out of integration in Minnesota, it's, you know, we've always looked at the Triple Aim across our Medicare and Medicaid programs. That's what our health plans use, even incorporating -- even though that seems to be more of an acute care model, they really do take that Triple Aim across all services. Minnesota long knew that decisions made by the primary and acute care, paid under Medicare, would drive state Medicaid and LTSS costs, and that's why we got into the business of doing integration. The state knew that we needed to get into the Medicare business in order to effect those costs.

And so combining them is just the first step. You really have to align those delivery services and the arrangements across those settings. You can't just have LTSS providers doing their thing and acute care providers doing theirs.

And so in my remaining minutes I'm just going to talk a little bit about some of the practice incentives, rebalancing, and improved outcomes we've seen.

We have a system in our contracts that we've called integrated care system partnerships. It was really building on some of those value-based purchasing initiative that obviously health plans have long ago created as a way of managing care, particularly on the acute care side. And so we were interested to see if they could expand that into some of their other -- with other providers, particularly LTSS providers and some of our behavioral health, using the D-SNP platform and combining those opportunities across the settings.

As Michelle stated, it is difficult to introduce some of those VBS initiatives into some of the LTSS services in the same kind of way, and so a lot of it has been building off some of the things the state has already been doing across our provider settings, particularly in nursing facilities in some of the VBS service provisions that we've created on our fee-for-service basis, and having our health plans kind of build on that and use some of the same outcome measures.

We just have a real formalized report card for our nursing facilities in Minnesota, and just a couple of days ago we were rated as -- given an A rating, one of only two states, for our report card. And so many of our health plans have used some of that information to then, in turn, contract with nursing facilities to build on some of those outcome measures that they already have to meet for, you know, on a state-wide basis, but then the health plans can build on those existing outcome measures. It's kind of an example of how we've been building on some things that do currently exist.

As far as rebalancing, this slide shows, you know, similar to Wisconsin, and from 1996 to, this slide says 2012 -- I do actually have the 2016 numbers that continue to show -- but you can see we have almost a complete reversal of people that were in the nursing facility in 1996, was over 60 percent, and that has basically been replaced by people in the community.

Now during this time period, the state was doing, you know, service provisions, you know, assisted living was being developed, to a large extent, but also during this time we were moving our elderly waiver into managed care.

So we always used our managed care plans to implement the policies that the state was creating. So we, you know, we can't give our managed care plans 100 percent credit for the rebalancing but they were the ones who are implementing the policy, I guess, is the way that we like to state that.

So we are quite proud of the rebalancing efforts, and as I said, the trend continues. We now have about 20 percent in nursing facilities and the remaining 80 in the community, so it almost matches what Wisconsin is seeing.

Lastly, I want to just remind folks about a study that was done in 2016, by HHS. This is the details of that study. I always want to give credit where credit is due. But it was really comparing our MSC+ program, which is our Medicaid-only program that has LTSS in it, remember, and our Minnesota Senior Health Options program, which is our integrated program, and it was the study years from 2010 to 2012 that they compared our data across settings.

And what they found, first of all, is that -- and we kind of knew this, but very few MSHO people dis-enroll. Once they're in the integrated program they stay. But we have a lot of movement from our MSC+ into MSHO, and then once they're in MSHO they stay there.

And these were the results. You can read them, but they were quite significant, particularly they were 48 percent less likely to have a hospital stay, 6 percent less like to have an ED visit, 2.7 times more likely to have primary care, no more nursing facility admission, which is always -- you know, people say, "Oh, they're going to just put them in a nursing home." But then related to MLTSS, they were 13 percent more likely to have HCBS, and then use of -- less likely to use the assisted living, which is, of course, kind of the nursing home of today.

And so we were very, very pleased. You know, it's kind of things that we knew. It's, you know, anecdotal. You know these things but until you have a study that shows that, we were very, very pleased with these findings.

So leading, finally, to the challenges, it's kind of what I alluded to. Integrating Medicare and Medicaid is never done. You know, we seem like we have something fixed and one side or the other changes a policy that we have to kind of continue to redo. Integrating and using Medicare and Medicaid data is very complicated. We have gotten the data. We have it kind of sitting, but now it's needing to

get it in our state system and making it used. We are really hoping to replicate the study that I just spoke about for some future years, and so that really is on our docket.

Related to quality measures for a chronic, elderly population, the average age of our MSHO population is 80 years old. So, you know, it's like people live long in Minnesota. A lot of people say it's because it's so cold, we're just well preserved there. I don't know if that's the case.

[Laughter.]

MS. KVENDRU: It is snowing there today, so I'm glad to be here. But back to the measures, the measures that exist just really are not designed for the population so we really have some difficulty there. And then many of our providers are very small and their real capacity to participate in any value-based purchasing is very limited. So when you're really trying to look at some quality things it does get to be quite difficult.

And so I just want to say thank you for my time, for your time, and my contact information is there. Thank you.

CHAIR THOMPSON: Thank you, Sue. Thank you, Curtis. Welcome back, Michelle. That was very useful and very helpful. I think that gave us a lot of different things to think about.

I'm going to ask Brian to kick us off in terms of our round of questions.

COMMISSIONER BURWELL: I get to use all the time, Penny?

CHAIR THOMPSON: No. No, that's not what I said, Brian.

[Laughter.]

COMMISSIONER BURWELL: Sorry. Thank you all for coming. As you may know, this is an issue near and dear to my heart. I really appreciate you taking the time to come.

I guess the one question I'm going to choose to ask has to do with care coordination delivery models. It's also a real issue. Various states think about this in different ways. The care coordinator is no doubt an extremely important person in the consumer's life and kind of the link to the plan and the person who the consumer interacts with most directly. Some people think that the care coordinator has to be an employee of the plan itself

in order to facilitate coordination. Some people believe that the care coordinator should be independent of the plan, so that he or she can continue to serve more of as an advocate for the consumer. And there are a number of different delivery models used.

I wonder if you'd just comment about the care coordinator delivery models used in your programs and your own personal opinion about, you know, the relative advantages of different models.

MS. KVENDRU: I can address that. On my slide I said we had flexible care coordination models. I think we've probably used any and all of the type of models. Early on, we really didn't have a model and so we kind of said to the plans, "Ooh, come up with what you think."

And so currently we do have, within a health plan, we probably use various models. I don't think any one health plan has one model, because we needed to have capacity. We were a county-based system, you know, and we still are, and so initially in our rural areas many of the health plans actually subcontracted with counties, and so the counties became delegates of the health plans. So just kind of think about that and how interesting that was, and

continues to be.

But, over time, many of the health plans, in order for capacity and in order to accommodate all the primary care docs that wanted to participate but couldn't necessarily provide the care coordination did. Some of our larger plans did create their own care systems per se, to provide that care coordination. We also have used community agencies, particularly with some of our cultural -- provide some cultural competency within that.

And so we have many, many different models of care coordination within our MSHO program. To your response of which one is better, I -- you know, I could not say. They each bring to the table their uniqueness and I think that within a health plan they also appreciate that. They try to have a common model of care which is required under the -- as a D-SNP, and so they have that common vision of what their model of care is and expect whoever is providing it to provide care coordination in that similar fashion.

We have always promoted that our care coordinators are advocates for the members, and that's in our contract. And so health plans really have had to

create firewalls if they, in fact, are employees of the health plan, to provide -- so there isn't that conflict of interest. And so we have not had that.

So I don't know. I know that's a lot of information but that's kind of how we've created it in what it exists currently in Minnesota.

MR. CUNNINGHAM: In Wisconsin, we really focus on what is called an interdisciplinary team. So that is the case manager, social worker, and an RN, and then the member, and then anybody that wants to, you know, that member wants to be there. And that is the interdisciplinary team that works to develop the care plan. So it isn't just a case manager and, you know, and the member.

So, and the other thing is that I talked a little bit about the outcome-based model. You know, you'll get a lot of people coming in and saying, "Well, my -- I don't know, my elderly mother needs assisted living, because, you know, she can't live at home." And, really, the outcome-based model questions that, and through this interdisciplinary team process says, "Well, you know, let's talk about that. Why does she need to be in assisted

living?" "Well, she can't make her lunch or can't make dinner."

So then you talk about, well, okay, you know, maybe the daughter makes lunches for the kids every morning and they could put the lunch in the fridge for the grandmother and do that. And so that's a natural support. And then maybe at dinner you do need to have services come in. But it's this outcome of wanting to still live in the community that drives that.

And then we also have denial process, that if, then, there's a denial of assisted living, then that does go and the member has the right to appeal.

COMMISSIONER BURWELL: So the member -- so, you know, somebody's going to come to the house and provide personal care services, and the consumer has a complaint about that person's behavior or whatever, is there one person that that member can call?

MR. CUNNINGHAM: There's -- yeah. So there's -- there is a care manager in the MCO. It's part of the MCO. That's the only service --

COMMISSIONER BURWELL: And is it a member of that team?

MR. CUNNINGHAM: The -- yeah, it's the member -- yeah, they are a member of the interdisciplinary team.

CHAIR THOMPSON: I'll go with Alan and then Chuck.

COMMISSIONER WEIL: So, it's a comment more than a question. I was struck, Michelle, you started with what I would agree is true, which is we don't really have an evidence base, and yet it's hard to call what we just heard after your presentation not evidence. And so I'm trying to think how we can play a positive role at MACPAC in this.

I got a call from a reporter yesterday, asking -- who's doing some investigation in a state that's in the middle of this transition, and the first question, of course, is, "Is going through MCOs good or bad?" as if there's like an answer to that question, because it all depends on the how.

And so I'm thinking, although we're a little late to the party with 22 states, that's still not quite at the 50 percent mark. It does seem to me it could be very helpful for us to weigh in, along the lines, I know, of the support work that you are doing, on sort of the precursor to the definitive research answer. You know, we don't have

clear quality measures for many of the populations. Most of these weren't designed as experiments so you're going to have limitations.

But I still think there's a lot we know about what ingredients are necessary to increase the odds of success, and it just seems to me that given -- again, some states, I think, have moved out in front of that, but given where that first map shows us, there's still, I think, a real opportunity for us to weigh in. I'm not sure where that would go in terms of sort of recommendations, in terms of federal policy, because I'm not sure I can map there, but this just feels really important to me.

CHAIR THOMPSON: Chuck and then Bill.

COMMISSIONER MILLIGAN: Thank you very much. I think they were great presentations.

So a little bit of context on me first. I'm in New Mexico. I'm with a health plan. We have MLTSS. We have a D-SNP. I think, Curtis, it's more of an aligned model than an integrated model, so just context.

Two questions and I'll ask them both, and really, Curtis and Sue, they're for you. The first is, in New Mexico, the state, it's not a FIDE. It's, you know,

individual options and then we integrate stuff at the plan level -- single model of care, single member record, single HRA, all that stuff.

But the challenges are really in rural and frontier areas, for a couple of reasons. One is it's hard to get a D-SNP approved by CMS in some of those, for geo-access reasons, and it's a very difficult lift. And I won't get into a lot of the details but there are some counties we just can't get to in an approved D-SNP. And it's harder, in a lot of rural and frontier areas, to get physicians and others engaged. They're not as sort of embedded in the Medicare stars world and all of that stuff.

So my first question is if you could shed some light on western Minnesota or northern Wisconsin, kind of how you're approaching your integrated models with those complexities, especially on the D-SNP, CMS, and provider engagement sides.

My second question is that in our D-SNP, at my health plan, we also include partial duals, and so there, by definition, not integrated in that sense. They're, you know, Medicaid cost-sharing kinds of things but not Medicaid benefit kinds of things. But part of our thought

process is that it's to try to provide some supports for the pre-nursing facility level of care folks and to try to give some kind of delay-or-avoid institutional level of care. And I'm wondering what your thoughts are about how your states are approaching or thinking about partial duals and -- in your models, because by definition they're not integrated.

So those are my two questions.

MR. CUNNINGHAM: So in regards to rural areas, and, overall, I'd say we do have another program that's a self-directed program, and that's been very beneficial for the long-term care side.

That is one of the problems with partnership. In our state right now we only have it in about eight counties, because of the Medicare. We are going to look to expand that, but the reality is we had to establish family care as our statewide base program, because, for these vulnerable people, we cannot rely on Medicare certifying or not certifying an area. In fact, you know, in 2006, '08, somewhere around there, we did have an MCO that wanted to switch to partnership. They tried to and then Medicare did not certify that area. The MCO went under, and we were

left scrambling to figure out, you know, how to get a family care provider in that area, to serve those individuals.

So states need some base program, and then I see partnership on top of that, at least for now, because of it's an alignment and, you know, you have two programs and the state has the onus to make sure that no matter what -- no matter what Medicare does we have to serve those members.

Other things about -- so we are -- in our budget this year we are looking to expand partnership, and one of the things will be, one, do you get a D-SNP? You're looking 18 months out for a new, you know, plan to look at getting a D-SNP certification. And, you're right. It's not going to be statewide, because in the rural areas they're just not -- it's not going to happen.

In addition to the non-nursing home level of care, we have SSI managed care, which is just a medical side, and that's for non-long-term care. So, you know, trying to prevent movement into the long-term care system. And then we also have a category in our long-term care system that is a non-nursing home level of care. So if you

screen out at that level, you can receive state plan services through the Family Care program, and so that prevents, tries to prevent the movement into a more intensive program.

I would say that, just some stats, about 80 percent of all our individuals in our program, of the 65,000-plus, are dual eligibles and 20 percent are not. Especially in the IDD population, you have non-duals. So our model really serves everybody, and if Medicare is there, then the care is coordinated.

CHAIR THOMPSON: Bill -- oh, I'm sorry. Sue, did you want to add to that?

MS. KVENDRU: Yes. Interesting, I mentioned that we were in a demonstration with CMS. One of the components of that has actually been looking at network adequacy and testing health plans' networks particularly in rural areas and how CMS' model is not very flexible in that respect. And it has been quite interesting, needless to say. And when you are talking about a D-SNP where Medicaid is being added, we have to keep reminding the Medicare side that Medicaid has transportation, and Medicare doesn't. And so even if a provider doesn't exist within their miles that

they say, there is a responsibility of the health plan on the Medicaid side to get that person to that specialist. And so that was like kind of an aha moment to them about if you're really looking at an integrated plan, you maybe need to look at network differently.

So we've been looking, and, in fact, we're just doing it -- next week, that is when I have to look at the exceptions to our health plans. Our health plans also wanted a way of using telehealth, or we have some models in our rural areas where doctors are now going to some of our customized living, our assisted living, or to residential places and seeing people on-site. And the Medicare model doesn't allow to account for that either, and so CMS was really intrigued, and so we are testing through our adequacy some of those things.

So I don't know what they're going to do with that, but I know they're interested in particularly rural areas of how can CMS approve plans knowing that there's not all these specialists there, but that people will have access to them in maybe more unique and different ways. So that's just something I can offer.

As far as partial duals, we do not enroll them in

managed care, but we do have some programs, the pre-nursing home, we have an alternative care, we've gotten some transitional services approved. It is an important population because it does -- and we've had some programs, return to community and things trying to keep people from moving into that next level. So I do agree that it is an important area to look at.

CHAIR THOMPSON: Thank you. Bill.

COMMISSIONER SCANLON: Yeah, and thank you for coming. What you've accomplished in Minnesota and Wisconsin is incredibly impressive. In some ways I'm not surprised. I went to school in Wisconsin, and I've worked in both Minnesota and Wisconsin. But I also think that we shouldn't underestimate the length of time you've been doing it. I can probably trace it back to close to 30 years that there's been some activities in these areas.

Also, going to what Alan was talking about in terms of what we know with respect to the broader group of states that are doing this, there seems to be an element of what I'll call "special factors" that maybe sort of are helping your success or contributing to your success. And part of that, I think, is maybe that you've helped develop

sort of managed care, sort of entry into this area, because the one thing I think about when I hear about LTSS is do managed care organizations understand what they're getting into, because I don't think of LTSS as the same as health care, that it's different in a couple of ways.

On the provider side, you're dealing with nursing homes that in many areas have what I'll call "monopoly power," and the states have been able to sort of deal with that because the state has monopoly power, too, with the strength of Medicaid.

And on the home and community-based side, you know, you hear so often from people that are trying to access these services there really isn't a good supply side. It's not very visible. It's not very organized. And so the idea of sort of negotiating for services is problematic sort of in many cases. So I'm thinking that a managed care organization has a potentially tough job in terms of trying to sort of organize and operate sort of in this area.

And so, Michelle, I guess I'm wondering if you could have any information at this point about sort of how other states are working to try and, I would say, build

this capacity as opposed to sort of trying to simply contract out and assume that the capacity will be there.

MS. SOPER: So is your question how they work with health plans to demonstrate that capacity, or with an MLTSS contract?

COMMISSIONER SCANLON: To demonstrate, but also on an ongoing basis to assist, I mean, because my sense is Wisconsin is not a hands-off approach. For sure in Minnesota the same. I mean, it's the issue that there's a lot of ongoing sort of -- it's integration of another type.

MS. SOPER: Yeah, absolutely. And, I mean, I think that some of the most important lessons learned -- and I know both of you -- both of you mentioned this. Both, you know, in the design phase and implementation and then ongoing, very strong stakeholder engagement, and that includes health plans. You know, I think a lot of -- some of the most successful states that we've worked with in these programs have sort of a dual oversight but partnership relationship with the plans that they work with and, you know, will provide training, will help with resources.

I know Virginia, for example, which has just

started launching a new program, it's based on their financial alignment demonstration, but they've been working very, very closely -- they have ongoing meetings with their plans. They have dedicated a new -- they've actually reorganized their agency or the departments that focus on this to have a care management unit within their staff that actually deals with care management issues that the plans can come to in a non-punitive way. So it's not attached to compliance. It's a way for the plans to come to the state to help work through issues without fear -- I mean, of course, in an appropriate way. If there's a problem they address it. But without fear of, you know, the state taking compliance action.

Massachusetts is another example of a state that's done a lot of work in this area, and they have -- again, this is through their demonstration, but I know they've done a lot of work with their SCO program, which is for seniors, and it's a D-SNP MLTSS model where they have a council that's comprised of primarily consumers but also providers and other stakeholders, and they involve health plans in these meetings where they set the agenda and they work together to address issues that are brought to them by

the consumers in a way to continue to improve their programs.

So I would say that that's very important. You know, Tennessee is another state that comes to mind that has a very, very strong oversight and collaborative relationship with the health plans. We've worked with the state in many scenarios and also with some of the plans in that state. And the first thing that both parties, you know, will say is that that relationship and that back-and-forth and sort of open forum for suggestions and continuous improvement have been really, really crucial to helping them understand.

And then I don't know if either of you have comments on that as well. But that is very important, you know, especially understanding ties to the community and some of the social service needs that these individuals need that might not be obvious to plans that are built on a medical model.

MS. KVENDRU: I was just going to say I would concur about the partnership, you know, over the year with our health plans. You know, I think that over the time, you know, health plans have learned the community model,

but then the health plans have also been able to share back, some things back to the community model as to -- you know, there's learned experiences, and I believe the state has helped forge those conversations, but that it is really a true partnership with our health plans, and that just isn't a compliance role. I think you really do need that.

MR. CUNNINGHAM: Just real quick, I'd add, you know, you got to have a sense of what the mission values of the program are, because you're never going to write a contract that can address everything. In fact, you want to be able to have a contract that is very flexible, that if you need a face-to-face visit in the home once a year because it's an elderly person that's stable versus a highly vulnerable person where they want to -- you'd expect them to go in three times or four times, or every month, for that matter. And that's why, you know, also you have the relationship with the plans. You also have a contract oversight and then you have a quality oversight, and those two things, there's a distinction there, but quality oversight really is the one that talks about how to improve the quality, improve the services under the existing contractual framework.

MS. SOPER: Yeah, and just quickly I would add to that that, I mean, this is by no means solving it. It is an ongoing challenge, and I think that some of the states that we've worked with that are newer to MLTSS, one of the challenges that they have raised is that, you know, even when plans are meeting contractual requirements, they're managing to the contract and not going in all cases above and beyond where they should be going to really truly wrap their services around what an individual needs and, you know, embrace the true concept of person-centeredness, even though they're checking the boxes and meeting the requirements. So I do think that that is something that continues to be an issue.

CHAIR THOMPSON: I'm going to have to bring this to a close because we're at our time, and as expected, we could continue this conversation for many, many more hours. I want to thank the panelists for coming to address us and giving us such great presentations and food for thought, and we really appreciate your time.

I'm going to ask the Commissioners to stay for a second. Some people are eagerly looking for their break. But before we move on to the next session, just to have a

little bit of conversation among the Commissioners about thoughts on next steps around this subject and things that are drawing your attention where the staff can begin to do some analysis and research that could help us in that direction. Toby.

COMMISSIONER DOUGLAS: First, I want to second Alan's comments and direction. I think that could be a very useful place for us to play.

One area I'd explore, too, which is a distinction between the Wisconsin and Minnesota, is just the stand-alone MLTSS versus integrating it into more of an acute, whether it's with the Medicaid managed care plans providing acute services as well as with Medicare. So just kind of the importance of MLTSS stand-alone versus integration, you know, is a question whether that's essential elements.

CHAIR THOMPSON: Okay. Bill and then Chuck.

COMMISSIONER SCANLON: My sense would be that it would be helpful to in some respects provide sort of the information that demonstrates that LTSS is not just another service that you can add to a list of services for a plan, that there's so many unique circumstances about serving this population, the types of services that they're going

to get, that that should be taken into account.

And then I think it would be helpful to talk about best practices that have been developed to date. I'm not sure that at this point, since there's so much action here, that finding out what the prevalent sort of practice is would be very helpful, because I think it's going to be changing a lot sort of over time.

But there are, again -- I mean, this is almost like we're helping people think about this. You know, what are the issues? What are approaches to dealing with these kinds of issues? And I think you heard some good examples today. There are other examples, I'm sure, that are present in other states that would -- it would be an informative report for people that are thinking about this.

CHAIR THOMPSON: And that sounds a little bit like what Alan is saying, too, about what contributes to success. It's not necessarily a clear equation, but what are the elements or characteristics of action that seem to -- especially in the maturing systems, who have done some evolving. You know, we tried this, and we were here, and now we're someplace else, and what do those look like and how could those be potentially reflected back to states

that are in an earlier stage of development so that they can take the benefit of some of that learning?

Chuck?

COMMISSIONER MILLIGAN: One of the things I think would be a helpful element is to try to capture the lessons learned from these states around dual-eligible integration. We've talked about dual eligibles a lot over time. But I get new insights every time, and, you know, some of the insights about the geo access and physician issues that came up are not as talked about as kind of the single member card and grievance and appeals and membership information and enrollment stuff. But I think to the extent we can collect the determinants of a successful member-centered model, to help the success for duals and some of the lessons learned from these states and from the research from CHCS and others, I think to me, to help inform our agenda, potential recommendations, potential issue briefs, et cetera, around duals is where I think the work could best manifest.

CHAIR THOMPSON: Yeah, I thought your conversation with Sue and Curtis was very interesting around that subject.

Marsha, then Darin, then Brian.

VICE CHAIR GOLD: Yeah, one of the things -- and this is the question I was going to ask CHCS for their perspective on, but it seems to me -- you know, in the past I came at things from a Medicare Advantage perspective, so you think SNPs, which is the Medicare down. From the Medicaid there was financial alignment, and we've tended to focus on that. It seemed to me what I was hearing is there's sort of a convergence -- I mean, when you start talking about these different models, however you get there, you know, there's more -- less separation and more common knowledge, especially when you get into the fully integrated D-SNPs. And so I thought when we're looking at it, it's important to bring -- to see if that's true and to bring lessons from both of those into consideration. I mean, how many of the financial alignments demonstrations ultimately have gone the D-SNP route, and the D-SNPs, are they pulling things in? Because ultimately -- I'm not sure it matters which way you get there, if you get there, and then we can talk about it.

I also think -- I mean, these are two really experienced states. I'm more familiar with Minnesota, and,

God, what they've been doing forever, I mean, the feds messed them up for a long time, and the reason they needed a demonstration was to go back to what they were doing before the feds told them they had to be a D-SNP. And so I don't know -- and I think the more we can give a sense of how much things have advanced over the next few years, which types of states and what scale these demonstrations are, where the most immediate low-hanging fruit is to making this move further and over the long term what one needs to do if one really hopes to get more dual eligibles into a dually managed system, the better it would be, because I'm a little concerned with getting too far into all the weeds without keeping in mind the longer-term overall goals of where we're trying to get to.

CHAIR THOMPSON: Okay. And we're going to do Darin, Toby -- oh, you did. Darin, Brian, Sheldon, and then we're going to have to bring it to a close.

COMMISSIONER GORDON: You know, part of what I've seen from some states that have tried to venture down this path is not a -- and this was alluded to by the panel -- a full appreciation and understanding of exactly what they're wanting to achieve with their approach and understanding

their expectations, which then goes to helping the plans understand what's expected of them. And so, you know, as we went that process, there was a back-and-forth dialogue and is a quite detailed contract starting out. And so in some cases, we had folks in some other states call and say, "What did you mean by this?" They were taking that and just transplanting it. And that's not always going to work because we had a different approach, a different model, a different maturity on the other parts of the program before we layered that in. And so part of it is understanding those types of things, and I know CHCS is trying to help states gain that appreciation of what they're trying to achieve and making sure that they have the necessary components to take the next step. And you can do too much too quick. If you're going into, you know, the whole dual alignment and/or dual integration at the same time, that's probably too much. But it's kind of -- this is a hard one. I think it's absolutely the right thing to do. I think fully integrating and breaking down these silos is incredibly helpful when we saw those results, tremendously. But I think trying to get to a point of a recommendation on this one is a little complicated.

CHAIR THOMPSON: I don't know that that -- and Alan sort of alluded to that at the outset of talking about what we might do here. I don't know that we should have that goal in mind at this point given where things are. But I do think that some of what we've talked about here in terms of understanding some specific elements that deserve special attention --

COMMISSIONER GORDON: Key components, yeah.

CHAIR THOMPSON: -- that, you know, et cetera, can be helpful. And then, you know, we can kind of take a pulse at that point after having done some of that work and see if there's anything where we feel like there are real advances that can be accelerated through some federal policy or some barriers that really need to be --

COMMISSIONER GORDON: Yeah, I think it's one of those where -- and we've said this in a couple areas as well, where resource support to do this and do this well is critical. And, again, there's different organizations trying to, you know, pull together those best practices and trying to spread those learnings. But it's a heavy lift, one worth doing, but, you know, the folks -- our panel today and there's a few others that have already gone down

this path and trying to leverage that experience effectively is just -- it's a hard thing to do, but it's something that needs to be done to do it well so the others are successful as well.

CHAIR THOMPSON: Brian, Sheldon.

COMMISSIONER BURWELL: The MLTSS aligned with the D-SNP does seem to be like the emerging model for serving dual eligibles, and I think a focus on that and the challenges that states have to achieve full integration in that model is something that we could focus on. There are million issues that you can talk about. I would like to see the evaluation of the Minnesota -- I mean, they're a special model, and so I think that report -- just so that other states don't have to spend the 20 years to get where they've been.

But another issue that I haven't seen anything on is the whole financing side. You know, this is a risk model, and there have been plans that have gone under and have lost their shirts on this population. And so we really have no data on, like, how have plans done entering this market. You know, kind of building on what Bill said, it's a very robust market now. I mean, you put out a bid

now, Pennsylvania -- there are a lot of plans that want to participate in this market. So it's not a matter of their not knowing what they're getting into. But we really don't have any real information on, you know, how the market is doing, and I think that would be an interesting approach.

CHAIR THOMPSON: I was going to ask Curtis about termination --

COMMISSIONER BURWELL: They've had a number of -- their partnership plan went under, which was their fully integrated model.

CHAIR THOMPSON: Kind of the opposite question, right? Sort of like what contributes to success, sort of like what were the elements that contribute to a failure.

COMMISSIONER BURWELL: But the transition, I mean, they had to take everybody and put them in other plans, too, and that was quite a task.

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: Yeah, I just wanted to make a comment at the end here, that one of the issues that I think that the Commission should examine or at least participate in is in the evaluation of opt-out rates, particularly in the financial alignment demos. And I don't

know about D-SNPs. But I think when Medicaid meets Medicare, that is one issue that is obviously foreign to the Medicaid where you can have mandatory enrollment and not in Medicare. And it's clear the variations among the states is extraordinary and unexplained. There was actually an article or a piece written by Don Grabowski regarding the financial alignment expectations that have not been met, and I think that's something we could really contribute to.

CHAIR THOMPSON: Good. Okay, great conversation. Let's go ahead and bring that one to a close and move on to our next session about multistate collaboration.

[Pause.]

CHAIR THOMPSON: Okay. Sorry to keep you waiting, but let's talk about multistate coordination as our last subject of this session.

INCREASING EFFICIENCY THROUGH MULTISTATE COLLABORATION

* MS. FORBES: Thanks, Penny.

So MACPAC has previously examined the role of state and federal administrative capacity in managing Medicaid and CHIP effectively.

In the June 2014 report to Congress, we identified many of the obstacles faced by states and some of the strategies used to strengthen administrative capacity. Multistate partnerships were identified as one of the ways that states can increase capacity, and Commissioners have asked for more information on how states can collaborate.

So we've started looking into this primarily through a literature review. So I'll present our initial findings, and then I'd like to hear about what additional information you'd be interested in.

So state Medicaid agencies collaborate for many reasons. We'll discuss as few of them today: to discuss the time and cost associated with implementing new systems or programs, to leverage the increased purchasing power associated with their combined size, to share information on issues of particular interest to Medicaid. And they collaborate through a number of mechanisms, which we'll discuss on the next few slides.

Several states have partnered to share information technology, or IT, services or systems. A few pairs of states have partnered, where one state contracts

with another to use its MMIS. In some cases, groups of states have worked together to develop a new IT module they can all use. States partner together to share in the development and operational costs, and these arrangements can also result in significant savings for the federal government, which provide significant matching funds for MMIS development.

The Medical Assistance Provider Incentive Repository, or MAPIR, is a great example. This is an IT tool designed to manage the Medicaid EHR, electronic health record, incentive payments, which was a completely new system requirement in 2010. Pennsylvania took the lead and 12 additional states signed on, with Hewlett-Packard enterprise serving as the technology vendor. The states split the cost 13 ways. For the application itself, they decided to use open source technology and have a web-based interface, so that it could be integrated with any state's MMIS and it could be adopted by additional states for no additional cost.

States have found that working together on IT projects also creates opportunities for states to have to share information on related policy issues. For example,

while working on that EHR module together, states also had to figure out things like how to publicize the EHR incentive program to providers, which is an IT issue, per se, but the existing structure that they had where the 13 states were coming together to talk about IT-related issues gave them a platform and a group of peers to discuss policy issues as well.

Under 2004 federal guidance, it allows states to form a pool to negotiate lower prices with manufacturers through supplemental rebates. States have formed joint purchasing arrangements to obtain lower prices for prescription drugs, and now about half of states are in these joint purchasing pools.

For example, the National Medicaid Pool Initiative, which was the first approved multistate drug purchasing pool, currently has 11 participating states, and those states cover about 3.8 million enrollees. This first pool is administered by Magellan, and they've negotiated supplemental rebate agreements with about 90 pharmaceutical manufacturers.

States are also increasingly working together to negotiate agreements for specific drugs, particularly some

of the high-cost specialty drugs, such as those to address Hepatitis C.

As required under the federal guidance, these arrangements in joint purchasing are purchasing arrangements. States still maintain responsibility for managing their prescription drug benefits. They maintain their own preferred drug list, and they exercise clinical oversight.

States form many voluntary collaborations based on specific opportunities such as staff training, evidence-based primary care practices, regional data collection and analysis, clinical studies, and quality improvement studies.

Some examples are 12 states that formed the Drug Effectiveness Review Project, which you've heard about at an earlier meeting, which examined multiple drug studies to help policymakers purchase the most effective, less expensive medications.

Six New England states and the University of Massachusetts Medical School formed the New England States Consortium System Organization, which is a nonprofit corporation that identifies collaborative opportunities.

It manages multistate projects, such as research and evidence-based primary care practices, and provides technical assistance to member states. They also operate a data warehouse for data -- Medicaid claims data from the six New England states.

Private organizations also sponsor learning collaboratives and other cross-state opportunities. We had someone from CHCS today, which helps RWJ run a lot of grants. The NGA sponsored the Medicaid Transformation Learning Academy, which provide technical assistance to states and opportunities to work with peers to develop statewide Medicaid reform proposals. AcademyHealth now sponsors the State University Partnership Learning Network, which supports collaborations between state Medicaid agencies and state university research centers, so there's a lot of these opportunities out there.

Of course, we've mentioned all these ways in which states work together, but while partnerships are a way for states to address capacity issues, setting up a partnership itself requires a short-term investment of time and often money, which while they can result in cost savings, improved quality, and greater efficiency, there's

a short-term cost associated with what are often long-term benefits.

Many of the CMS and third-party learning collaboratives designed to help states share information to solve clinical and policy problems often require participating states to provide data, access to expert staff, and other resources in what's on already short-strapped environment, and there are other impediments to collaboration, including technical, legal, and financial barriers as well as the loss of autonomy that states give up when choosing to partner with other states.

Some states have noted that they don't want information system design decisions to drive policy. So the more that they collaborate with each other or the more that they use modular design elements, the less they may be able to customize to accommodate state-specific policies.

And finally, to tie this to some of the other things you've been talking about during this meeting, federal policies have encouraged, incentivized, and funded state collaboration for many of the same reasons that states have pursued these opportunities, to reduce cost and duplication of effort, increase efficiency, and improve

program administration. And as I said, increased state collaboration can reduce federal cost and these federal capacity constraints.

Medicaid IT guidelines explicitly require states to promote sharing, leverage, and reuse among each other, and as part of the review of state IT planning documents, CMS works with states to determine if there are opportunities to use software or modules that are available commercially or that have been developed for use by other states.

Federally sponsored websites provide states with secure mechanisms to share documents and advice. The Collaborative Application Lifecycle Management Tool, or CALT website, was developed to assist states with the rapid development of the significant eligibility systems changes that were required as part of the ACA. This expanded to help states collaborate on a variety of IT systems development since states find themselves wanting to learn from each other in a secure environment.

And we heard yesterday about the Innovation Accelerator Program, which offers cross-state learning opportunities on a lot of targeted issues.

So that's a quick summary of some multistate partnerships, the ways in which federal policies help support some of these arrangements and some of the impediments we've identified, but that was sort of our high-level scan of the environment. What we'd like to know is, are there areas in which you think MACPAC could contribute to additional federal policymaking or if there's additional analyses that you think could be helpful?

CHAIR THOMPSON: Thank you very much.

And I'm sorry that we don't have more -- the fact that we're giving you a little bit of a shortened timeline is not a reflection of the importance of this topic because I think it very much follows on a set of conversations that we've been having about how to help states with capacity and how to promote some efficiencies.

I think of this as there's a -- you identified a whole range of different kinds of action, and I think there is some categorization here that would help and that could drive us to think about what we would actually be doing.

So one is there's some element here that's just what I would almost call "staff augmentation," like states need more people, and some of them may be a set of

expertise that they don't necessarily have in-house, and some of it may just be people at a given point in time when they're doing something that requires some thinking or some action. And some of it may be just "I need more hands." So that's one kind of activity.

There's another kind, which is collaboration and joint action, which is people coming together, convening, discussing, identifying some areas, and maybe then actually doing some execution together.

And then there's another where we're thinking about it more in terms of it doesn't make sense to have everybody making the same kind of investment, and that there's some benefit from some economies of scale here. And in that latter category, I think you get more into some of the operational and technology ideas, and I think it's possible that you can make a case that those projects are so complex and so business-critical that you -- and I think experience tells us that we need to do more to incentivize states to enter into those economies, and that there could be opportunities for both state and federal savings, even with a change in a federal match for some kind of multistate commitment around some of those kinds of issues.

So I think you're right about all of the kinds of barriers. The mere initiation of these kinds of efforts takes time and effort to bring people together to begin to think about how would we do this, who do we need, how does this work, the governance around whatever you're doing.

When you mentioned the Pennsylvania example, for instance, the state of Pennsylvania stepped up and said, "I'll take on kind of the project management role here," and I'm not entirely sure that some of that seems to be driven more by people's interest and desire and sort of a general view about "I'm going to do something for the benefit of the whole," rather than a very specific "This creates an ROI to our state that I can kind of bring forward and get everybody to buy into," which is another exercise that people have to go through.

I think that there's some things here that we might want to explore in terms of how federal policy or funding could change the dynamic to make it easier, to make it more accessible. I do think we should be asking the states because to the extent that they would say, "I would never do that. I would never be a part of that. I just have a dynamic in my state," you know, I think in some

cases, some of these make more sense for smaller states than for larger states, and that's worth thinking about as well.

So I know we have a number of folks.

COMMISSIONER WEIL: I agree these are different categories. I would put the TA in a totally separate category, and I guess I think -- I mean, that's the world I lived in for a long time. I don't think that's our -- I just don't think that's where I would focus.

I think this shared negotiation, shared procurement, I didn't even know before I read this that there were states that had shared MMIS, but wow, that's good.

And when I was NASHP, it's not in our purview, but the ACA also allows multistate insurance exchanges, and we did an analysis for a state that was interested in that. You can see that they did it, implemented it. That's a joke.

Anyway, I think there is a real opportunity here. I'm not exactly sure what our role is, but I don't kind of want us to drop it, and maybe the next step is whether it's to take the -- I've forgotten -- NESCSO or whatever they

call it, you know, whether to take a couple of these that exist. I think we have to be very discrete. They are very different models. There's joint procurement. There's joint analysis. There's joint operation. But maybe the next step is to get a couple of these.

I'll just say I think the vendors make a lot of money on the barriers, and so I think if we could overcome some barriers, we could save some state and federal money.

CHAIR THOMPSON: Kit, then Chuck, then Marsha. Is anybody else trying to weigh in?

[No response.]

CHAIR THOMPSON: Okay.

COMMISSIONER GORTON: So I agree with what Alan was just saying and to build as well on what you were saying, Penny. I think there's an opportunity for us to look at both sides of this.

On the one hand, what are the success factors? And I think the NESCSO example points out one, which is these six little states in the northeast of the country talk together all the time about all sorts of stuff, and so regional cooperation in New England sort of is already baked in.

I think there are those sort of regional collaboratives in other places, and it would be interesting to see whether that's a necessary precursor or what are the success factors that allow these -- is there a common set of success factors that allow these things?

CHAIR THOMPSON: So do you do some trust building before you start to do some of the things?

COMMISSIONER GORTON: Before you start doing it, yes.

And then contrary to that, I do think we can dig a little deeper on the barriers because I think part of what gets in the way are state primary care rules. It's more than just the sense of autonomy around policy. For 150 years, states got into trouble by being bad procurers of things, and so over time, we've layered on control after control after control to try and eliminate state corruption. And it gets to the place where they almost can't do anything without threading an intricate set of needles.

And so I think it's worth looking at -- again, are there common barriers, and are there ways that the states could come together to solve that? The model I

would point to there would be the NAIC, and what the insurance commissioners do to try and achieve some standardization, to try and achieve some cost efficiency, each of them has to be its own thing. But to the extent that they've moved to common templates and common processes, then it enables everybody to function more easily.

So I think there's work that we could do to look at the barrier side and maybe models for eliminating barriers, and then I think we could look at success factors. And by eliminating that and pointing out where these things are going on that other people -- I mean, if Alan doesn't know that something is going on, that in itself is shocking to me.

[Laughter.]

COMMISSIONER GORTON: But I do think there's room for us to shed light on this and inform the conversation.

CHAIR THOMPSON: Chuck and then Marsha.

COMMISSIONER MILLIGAN: Thanks, Moira.

I actually want to focus on MMIS and focus on a couple of specific things.

One is I think that there's been some good work

at CMS around modularity and around sort of open-source issues, and there's collaboration in terms of joint primary care, but there's also collaboration by having the vendors do things in an open-source kind of world, so that you don't have to buy the same code twice.

And so I think one of the areas where we may or may not want to weigh in down the road is how something developed once can be used twice, and it could be in an MMIS space. But I think shedding a little bit of light on how open-source rules or open-access rules are advancing or hindered, I think would be helpful.

And it applies, I think, beyond the MMIS space to preferred drug list development and other things. So I think item number one to me is what the federal policy landscape is around forcing development to be done in such a way that the federal expenditure can be leveraged in other markets without formal contractual joint procurements and things.

And then the second, I want to just comment on -- I want to make the comment that vendors make a lot of money. I want to talk about federal -- FFP. One of the issues you hear about with MMIS development and a lot of

technology development is that development is 90/10, so it's 10 percent state dollars and 90 percent federal dollars, and therefore, states aren't good purchasers because the states have less skin in the game, and vendors kind of oversell the development cost because states aren't good purchasers and get the same thing purchased more than once.

Then once the technology is implemented, it reverts to kind of 75/25 for maintenance of a system, and there's arguments that have been made in the past that that's backwards, that it encourages building the same box over and over again.

Here's my point. I wonder whether FFP rules are a tool here for 90/10 only if you collaborate, otherwise it's 80/20 to develop a new -- I just think that where we may or may not have a place to weigh in is around how the federal financing match rates create incentives that are adverse to some of these outcomes we're talking about.

And I don't know the ground rules around all of that anymore, but I think that learning about FFP and whether it's tied to open source, what kind of the degree of freedom is around that would be helpful.

CHAIR THOMPSON: You know, I think that's right. I also -- and, of course, you know, at one point in my career worked for an MMIS vendor -- and I think there are a lot of misconceptions about what drives the cost of some of these -- as Kit did too, together -- what drives the cost here. And so I think it would be helpful to kind of put that out on the table. And I think that the issue of funding and what gets incentivized so that even, Chuck, not whether you drop a funding, you know, the point about maybe you get a 5 percent additional bump in your state's share for doing a multi-state, you know, it's very easy for me to do a back-of-the-envelope calculation and say the federal government still comes out better in that deal.

So, you know, describing what that would look like and the terms of that, et cetera, I think the other point, cost allocation rules come into play and complicate life when you try to get folks within a state, even, to come together around a common set of services at the enterprise level in support of a number of different state programs. And I don't know if we're trying to take that into view here. That might be too much.

COMMISSIONER MILLIGAN: Yeah, and I'm sorry to

jump back in. I know we're running out of time. I agree with you completely, that, you know, OMB A87, which we learned and know well, helps for a lot of important developments with eligibility systems as part of the ACA. And what we have seen is matching rates drive adoption, whether it's EHR, meaningful use, all of that stuff. And so, to me, that's the focal point for some of where our next work ought to go.

CHAIR THOMPSON: Marsha.

VICE CHAIR GOLD: Yeah. I think I wanted to pick up a little bit where Penny started out, which is sort of typologies, which problem we're trying to solve with these different things. And it strikes me that there's a difference between things that are applicable to sharing across all states and things that solve specific problems, like of small states in a federal system, where you have -- you know, the scale of California or New York, you could put five New England states together, or, you know, a bunch around Montana, and they, at least population-wise, be somewhat similar.

And so problems that are common to all states, even though some may be more interested in participating

than others, are different than problems that deal with the fact that in a federal system you have varying sizes and capacities across states. And the reason I think that's important is that it also affects the remedy. So federal matching formula can be relevant when it's all states. When it's a problem that it's a few large states I think you need a more targeted remedy than something that gives something to some states that it's relevant to but doesn't let the other ones take advantage of it because it's just not relevant to them.

So I think when you combined them all and sort of -- you know, like the MMIS is an example, I would think, is a more generic thing that there are economies that could be relevant across all states, whereas drug purchasing potentially is most helpful to small states, though larger states could benefit as well.

So I think talking about what problem and recognizing the diversity in the country is really important so our policies are aligned with what we're trying to achieve.

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: And along that line, just

to throw in another layer there, I think we ought to pay some attention to the territories, because we don't pay much attention to the territories, and, you know, they run Medicaid programs that operate under slightly different ground rules. And we ought to see whether there's some way -- I mean, hopefully the country is going to help Puerto Rico and the Virgin Islands rebuild. What are we building, and are they going to start from scratch or can we use some of these collaborative and joint things to help give them a leg up, right?

CHAIR THOMPSON: Any other comments on this?

[No audible response.]

CHAIR THOMPSON: Okay. Why don't we have some public comment? We have some folks out there who might have some thoughts on this morning's discussion.

Thank you, Camille.

PUBLIC COMMENT

* MS. DOBSON: You're welcome, Penny.

Hi. Camille Dobson, Deputy Executive Director at the National Association of States United for Aging and Disabilities. We partnered with CHCS to do the value of MLTSS programs.

I listened with great interest this morning. This is all I do, most of what I do at NASUAD, after spending time at CMS working on Medicaid managed care. And I think that the ingredients for critical success -- I think is how Alan put it -- would be really helpful. You know, states are starved for commonality, and it's a real struggle. CHCS does it with their collaboratives. We try to do it as much as I can with our state members, but it is a real challenge to try and pull together the research and put on paper what has been successful. And, you know, some of them are pretty easy -- time and good management at the state agency. I mean, there are some basics, like sort of no-brainers that I think we all know.

States taking that up is a very different situation, and I think it would be a useful addition -- and part of the reason we did the study was to prompt further research, was to identify the fact that states don't take the time to do baselines before they move to an MLTSS program, the fact that there's a hue and cry about how quality is going to decrease when managed care gets involved, yet there's no real barometer at all about how the real quality is playing out for people -- not just

services but how they're actually making a difference for people in the fee-for-service system.

And I was very frustrated about the lack of research that was out there, which was why we did what we did. But that's a survey of the states who are willing to answer, as a state member, our survey, and give us their information. It was not at all rigorous. It didn't have any of the methodological sort of underpinnings that would put it in a journal, for example, and there's really a dearth of that. And I would -- if the Commission could add anything to that, I think it would be very valuable.

CHAIR THOMPSON: Thank you, Camille. Any other comments on any of the subjects from this morning? Jess.

MS. KHAN: it's the CMS alumni show.

[Laughter.]

MS. KHAN: Mary Ellen, you're next.

Hi. Jess Khan. So just to add a few fun facts to this and then I'll get to an actual comment, West Virginia hosts U.S. Virgin Islands for MMIS, so despite pretty much nothing else working in the U.S. Virgin Islands, they are actually able to pay their providers. They also are going to host a Midwestern state soon. And

Arizona hosts Hawaii for MMIS. So I just wanted to say that, and Michigan is now hosting some of Illinois. So there are some really good examples out there, and, Moira, you know where to find me. Just call me.

So what I would say, a couple of things. One is that I think there's actually relevance between these two topics, back to back. I mean, it occurred to me, and was sort of whispering with Camille, if a state is going to do managed long-term care services and supports well, then that means they will probably be managing their MCOs well, and there's an infrastructure that goes into good MCO management. It's having that data, having that analytics, surfacing it in a way that the leaders can use it for decision-making. That's they technology side and it doesn't have to be different from state to state to state. That's a really great example of a multistate collaboration opportunity, identifying what those elements are and identifying tools to do that.

Darin's already left but he's talked to many states about what he did in Tennessee that was self-built, that could be replicated elsewhere. There are some vendors out there that have products, but if you don't know what it

is that you need, then sometimes just multistate collaboration sort of crowdsources that thinking from other states who are maybe more mature at understanding what you need for good MCO management, and that, of course, includes MLTSS as part of that as well.

So I would just encourage us to think like a little layer deeper within the MMIS to some specific examples of technology that states need that can be replicated more easily. There's always going to be room for making it particular to a certain state, but the core is probably 80 percent is the same, and in most states it's a question right now of having nothing for good MCO management, from a technology and data perspective. So there's a lot of room for improvement there when that's your baseline.

The other thing I would just note, the statute defines the match rate definitions. Believe you me, I tried to tweak that. But that doesn't mean that there isn't room for rethinking what those could look like and making some discussions about it, and maybe even thinking about what those definitions are and other ways to incentivize.

CHAIR THOMPSON: But we can certainly make legislative recommendations, for example.

MS. KHAN: Yes, exactly.

CHAIR THOMPSON: So to the extent that that statutory language --

MS. KHAN: That's right.

CHAIR THOMPSON: -- that's a problem, that's something that we can make recommendations.

MS. KHAN: And there are administrative incentives, perhaps, as well. An expedited review by CMS of EPDs, of funding requests if it's multistate. That's actually what happened for the Pennsylvania MAP, for example, that Moira gave. They shared that language and basically cut and paste and just updated their particular budgets 13 times. Well, those things got approved really fast, and it worked really well, and it was really a reduction in EPD burden.

So there's some other sort of administrata that might make it worth their while, given what it costs now. And then we also have some good examples, just to add to the list, of multistate purchasing agreements. They do it for commodities. You know, there are a lot of these.

National Association of State Procurement Officials has one.

And so the argument there is that some kinds of IT can be used as a commodity. You know, don't just do mass purchasing of toilet paper. It's true, sanitation, sanitary supplies are one of the things that states buy well together, but like actually think about how IT could also be something, certain technology services that they could use. And that tends to settle some of the procurement officials' concerns, because they're very familiar with those tools in other areas.

So I just wanted to add a little flavor and say, of course, I love this topic.

CHAIR THOMPSON: Thank you very much. Wonderful.

Any other public comments?

[No audible response.]

CHAIR THOMPSON: Yeah. Okay. Great. Thank you and we are adjourned.

[Whereupon, at 12:03 p.m., the meeting was adjourned.]