PUBLIC MEETING

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

Thursday, September 14, 2017
8:45 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
MARSHA GOLD, ScD, Vice Chair
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FREDERICK CERISE, MD, MPH
GUSTAVO CRUZ, DMD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
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STACEY LAMPKIN, FSA, MAAA, MPA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[8:45 a.m.]

CHAIR THOMPSON: Okay. Good morning Welcome, everyone, to the September 14th and 15th MACPAC public meeting. We have a packed agenda today, but we are very fortunate to be able to kick off this meeting with the esteemed colleagues in front of us, Gail Wilensky and Andy Slavitt, who need no introduction, but I will do it anyway.

Both former CMS Administrators, Andy currently serves as the Senior Advisor to the Bipartisan Policy Center, where he co-chairs an initiative on the Future of Health Care. Andy serves as the Acting Administrator for the Centers for Medicare and Medicaid Services under President Obama. Gail Wilensky is an economist and senior fellow at Project HOPE, an international health foundation. She also co-chairs the Bipartisan Policy Center initiative on the Future of Health Care and directed the Medicare and Medicaid programs under President George H.W. Bush.

We were very interested in having Gail and Andy come talk to us today because of an article they published in JAMA talking about areas that they felt were fruitful and constructive areas of focus to improve the Medicaid

program that could generate bipartisan support, and so we wanted to have an opportunity to hear more from them on their thoughts as we shape our agenda and work for the coming cycle.

So let me kick it off to Gail and Andy to start with some introductory comments and remarks.

OPPORTUNITIES FOR MEDICAID REFORM: VIEWS FROM FORMER CMS ADMINISTRATORS

* DR. WILENSKY: I will say a few -- I will have a few opening comments and turn it over to Andy. I know from my days as MedPAC Chair, you'd much rather keep most of the time for Q&A and interactions, and that's fine with us.

Thank you for having us. It's been interesting. Occasionally, I feel like we're doing The Gail and Andy Show, although BPC is quite happy to tap into volunteer time, and so I share time with a number of other people.

But the effort that we made, I think is important because it shows that despite political differences, and there are areas when it comes to Medicaid reform where we have somewhat different views. There are a lot of areas where we have overlapping views, and I think there are ways we can constructively make the program, which has borne the

brunt of the responsibility of picking up most of the newly insured in the Affordable Care Act and has performed, to my mind, without as much drama and trauma as occasionally has gone on in the exchanges. And so our interest was not in highlighting our differences but in talking about ways that we thought we could make the program stronger.

I'm going to mention a few of the policy ideas. There were, I think, six. I will let Andy talk about a couple of the others that I don't mention. But tie it into some other thinking that's going on now because I think there is some overlap with the new attempt in the Senate to try to have bipartisan discussions, led primarily by Lamar Alexander and Patty Murray in their various hearings that are going on with the HELP Committee.

And there is one area in particular, one that I had addressed when I spoke to the MACPAC Commissioners a couple of years ago in terms of dual eligibles, so I want to have a chance to at least mention a thought there.

As I indicated, we have been impressed that Medicaid has been able to pick up the majority of the newly insured, and while the costs are greater than CBO projected, both in total because it had more people covered

than was anticipated and also on a per capita basis because the drop was not as great after the first year of coverage than had been anticipated, nonetheless as a per capita level, the growth in spending has been relatively modest.

We mentioned a few areas that we think could be helpful in our joint forum that have to do with the financing and mainly getting rid of some of the special payments that have grown exceedingly large and that mean less money is available than might otherwise be available.

Some of this has a very long history, going back as being problem children when I was the administrative in the early 1990s, and has to do with disproportionate share and some of the other special payments that are under Medicaid. And our concern has been that they have become such a large piece of the Medicaid reimbursement and end up distorting what is otherwise available. That some of the areas that get raised that are only tangential to that, to the issue like whether or not there is proper access to care under Medicaid, would be so much easier to address if, in fact, you didn't have the very large amount of money going off through the special payments. But they also take away from the kind of structure that you would like to see

available for the financing.

So while the politics will be formidable in trying to get that money back into the general pot, we recognize that there are a number of areas that could be handled more easily if you could get a more directed piece of money without these separate areas.

In particular, one of the issues that I had addressed earlier -- and I don't know, other than I know Anne was there, how many of you were around the last time that I spoke to the MACPAC Commissioners -- has been my concern about what happens with the dual eligibles.

As you well know, they are relatively small but a very needy, medically needy, high-spending group that historically have represented very deep entrenched siloes. Medicare itself remains one of the most siloed health care programs that we have in the United States, particularly the traditional part of Medicare, and the Medicare/Medicaid duals have these two siloes, one of which already is very soloed, even though they're such a high-spending group.

There has been increasing interest in trying to have that coordinated, and there was a number of demonstrations that were started when Andy and his

predecessor were there.

The problem is one that I had discussed previously with MACPAC, and that is that the work to get the savings -- and it will take serious effort; these are, by their nature, very sick individuals -- to have better coordinated activities and plans in terms of how to treat either the disabled, the frail, elderly, or those who are both aged and frail, elderly as duals, will happen on the ground. This is done. Health care, as you well know, is provided locally, and the groups that will make the effort to better coordinate care will be at the local level.

The challenge is that the savings will primarily go to the federal government, and the reason is very straightforward. By definition, all the Medicare savings will go to the federal government, and the majority of the Medicaid savings will also go to the federal government, particularly if they're in the expansion population, but even if they're not, with the federal share being 50 to 73 percent, you have the clear bulk of the savings of any efforts from a duals program going to the federal government, when it's the state government or the local people, who are going to be putting all of the effort up.

I am an economist. That is not a good set of incentives to have to encourage people to make the effort to actually provide better care.

This has been, I think, a problem from the get-go. It wasn't anything the Obama administration added. Actually, something that happened last summer gives me a slight glimmer of hope that there may be a way out, and that's the 1332 waiver that Alaska got, because some of the same problem occurs in trying to have incentives for risk pools under states running them through a 1332, and the higher the premium rate, the more the problem is. And that was a case.

Alaska comes in as being infamous for having the very highest premiums, just because it's such a high-cost area, and CMS -- I assume it was CMS -- was willing to share some of the savings that would have been generated, making it not such an attractive idea for Alaska to engage in what has been a very successful high-risk pool, which has helped them stabilize the market substantially and a good less to at least above average cost, other exchange states, that if they could see themselves to doing that there, that is, giving away some of the savings that they

could have legitimately claimed as the federal government to the state to encourage them to behave in a way the rest of us would like them to behave, maybe that will set a marker for what I think has been one of the serious barriers in getting better Medicare and Medicaid coordination in the dual eligibles, getting over that hump, that the work is going to have to be done by the state and local providers of care. And the savings by their nature will be predominantly federal.

There may be other issues among them. That this is a challenging population to deal with, but I think that really does make it very difficult.

So I am slightly more optimistic in this area which has bothered me a great deal for many years because of the siloed nature and very high cost of the care provided that maybe we now have a precedent that will turn out to be helpful in resolving it.

We've talked in our short forum about the need to look at outcomes and get better analytics infrastructure and data and technology. That is an area that Andy has worked in, both while there and before coming to CMS. So I'll let him talk a few minutes about some of those ideas.

* MR. SLAVITT: Great. Good morning, and thank you for having us. And thank you all, also, Commissioners, for all that you do as part of this Commission and your commitment to this program. I think it's such an impressive group, as I look at all of you and the backgrounds you bring, so I just want to say thank you on behalf of certainly the people that we've served and I know that many of you served there, certainly in Tennessee.

A couple of thoughts just to share; first, just on the approach that we took as we put this together. I don't know if you have this experience, but generally speaking, if you talk to a Democrat in health policy, they're going to talk to you about covering more people, and when you talk to them about Medicaid, they're going to talk about all the additional lives that can be covered. And that's clearly -- appears the primary policy aim.

And if you talk to a Republican about health policy, you're likely to hear about sustainability and cost reforms and ensuring that the program is fiscally sound, and a couple things just strike me about that. One is both are obviously right. You can't have any expanded coverage unless you have some strategy to control the cost of care,

and likewise, you can't just cut cost and expect to get better care and make the program work better.

So we both -- and I think Gail and I in putting this together -- wanted to demonstrate there is a recognition that both sides have to understand one another, because these are interdependent goals, and I believe -- I may be wrong about this -- that, in part, it's because both sides don't acknowledge the other's point often enough. That they get more entrenched at having to make the point, and so the divide gets further and further, when, in fact, if you sit down with people, with a variety of beliefs and an investment and an interest in this country, in this program and the people served by this program, there is a lot of commonality. There may be different paths to get there, but people of goodwill tend to find them.

So I think, in principle, an important statement for us to make is that Medicaid is reformable. It is in need of reforms. It could use reforms. It has a lot of outdated elements, but also, Medicaid is not a piggybank. And it should not be dragged into a policy discussion with other policy aims, whether they're health care policy aims or tax policy aims, without proper debate and discussion

and commitment of people who understand the program. And real reform begins with things that make the program work better, not by arbitrarily just making cuts to the program.

So our hope and our thought and our goal is that there can be serious discussions about Medicaid that people of all sides, with all perspectives can participate, and in the course of the last few months, as we've gone through various phases of things being heated and not heated around health policy debate, a couple of interesting things have happened that I think I would say are unexpected or at least unexpected to me.

First of all, the journey of Medicaid in the public mind, I think has undergone somewhat of an interesting transformation. I think the fact is that the Medicaid program, as people became more educated about it, is more popular and more engrained in people, as people begin to understand that they too are very likely either personally impacted or will have family members impacted or no people impacted and served by the Medicaid program.

And then, in fact, Hoosier Care or Aloha Care, all those cares are actually Medicaid, and I think that's a great positive that has come from this, is people

understand where we are investing all this money as a country and what's happening and what's getting served by it.

Yesterday, I was with Senator Schatz from Hawaii, which I will describe as another thing that's come up from this. If you would have sat in this room six months ago or nine months ago and said that somebody would put a serious proposal on the floor to allow people to buy into the Medicaid program, people might have thought we were crazy, that that would be a potential serious consideration. And, indeed, I think while there are details to be worked out, things like -- I love the name "Sprinkle Care" in Nevada -- and other opportunities to use this platform, I think are powerful.

Now, there are people that will disagree with that and cite originalist construct of the 1965 law and say that's not what Medicaid is intended for, but I think, as Gail points out, the Medicaid program has proved to be fairly durable and extensible at least in Medicaid expansion.

And until and unless Senator Sanders' bill passes tomorrow, we are living in a piecemeal system, and if we

want to make gains on coverage and if we want to make improvements in the system, it's going to come from one of our existing programs very likely.

So when we think about what would be necessary to make Medicaid reform work, I want to emphasize something that Gail said. Putting payments into rates that reimburse for care instead of into pools allows you to do a whole lot of things if you can get that done.

First of all, it saves us a bunch of money. Secondly, if we do it right, we can reinvest it in the things that we know we need to reinvest in -- additional access, because we can improve rates for actually people providing care; social determinants of health, other things that we've mentioned, investments in data, and all things that are worthy of investment. So we are a little bit trapped, and like everything else in health care, there are some of the interdependencies, that we're wise as a country if we take these things on as collective and work on a package with experts who can construct something that -- let's face it. We're better off as a country if the things we get out of Congress in health care pass with bipartisan support, and if that's going to be the case, what are the

ingredients for that? The ingredients are obviously good policy that works, but it's also tapping into public support.

And to my mind, if you have something that's 60 to 70 percent of the American public support, you have a fair shot at bipartisan legislation, and I think given where we have come, we may have opportunities to take a serious look, to take some time, to put these ideas in the room. And I think as Gail and I constructed this together, she is absolutely right. There's things in here that we both felt strong agreement on. There are a number of other things in here which we both felt were acceptable because as part of a broader package. And all of a sudden, things that you adamantly oppose from one perspective don't look so bad in the context of a bunch of other things that look better, and obviously, that's a lesson that we knew at one point in this city and are going to need to relearn, or we're going to be in the same kind of situation.

So there's as much a political commentary of what's getting in our way in Medicaid as it is a policy commentary, but I think there is a reasonable chance that when the politics come back, we have some of the

ingredients at least to really take a serious look at reforming a program that is so beloved by the people who know it and should be so beloved by more and everybody.

I think that's where I'll stop.

CHAIR THOMPSON: Thanks.

Let me open it up to the Commissioners. Brian.

COMMISSIONER BURWELL: Good morning.

So I'd like to follow up on your conversation about duals because that's a topic that we're very interested in as a Commission, and I personally totally agree with you about how savings should be shared at the more local level with states or the plans that participate in the program.

But the duals issue has been around for a long, long time, and there are those who feel that this problem will not be resolved until we truly create -- we kind of start over from scratch and enact a program that is entirely focused on this population. That in the current environment, it's still two programs. Any plan that participates in the demos, et cetera, it still serves two masters.

There is the intention of negotiating agreement

between the Medicare side of the house and the Medicaid side of the house of about kind of more uniform requirements and reporting and all that kind of stuff, but the reality seems to be the Medicare side of the house says, "Yes, we're willing to negotiate, and we'll do it the Medicare way."

So as CMS Administrators, I'd appreciate your kind of commentary on kind of the organizational and structural approach to resolving this problem, you know, from the top down.

DR. WILENSKY: I don't disagree. My immediate reaction is life is too short to wait for that to happen. We have a problem that if we can find our uniquely American patchwork way of fixing it until we can get around to something more elegant works for me.

When I went there, I did a "go back to the future" move. I reestablished the Medicaid Center, pulling what had been a joint Medicare-Medicaid operation out. What had been the case with my at least two predecessors had been that in operations, operations would include both Medicare and Medicaid.

Now, of course, the financing was very separate.

It was an attempt by the agency to have all of the activities that were concerning certain functions together. But what happened was that Medicaid tended to get short shrift doing that and represented maybe 10 or 15 percent of the time and attention of the people in the various operating areas of the agency. And the reason is because Medicaid is fundamentally a state program with federal oversight and Medicare is a federal program. And so unless or until we change that, as far as I can see, it's the world in which we live.

Now, I tell you this story because the first is all I did is actually re-create the structure that had been there at an earlier, before-my-immediate-memory version. So I was attacking the problem that I saw, which was Medicaid was not getting enough attention because, for somebody in operations or payment or legislation, it represented too small a part of their activity relative to the dominance that Medicare represented. But they were in the same place, and so it may have solved some of the issues about having "I'm Medicaid, you're Medicare" in terms of your hat.

But what happened was, you know, they were the

neglected stepchild, as best I could tell, in a way that I thought was unfortunate. And so pulling everybody involved in Medicaid out and putting them together would allow them at least to interact, give more visibility to the Medicaid program, but exacerbated the problem that it is separate from Medicare, which, for the most part, is not a big problem except for those very needy, high-spending dual eligibles.

So we can resolve that, but it really would be by reconstructing, which has been periodically suggested for all sorts of reasons, including how at least prior to the ACA the long-term-care elderly part of Medicaid was such a disproportionate part of their spending, although not the people involved. But unless and until we deconstruct Medicaid as we have known it and pull out those different pieces and then decide whether those that are dual eligibles belong to some different attachment of Medicare, I don't know how we solve that problem. Those are -- you know, this group, many of you I know have worked on these issues longer than I have or more focused than I have in terms of how to try to have a more rational long-term-care system in the country. But it is one of the few areas that

pales in terms of taking on expanded coverage, if not universal access, for the general population.

So I don't disagree. I just don't want to wait to solve the problem. And it may well be a function of both my age and my time in Washington that it would be -- it is a problem because, by virtue of there being the two separate programs, you do have issues. But they're not irresolvable issues. I mean, you could imagine administrative structures that would allow for this overlapping population to be treated differently and to have -- I mean, they are in the same frigging building, at least in terms of Washington, that you could allow for a much more integrated way of treating the overlapping groups. You would have to very carefully think about what can be done administratively and what would require a legal change, legal structure to support the change that would make that happen, without trying to undo or take on these very broad issues about what do we do with long-term care. I have spent on and off in the last ten years time worrying about that. I don't want to wait to try to solve this problem or make it better until we figure out the answer to that.

MR. SLAVITT: So there are two things that I think we all know is true in our private lives. One of them is that if we give two people the same problem and they are both half-responsible, they can each blame one another -- I happen to have two kids, so I know that -- for why it doesn't get done. And so it's not a good way to do things.

The other thing we know is that we need to focus a disproportionate amount of our time and attention and effort on the part of our system that spends the most money but also has the most complex sets of issues that require investment and specialization. So this population -- so we're doing something wrong. I mean, we know we are. And so I won't cover the ground that Gail covered, which is to say how do we live within the system. But I think if we're -- you know, I think I would be in favor -- see, every new health care idea that you put out without much thought is a very stupid thing to do. So I reserve the right in this very public forum to say that's not what I meant. People do that these days a lot.

You know, to allow a state, subject to some important guard rails, to be able to adjust their match

rate and take on, you know, the populations as part of some waiver, what's to stop that? Because at the end of the day, it's probably going to come down to either some Medicaid managed care plan or Medicare Advantage plan. And they, by the way -- and I can tell you this -- they live in very different worlds with their own organizations. They don't talk to each other either.

So, you know, until there's a reason for that to change, until there's a reason for there to be, you know, whatever health plan you want to pick, a duals organization that is focused on social determinants of health and LTSS and home and community services and all those sorts of things all in one place without having to reach across and grab -- until we give people a reason to do that, presuming that -- and I'm not here to toot the horn of managed care, but just to suggest that that's where we live, that's where we are. If you're going to manage this population and give the -- put in the investment for people in this Committee which require investment, we don't want to be chasing people. We want to be actually going into their homes and looking at their lives and helping invest in things that keep them well and healthy.

We ought to just remove the barriers from doing that, because it's hard work. I mean, everybody that we all know, that we meet that works in the duals population, I walk away feeling grateful as hell that people have chosen to do that, because it's so hard. And we have got to take all the things that make it harder and get rid of them.

CHAIR THOMPSON: Alan, then Bill.

COMMISSIONER WEIL: The most important thing I'll say today is I want to thank you both for your strong, unambiguous, bipartisan comment to the public that Medicaid shouldn't be fundamentally restructured in the midst of a larger debate over the repeal of the Affordable Care Act, and I'm grateful to you both for taking that --

DR. WILENSKY: Or serve as a piggy bank.

COMMISSIONER WEIL: Or serve as a piggy bank. So that needs to be said.

As two very thoughtful people in this area, I am hoping you can help me understand -- and hopefully others will be interested in a tension that I feel in your recommendations and in our own discussions which has to do with, on the one hand, the desire to move toward outcome-

based and performance-based; on the other hand, your comment about eliminating pools and moving dollars back into individual services.

Our case study work around DSH, which is sort of the original pooled funding, indicates and my personal experience indicates that in many instances those dollars were used for system improvement, exactly the kind of performance outcomes we would want.

Andy, you just mentioned managed care. Certainly the language of managed care is that when you liberate these organizations from the fee-for-service dollar-by-dollar payment, they can make the right investments to improve care and outcomes. The new use of DSRIPs, the early ones were primarily around preserving dollars, but now we see them more tied to outcomes. So I'm struggling with the tension between, on the one hand, from an accountability perspective, moving away from pools, but by doing so you're reinforcing a fee-for-service system that tends not to have much accountability built into it, and then sort of ties up the dollars in ways that make it hard to achieve the outcomes that you say you want.

So how do we simultaneously have the fiscal

integrity associated with getting rid of the pools, but also enough -- I hesitate to call it "slack," but enough of a distance between paying just service by service that makes it possible to achieve outcomes?

DR. WILENSKY: You just have to get away from focus on the inputs. I mean, I think the issue that we've each tried to address is that historically in fee-for-service Medicaid and in fee-for-service Medicare, all of the focus is on inputs. So if you look at the relative value scale, it was all on a payment basis for inputs.

What we've tried to suggest here, without a lot of detail, but what I think is a consistent message, is that you need to have a larger pot of money, which means you won't try to have the control on the input phase that you might have in fee-for-service but get much more serious on the outcome metrics and on the data analytics.

I think Andy and I have both historically been proponents of more coordinated care, whatever name you want to use, in either Medicare and Medicaid. Basically, the sicker, the frailer the population, the more trouble you get in in siloed delivery systems. And, again, for me, Medicare fee-for-service is the ultimate siloed delivery

system left in the United States right now, although with a lot of serious attempts to do work-arounds by having people who have the same siloed delivery system but you have a care coordinator that sits on top of it.

So we think the focus has been -- we haven't had detailed discussions, Andy, to say whether I misinterpreted what I heard him say or seen him write -- is that the focus needs to be on the outcomes and the data analytics, and you need to give more flexibility in terms of how it's used, but hold the groups more accountable. That has really been the whole history of Medicare Advantage in its various names where there isn't as much flexibility as there could be on how they are able to use their inputs, which I think is a little bit too bad. But it was the only part of Medicare early on that required information about what happened to people, about the actual outcome metrics and the quality. And for a very long time, physicians in private practice in Medicare got a complete free ride in terms of not having any kind of accountability.

So I think we need to get away from what we thought was accountable, which is focus on how the dollars go in and what they go to, as opposed to how well you're

able to use them in terms of outcome metrics. And, initially, that was probably of necessity because the thinking was still so primitive with regard to looking at outcome metrics and quality metrics. But while we still have need for improvement, as we're figuring out in MIPS and other places, it's so much better than what had, and that allows for a much more mingling of dollars, which, by the way, states were doing all the time. One of the areas where we, I think, have slightly less areas of concern is that if and when the states are responsible for a larger share than they've been under the expansion population, which has made states not really have to care so much about their part of the financing since it was 100 percent federal, will we see a return of what was going on in the last couple of decades where there was some question in many states -- not all states but in many states about whether there was any new money there other than the federal money? Because the fact is money mingles.

So my response is we need to be serious, but we need to be serious on what happens to the money and get off trying to worry about legislating how the money is used going in. I think it sounds good, but it actually isn't

what we should focus on.

MR. SLAVITT: So if I'm a hospital CFO, which is, I think, where a lot of reality -- a lot of health care decision-making comes down to, in my view, we have a couple phenomenon. One is I get these line item checks that come in every month, more or less regardless of what -- I've got a Compliance Department to make sure we're getting the checks, but that's in a separate compartment in my brain r patient care. Then I have this phenomenon where I can complain all day long about how much money I lose on Medicaid and how I don't want to see Medicaid patients, when you have tape recordings of CEOs of prominent health systems saying things like, "We shouldn't be serving Medicaid patients here if we can get commercial patients," and I'm sure all the things we don't hear.

And so a lot of this is if we can get -- I'd rather see -- and, by the way, there are other types of pools besides DSH, so this is a more pools comment in general, which have very little, if anything, to do with even the amount of patients you see there related to, of course, how much funding hospitals help provide states in the waiver process.

So all of these things have created a side business instead of economics and finances that have nothing to do with patient care. And I'd rather see a world where -- put aside the transition to get there, where that money was reinvested back in a quality bonus for the quality that you provided the patients you saw, and that Medicaid patients were treated like the rest of the population that you saw and the rest of your payer mix, and it didn't -- it wasn't this sort of put-aside. And then not to mention the fact that so many then of the community physicians won't see the Medicaid patient because, in fact, there's not enough in the rate. So if we're going to get money in the rate, to me this feels like an efficient way to do it, but you've got to do it in a coordinated fashion. You have to make sure the money actually gets there as opposed to just stripped out of the system entirely. So that's at least my thinking.

CHAIR THOMPSON: We've got a long line. We have Bill, Marsha, Chuck, Sheldon, Fred, Toby. So, Bill.

COMMISSIONER SCANLON: First I'd like to say thank you for pointing out that if we look at some basic principles, there's a lot more agreement than one would

believe from all the rhetoric that sort of is going on. And your recommendations are something that it's very easy to say these are all positive steps in the right direction. Beneath the recommendations there are some significant challenges, as we've already started to sort of talk about.

I'd like to go back to the part -- to the issue of duals as well as your recommendation about outcomes, because one of my concerns is that -- and when we talk about sort of outcomes in Medicaid, that we're talking about such a heterogeneous program, and the principal distinction I would make, as you brought up, is the whole issue of long-term care or long-term services and supports versus medical care. And we know the duals -- I think of them as two populations: sort of one group of people that are Medicare eligible but reasonably healthy, and another population that is very significantly sort of impaired, needs a lot of long-term services and supports, and they are essentially the costly ones.

It's that population that concerns me when we start to talk about outcomes because I don't think we have a good sense of what outcomes that we expect. And, Gail, as you mentioned earlier, you put out incentives, and

people do respond. And the idea of a savings for the overall dual population without having a good sense of what our expectations should be for that significant share that are getting sort of long-term services and supports concerns me because we've seen -- we have Medicare experience with home health. We've created a very strong incentive with no accountability in terms of what services would be delivered, and we had an incredible response to that, which was not positive. So it's how we can think about handling this in terms of Medicaid or any kind of integration or sort of Medicaid changes by themselves.

DR. WILENSKY: I don't disagree with your concern. I'm not actually looking to save big dollars on the dual eligibles. I'm looking to spend them smarter. What really bothers me is you have this very costly, high-need population who sometimes get very good care because they happen to live in areas where they've got serious providers of long-term-care services who know what they're doing. And other times you spend a ton of money because they're living in a siloed world.

I guess I'm a little more optimistic. I've been meeting on a regular basis with Vince More and Robyn Stone

because we're in an outside quality advisory committee that HCR managers set up when they went private, and we meet at least quarterly a year and discuss things in between, focusing on the kind of metrics that you either should or shouldn't do, and CMS has had lots of examples of both cases, you know, good intention, bad actually metric, but important attempts to try to move this forward.

So I would say that while the philosophical challenges in the long-term-care-oriented population are much greater because you are usually trying to focus on maximizing functional capability and quality of life for a population that is in declining health and just stabilizing that is a win, that it doesn't mean it's not possible to turn that focus to outcomes rather than the inputs.

So it is harder, but, you know, we're spending this money anyway. It's as much we're spending it badly, in my opinion, as opposed to looking for -- this is a pretty efficiently provided population. I'm a big Medicaid buy-in advocate, have been for the last several years, that people up to 200 percent of the poverty line ought to be able to buy into Medicaid if they want to use their exchange money, on the grounds that they -- Medicaid, while

it is the ultimate narrow network in most places, seems to be able to provide a large array of services, generally speaking, with good enough access. There are occasional exceptions. But relative to what I think is happening in the exchange market in some places for individuals, Medicaid doesn't look so bad to me, and done at very low cost, even though we're spending a lot of money, but we're taking care of a lot of people.

So I just think -- I mean, I'm not ready to throw in the towel here. And focusing on the inputs is just wrong because this is the group that needs coordinated care. I mean, I have hated for the last 25 years now the notion of legislating hours spent by various groups of people by law in terms of how care is provided to sick people or needy people of some kind. That puts your eyeball on the wrong place, and it focuses -- I mean, for economists, there are lots of different ways to provide services, and you want to try to have incentives to be able to be responsible for what happens to the people, but give them a lot more flexibility about how they do it because it will depend on who's there in the local area and what kind of skill sets they need and what kind of skills the people

that they're dealing with need to have available. And you can't do that in state or national input requirements, which is, I think, what we focus on.

So I just -- I mean, given the choices of where we've been focusing on inputs and where we are trying to move to, a greater focus on outputs and encouraging a breaking down of the silos, which is what good managed care is about -- I'm on the board of Geisinger, one of my many volunteer activities, and, you know, they provide examples. When they do it well, they do it really well. One of the things you learn as a director is they occasionally trip up badly in terms of their hand-offs, even though they are an integrated delivery system, because not all parts of them are actually part of the same system. You know, they use other people.

So it is a focus on -- because you have bad things happen on occasion, does that mean it's not a clearly better move and a better direction and you need to try to shore up the metrics and the oversight that will allow you to do it? But you've got to have your eyes on the right area, and focusing on the inputs just gets you in way too much trouble and in the wrong area of concern.

MR. SLAVITT: I don't have anything to add.

CHAIR THOMPSON: Marsha?

VICE CHAIR GOLD: I'm Marsha.

Do you want me to just -- so we can get more people in? I didn't know if Andy wanted to say anything.

CHAIR THOMPSON: No. Just go ahead.

VICE CHAIR GOLD: Okay.

My question is sort of a little bit on that track but more general. I mean, as someone who has looked at managed care for quite a long time in Medicare and Medicaid, I really like to focus on outputs rather than -- on outcomes rather than inputs and looking at what you're trying to accomplish.

What I was just wondering about as I read your article and I looked at it is Medicaid in general when -- the issue is what's realistic to assume, and maybe, Gail, you're talking about metrics, so it's metrics.

But the issue is the social risk factors and what medical care can and cannot achieve and what we reasonably expect of our health system, and we're not going to medicalize the whole social system and providers only have control over so much. And when you start moving to those

metrics universally, you run the risk that some of the providers who care for the sickest people or the hardest people have the hardest time looking good. The Institute of Medicine recently looked at that with Medicare.

And so how do you focus on outcomes but in a realistic way of what to expect of the medical care system? And I think that gets more complicated as you start looking at the different subpopulations within Medicaid.

DR. WILENSKY: I --

MR. SLAVITT: Go ahead.

DR. WILENSKY: I spent three and a half years on the WHO's Commission on the Social Determinants of Care, so it doesn't take a lot to convince me that most of what we need to focus on, especially in this country, where we are completely reverse to the rest of the world in terms of our ratio of health care to social services, which in most countries is 1:2 and we're 2:1.

I also firmly believe unless we can find a way to dramatically slow health care spending, I don't need to reduce it from 17 or 18 percent to 11 or 12 percent, not that I don't think technically that would be feasible. Politically, it's just a nonstarter for the redistributions

that would suggest, but slow it dramatically in order to be able to put greater amounts of money into the system.

Are there ways to actually try to encourage at the local level more integration between some of the social services and the medical service? This is by way of saying, of course, you're right, particularly in this population.

It probably isn't going to come as a shock when I tell you I'm one of the people who are very outspoken about the advisability of allowing 1332 waivers and Medicaid waivers to be jointly considered in terms of their impact on class neutrality and over a three- of four-year horizon like we traditionally do with 1115 waivers on the grounds that you need to invest in order to see savings for some.

It's a way to try to encourage thinking about whether the communities might be willing to pool their resources, which some communities on a local level are talking about doing. About a year ago, I was out in Hawaii. The Blues there were the dominant provider of insurance, are trying to set up structures that allow, because of the isolated nature of the population, some of the groups who are concerned what fall into the social

determinants rubric to cooperate together to support services.

You see this cropping up. Hilton Head is another area where there's been a real push by some of the retired physicians who have moved down there to reach out to try to augment the medical structure that exists.

It would be helpful to try to encourage that kind of thinking as much as you can, having at the local level linkages between the medical care system and the social services system. I mean, that's the only place you could imagine having that go on, is at the actual local level where the service delivery occurs. So that you can try to do things that would impact the well-being and outcomes of these people.

As really as 1992 when I was in the Bush White House, the leadership from Atlanta came into the White House with representatives. It was organized by the Carter Center. They had representatives from government, from the business community, and from philanthropy in the Atlanta area, and said, "We have enough money coming into Atlanta from all the various federal grants and other sources, the business support of health care. It's just all in boxes,

and we can't move them around, and if you could help us find a way to be able to integrate that money with commitments we have from the business and philanthropic community of Atlanta, we have enough money there." Needless to say, this was the kind of thing that very much appealed to the White House for Bush 41, but we couldn't come up with a way to get around all the committees that would be impacted and the Congress that would have to give permission.

Over the last 25 years, there has been increasing recognition that if we can try to find ways to do this, we would be much better off. We gradually are getting some mechanism, is why, I mean, I am looking to 1332 and 1115 waivers, because they tend to be -- as it happens, the exchanges are heavily, heavily focused on under the 225 percent of the poverty line, particularly in the 138 to 200 percent of the poverty line, just by virtue of who came in.

You don't run the risk that people have raised, "Will you siphon money away from the poor and low income to take care of the middle income and upper middle income?" and the answer is that's a legitimate concern. But at a practical level, that's not who's there, and the people who

are there, under 200 percent of the poverty line are one of the least stable income populations we've ever received, because exactly where they are on that income distribution depends on how much they're working and whether a second person gets a job.

So unlike high-income people or even real middle-income America, who usually has a formal work structure in place that provides them, unless somebody loses a job, with a certain amount of income, they get variations. But they don't get as much fluctuation as you get down at the lower level.

So sometimes we act as though these are really separate populations, when in fact it's the same people who are just moving around from place to place.

So it's challenging, but it's not outside the increasing thinking of large numbers of people who know what's going on. I mean, it is institutionally challenging because of the different structures you cross. It is becoming less challenging in terms of what people who are involved know, and I think when there are opportunities, either informally coming together or formally -- and I actually think that risk programs, the financially at-risk

programs, are going to be the mechanism that is going to be the organizer.

One of my now longest-serving activities, I'm a trustee, a neutral trustee for the United Mine Workers Health and Retirement Fund. It was set up in 1993. The UMWA, the co-owners, actually, have promised about every health care benefit known to mankind to miners and everyone who is related to them. It's a very comprehensive benefit package.

That means that the health and retirement fund is ultimately responsible for people defined in populations, depending on when it was they retired, but they do -- they can and do work in some kind of coordinated fashion.

And what that's meant is for the last 10 or 15 years, the Health and Retirement Fund has made investments. When they see an elderly person coming in with multiple fractions, they send somebody out to look at the house to see whether or not there's something that can be done on the steps or in the bathroom to keep that person from falling so often, because they are going to be stuck with them in terms of the medical care cost.

And even in a community where the individuals --

these are frequently isolated areas, where calling on ambulances for routine medical care -- they put in a program to cover for certain people, who otherwise had no access to those services, a non-ambulance ride service to get them to where they were going, because they were ending up paying for it, anyway.

So it is to me just a reminder that while we are not going to see the kind of very full benefit package anytime soon that we have there, as you're responsible, anyway, for more and more, it does make you more thoughtful about how to try to keep your own costs in check. And it is why, if we can find ways to lower some of the barriers, particularly to the groups who are at risk, anyway, and who know they need to work together with some of their local counterparts, we may be able to get models for, I guess, what -- I don't know. Marsha, you will remember when it happened and where it sent to, the social HMOs of the 1990s, I think, a great idea that seems to have fizzled out, but it doesn't mean that the idea wasn't a good one.

MR. SLAVITT: You know, just real quickly, we had two issues to deal with, to try to wrestle with your question when I was at CMS. One was how to account for

socioeconomic status in Stars, and the other was how to do it in risk adjustment. And so these are real live case studies that I'm sure our first go at it can be perfected and improved.

But I will tell you what are the principles that I thought were appropriate to apply. Two things. One is that there shouldn't be two sets of measures for people in America, depending on their status. In other words, a low birthweight baby is a low birthweight baby, and we're not going to give anybody any room to say, "Well, but there were extenuating circumstances." Just don't think that's productive and ultimately leads to the right place, and in fact, it could lead to a very bad place.

But, at the same time, it's a comp-setting measure to say, "If I want to give differential investment to somebody, I want it to be the people who are taking care of the harder-to-treat people," so the second principle was even though it was the same metrics, people who can demonstrate, people who are taking care of tougher-to-treat populations, those are the ones that ought to be rewarded so they can invest in those populations.

CHAIR THOMPSON: Thanks.

All right. As expected, we're going to be challenged here to get everybody in, but I have Chuck, Sheldon, Fred, Toby, Darin, and Stacey. So, Chuck.

COMMISSIONER MILLIGAN: Thank you both for being here.

I think I want to follow up on this theme about inputs and outcomes and contextualize it a little bit differently around value-based purchasing value-based contracting between health plans and providers and then kind of the program integrity payment, integrity of state, sort of fiduciary responsibility about tax dollars, federal responsibility about tax dollars.

Here's the specific question. I'm with a health plan in New Mexico working on a lot of these VBP arrangements with providers. There's a view that a lot of the investments that produce the outcomes we want are not investments that are easily encounterable and can be submitted to a state as a cost of delivering that outcome. So whether it's working with social determinants, housing and employee and food and certain kinds of transportation, criminal justice system and so on, whether it's at the health plan level or whether it's at the provider level, a

lot of the investments that might produce that avoided admission, avoided readmission, avoided ED visit, aren't easily captured and submitted to a state as an encounter or as a cost.

And that I know with a couple of large providers in our state, there's a view that because rate setting is based on encounterable investments, that the rate-setting process, which is, I think, completely valid, encounters are completely valid to demonstrate to the taxpayers that the payment, the capitation payment and so on is appropriate, I think that there's a fear that because we still pay based on inputs, even in encounters and managed care, that we're going to overstate the medical savings without capturing the actual cost of the inputs, and there's a secondary element of this, which is that the more we all focus on MLR, the more we -- and view admin expenses, something that needs to be made more efficient and more lean, I think that it's just -- I'm curious, because I've been on a state Medicaid director's side and on a health plan side, and I value the rate-setting states and federal stewardship piece of this. But I know that with health plans and providers, there's a fear that some

of the input-based methodologies to drive rate-setting don't capture the full cost of the inputs to produce that outcome, so --

DR. WILENSKY: You're right. I mean, you're right. The reason that this continued focus on either getting your money, justifying your spending on the basis of traditional inputs is just a bad idea, and it's going to fundamentally be you need to base it on risk-adjusted people that you're caring for and not on the input cost of treating them in a particular standardized way.

I mean, there is just no getting around it. I have a forum that will be coming out this week or next week that also mentions a point. This isn't that I focused on, but Ashish Jha has focused on, is the disappointment in some of value-based purchasing strategies because it's too diffuse. You basically need fewer metrics, more focus on the dollars, and more focus on the outcomes that are provided to providers in a quick and responsive way, is a point he's made both in writing and in speaking.

So it was like all of this, not meant to criticize early steps. Its early steps, not surprisingly, need to be continuously changed. The continuous

improvement concept is out there for a reason. Frequently, first-in, early initiators make incredibly important contributions, but if they are not continuously moving, they are going to be left behind, and early initiators are frequently not so much at the head of technology.

The VA's electronic medical system is just a great case in point for what had started out very early to be extremely path-breaking in terms of what was being done, but has taken longer than it might have in terms to get to next generation.

So, to my mind, yes, you're absolutely right, and if we don't stop thinking like that, we won't get this problem solved.

MR. SLAVITT: The only thing I'll add, which you already know, which is states just don't have enough money. So you can try to -- I mean, even if you work on those mechanics, we need to find ways to bring the costs down for the states continually. I mean, that's the big problem, so they're going to be appropriately watching all those, all those avenues.

CHAIR THOMPSON: Sheldon?

COMMISSIONER RETCHIN: Well, thanks to both of

you. Thanks to both of you for being here this morning. This has been a great dialogue.

I am going to go back to the duals, if I can, which I do think we all share the enthusiasm for the enormous opportunity.

As a provider in Virginia, we had a provider-sponsored HMO, and I will say the states really stood in line when the program was first demoed. So there was a lot of enthusiasm. A lot of states -- and I assume it wasn't out of cost sharing. It was just the desire to innovate.

Then, as a provider-sponsored HMO, I was encouraged to participate by the state and knew that I would lose my shirt. It was really the rest of my clothes that I was worried about, but I did it, anyway, out of, I think in retrospect, patriotism. But we were going to lose a lot of money.

And that's what brings me to my questions or challenge or maybe opportunity for discussion, and that is maybe this is really a problem of behavioral economics, but the opt-out rates in the dual demonstration have been extraordinarily unpredictable.

And from my own standpoint, I don't think a risk

adjuster is the answer, because you're dealing with people -- and, Gail, you pointed this out. These are high spenders, so they may average 25, $30,000 a year, but you've got some that are 100, 150, and no risk adjuster is going to do that.

Now, if the answer is, "Hey, we don't need to save money," I'll take some of that action, but I think in the end, we've got to solve the opt-out rates. I would have thought the default opt-in from a behavioral economist standpoint would have been the answer, but it obviously isn't. So --

DR. WILENSKY: Can you explain a little more who it is that you're thinking has the opt-out? Who is it that you're thinking about having the opt-out?

COMMISSIONER RETCHIN: Those that are non-institutionalized. I mean, that seems to be the pattern.

DR. WILENSKY: Oh, being in --

COMMISSIONER RETCHIN: Beneficiaries.

DR. WILENSKY: Being in an organized system?

COMMISSIONER RETCHIN: Yes.

DR. WILENSKY: Okay. I'm actually a big believer in making use of having opt-out as a strategy if you think

there is a strong preferred behavior like transferring 401(k)s when you change jobs, as other people have suggested over the years. And I would agree, I think, having people who are in the dual-eligible category opt out of an organized system rather than opting in makes a lot of sense. There would be a lot of political -- if that's what you're suggesting. Or did I misunderstand you?

COMMISSIONER RETCHIN: I think that is -- Brian, maybe you could shed light on that, but I think that's what has been done, and it has been --

VICE CHAIR GOLD: In financial alignment demonstrations, there has been opt-outs, and I think -- and someone, Toby probably can talk to this, too. What happens is some of the doctors, especially in California -- I'm not sure in other places -- encourage their patients not to go in, so they have a high opt-out rate. And so you have some political dynamics. It's not just the incentive on the beneficiary but how it works with the provider community. And it has complicated things, I think, Andy, in some states more than others. Is that right?

DR. WILENSKY: I mean, at some point I mean, opt-out says you get that right, and I guess you can think

about are there any reasonable, appropriate countermeasures to take to try to counter that? But, I mean, you do want to have -- I think you both for political and other reasons need to preserve the opt-out provisions. It's like, you know, why are they doing that? Can you counter that? I mean, if it's strictly the money, that can be tougher. But it is whether there are other outreach programs that might counter whoever is pushing opt-out, if it appears inappropriate and self-interested to the person suggesting it.

CHAIR THOMPSON: So just for everyone's benefit, we're trying to release Gail and Andy at 10 after 10:00 for some other meeting, so we've got Fred, Toby, Darin, Stacey.

COMMISSIONER CERISE: Good morning. Back to the issue of pools, I agree with you that we've gotten distorted in how we do these payments. But oftentimes what happens, you'll have a good idea of something that works, and then it gets distorted and we run the risk of throwing out the good part.

I'll give you a real example. I was thinking about a person who's been in the ED 30 times in the past month who obviously has a social issue, much more so than a

medical issue, and the solution for that person is a social worker, housing, some behavioral health assistance, and a job. And when that happens, they quit coming to the ED. A real example, and I've got many more that we could talk about.

The challenge is those resources to really address that issue are not going to get moved by rates. The hospital CFO that you talked about is not going to change behavior. You can't pay that person enough in Medicaid to take care of those problems, I don't believe. And so there's a balance here that we clearly have, I think swung away from rates, in some areas have neglected rates, and depended upon these pools. And I think in a lot of cases it's because the pools are a way that the states don't have to put up the state share. They can find shares somewhere else --

MR. SLAVITT: Right.

COMMISSIONER CERISE: -- to cover the pools, and then sort of spread the pools thin and wide, and you lose the impact of the pools at that point.

MR. SLAVITT: Sure.

COMMISSIONER CERISE: And so I guess it's a

comment and a plea to look at, you know, perhaps in these pool situations the source of funds and how you spread -- and how we're defining and expecting outcomes, because I think you can define and expect meaningful outcomes, but to agree to your point, I don't think we're doing that real well today.

MR. SLAVITT: Yeah, I think we're closing in on it, and you run a terrific system, which I had the honor to get to visit when I was at CMS, and, you know, there's Parklands all over -- if there were Parklands everywhere, life would be really good, better in a lot of respects. So a lot of kudos to you and your team.

So I want the safety net hospitals and community hospitals to have that money to invest. I just think that it has to come in ways that make sense with the amount of patients that they're seeing and with the accountability to invest it in those appropriate ways. And so I think we're probably -- you've taught me something with your comment, so I'll take that on, not to be so completely, you know, 100 percent adamant in that perspective.

Still, I think, you know, we can take care of -- we are expected to take care of other investments based

upon the work we actually do, and I'd much rather get us closer to that.

DR. WILENSKY: Also, what has been reported to me -- I haven't actually tried to do it, so it's hearsay -- is that some of the issues may be not obviously resolvable in terms of frequent fliers, but a lot of times they are. If nothing else, you can make sure they are at least connected with the other social services. I mean, it used to be that a health system wouldn't consider spending the time to try to link people with the right social service individuals in terms of housing or support or other needs.

It is stretching the obligation of the health system, but in a way that's completely self-interested, because anything that they can do to try to find ways to reduce the frequent flier population and their -- I mean, it's one thing when you're talking about several times a month, and it's another thing when you're talking about double-digit returns.

There are at least a lot of cases where active, not unreasonable interventions have been able to reduce those, but clearly not all the time. So it just at least pushes people if you don't have a direct reimbursement

system, where having people come back in is actually good for your bottom line, and what is particularly frustrating is when you talk to some of the integrated delivery systems, and they remind you -- we talk a good game in Medicare in particular -- about how much we're moving toward more integrated care. But, in fact, the reimbursement system is still dominated by if you do more, you get paid more; if you do more complex, you get paid more. Yeah, you might get hit by a readmission penalty, but the penalty is a fraction of what you get in terms of the basic reimbursement. And until we -- this is one of the points that Ashish Jha has made, is you need fewer moving parts and you need to make them bigger and you need to get the information to support them frequently and readily available so that you give people an incentive, because you can have rewards and penalties out there, but if you're talking about the tip of the tail of the dog that's affected and 98, 99 percent of the base payment is what it is under the old rules, you know, you can talk a good game, but you're actually not putting your money where your mouth is.

So, I mean, I have some sympathy for stuff that

goes way beyond your control, but there do seem to be a lot of instances where you can have an effect.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: I just wanted to build on a little of what Alan and Fred talked about. Clearly, there's the tension as it relates between the supplemental pools and value and infrastructure building.

The other tension -- and you guys talk a little about this -- is just the source of the financing and that most of these pools are coming from providers or intergovernmental transfer provider fees. And as you try to unwind and really create value, it gets to the question of what's going to happen with those dollars.

And so there's this tension here with the underlying Medicaid financing, and you both touch on it, but it's really hard to tackle this without thinking through the structure of the financing, too, and how that doesn't --

CHAIR THOMPSON: As to whether the dollars just go away --

COMMISSIONER DOUGLAS: The dollars go away and it destabilizes the underlying system.

DR. WILENSKY: Amen to that.

COMMISSIONER DOUGLAS: So I want you to talk a little bit about that.

DR. WILENSKY: I have been especially concerned about -- intergovernmental payments is one of these areas where it can be a completely legitimate source of funding, and it opens the door to all kinds of bad behavior and gaming of just moving money around in the system.

It is why ultimately, although this is a big issue that we don't have time to talk about here, if you had a reasonable base, if you had reasonable growth rates, and if you had a division according to the various populations that are under focus in terms of Medicaid, I don't think a per capita grant is necessarily a bad idea, because I think we've lost on this issue of knowing what kind of funding we've got coming in anyway. And I would be just as happy to recognize it.

It's very complicated and complex, and the potential for mischief and bad behavior setting it up is great. And any proposal that is purporting to save $600 to $800 billion as part of their transformation is clearly about saving money and not doing any kind of thoughtful

restructuring. So I don't want to use our present example. I just think there are other issues that we are going to see rise up again once we get away from the 100 percent federal funding that we really haven't had to face for the last five or six years, and also what seems to me the lunacy of having these different match rates with the highest match rates going to the least poor, the poor low-income population. But we will get there one day, someday, I assume, but not this day.

MR. SLAVITT: So, you know, we have to get serious about two things if we're going to do what we're talking about in a transition. One is actuarial soundness and the other is access standards. And that's something that we have to get serious about anyway, but certainly what we're talking about relies upon those two things working well. And I can't give you perfect confidence here that they would, but that's certainly part of the equation.

CHAIR THOMPSON: I think we have time for one or two, Darin, and then I'd like to ask one last question.

COMMISSIONER GORDON: Thank you both again. You know, as we talk today, as you have shared with us, there's the underlying theme of about relooking at some of the

incentives. You know, you talked about case improvement. We start with best intentions, and as things play out over time, you need to relook at those things and see if they need to be improved.

But at its core, you know, you have one of your recommendations about investing in data technology and analytics, which I would believe needs to be kind of the starting point for all else that we've discussed. In talking to states all across the country, you know, it's an issue that everyone's interested in, and maybe we need to do some more work as a Commission to understand what some of the barriers are here. But I would be interested in your perspective, if there's great interest and great desire in those areas in particular. What do you see as some of the barriers for states moving in that direction?

MR. SLAVITT: Well, I think -- and I'll try to be brief because we both have to run in a second, but the -- you know, we absolutely need at a minimum the same level of data and analytics infrastructure that we have for the Medicare program, and the truth is we probably need a much greater level of infrastructure because, you know, what we're talking about here are people taking two buses to get

to a dialysis center or their appointment, and having logistics messed up, and that causing, you know, 100 days in a hospital. So the data analytics handoffs here and the coordination because of all the service providers are even more complex.

So I think, thankfully, at the end of last year, we got a database product out from CMS. I think it has something like 38 states in it. We just need to continue to get working versions out and expand it. I believe we need to get data rights distributed more broadly. And I get you there is a whole ton of low-hanging fruit in managing these populations more quickly. So I hope this get some focus. I have reason to believe that the new administrator cares deeply about this area and will continue to invest in it, and I think it's just as if we were doing it in the private sector. You've just got to invest in it. You have to keep people on board. I think you've got to build scorecards for states with some of the data, get those scorecards to the states so that they can have a shared view of what's going on, and all of a sudden we'll be talking about a common set of metrics, and we'll be complaining about a common set of metrics and how awful

they are, but we'll be improving them.

CHAIR THOMPSON: That's great, and the good news is Darin covered the question that I was going to ask, so we are on time to release you as we had promised.

MR. SLAVITT: Excellent.

CHAIR THOMPSON: This has been, as we expected, a really deep and great conversation. We appreciate, Gail and Andy, both your ongoing work on this subject and your spending time with us. Thank you very much.

MR. SLAVITT: Thank you. Thank you all.

DR. WILENSKY: Thank you.

[Applause.]

CHAIR THOMPSON: We'll take a break and reconvene at 10:30.

[Recess.]

CHAIR THOMPSON: Okay. So now we have a presentation from Ben Finder and Rob Nelb on DSRIP.

IMPLICATIONS OF THE LATEST ROUND OF DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) FOR THE MACPAC'S WORK ON VALUE-BASED PAYMENT

* MR. FINDER: Thank you, Penny, and good morning, Commissioners.

I think the last session really set the stage and hopefully oriented you toward thinking about what expertise and insight the Commission can bring to bear on value-based payments in Medicaid.

So our presentation today is about the implications of DSRIP programs for the Commission's work on value-based payment, and DSRIP, of course, is an acronym that stands for Delivery System Reform Incentive Payment programs. I'll define these a little bit more in just a minute.

This is part of our broader work examining Medicaid payment policies, and before we dive into DSRIPs, I want to say a little bit more about MACPAC's work on Medicaid payment policy.

In our authorizing statute, MACPAC is required to examine state payment policies and their relationship to access and quality of care. We've done a lot of work in this area. Some recent examples include our efforts to compare Medicare and Medicaid hospital payments, which we summarized in an issue brief on our website.

We've also done a lot of work documenting payment policies, the methods that states use to pay different

types of providers, such as physicians, nursing homes, inpatient and outpatient services, and these compendia are also available on our website.

And we've done a lot of work on disproportionate share hospital payments, or DSH payments. Most recently, for example, we commented on the recent NPRM on DSH.

There are some key questions that will guide our work on payment issues this year. They are, “What payment methods promote efficiency and value? How can disproportionate share hospital payments be better targeted to states and hospitals that need them? And what is the future of value-based payment in Medicaid?” And our work on DSRIP really falls under this last point.

So to dive in on DSRIPs, today's presentation is on the implication of DSRIP programs on value-based payment. I'll start by describing some of MACPAC's prior work around value-based payment. Then Rob will review some of the findings from our recent study on DSRIP programs and discuss the implications of these findings in more detail.

We hope that this presentation will focus your feedback on what direction to take with MACPAC's work on value-based payment, and to that end, we'll conclude our

presentation with some policy questions that may help focus or guide that conversation.

State Medicaid programs have implemented a variety of value-based payment models, and these are models that reward providers for the value of care provided rather than volume of care, as under the traditional fee-for-service model.

Although states have long had the authority to implement many types of Medicaid value-based payment models, the use of these models has increased in recent years, and over the last four years, MACPAC has studied these models in three separate projects.

Between 2013 and 2015, we explored and described a variety of models, including enhanced payments to patient-centered medical homes, episode-based payments and global budgets in a report called "Paying for Value."

In 2014 and 2015, we dug deeper into shared savings payments made to safety-net accountable care organizations, or ACOs, and we published a chapter in our June 2015 report on DSRIP programs.

DSRIP is one of the largest programs in terms of spending, and although there is no formal definition of

DSRIP, we consider DSRIPs to be programs that provide incentive payments to providers that undertake delivery system reform projects and meet certain milestones. These milestones can be based on implementation goals, such as hiring or building infrastructure, reporting milestones, or performance milestones.

States implement DSRIP programs under Section 1115 waiver authority because states can't otherwise direct supplemental payments to providers under capitated managed care programs.

As I mentioned earlier, we first reported on DSRIPs in our June 2015 report in which we described the genesis, design, and goals of the DSRIP program. We conducted a follow-up study between August of 2016 and August of 2017.

For this study, we contracted with the National Academy of State Health Policy, and I should pause here to thank our colleagues from NASHP for all their work on both of these studies.

Both studies were carried out in three phases. The first phase was an environmental scan of DSRIP and DSRIP-like programs, which includes, for example, waiver

special terms and conditions, project protocols, and interim and final evaluations, if they're available.

The second phase includes key interviews with state Medicaid officials; provider organizations, for example, hospital associations; evaluators; and in a few cases, managed care officials. We also spoke with officials from CMS.

And the last phase included site visits, most recently to New York and Massachusetts.

During our follow-up study, we noted several differences between earlier DSRIP programs, which we're defining as programs that were approved prior to 2014, and more recent programs. For example, newer DSRIPs do not have the relationship to prior supplemental payment programs, such as upper payment limit payments, or UPL payments. Newer DSRIP programs also tend to use designated state health program funds, or DSHP funds, as a source of non-federal share.

Under DSHP, the federal government allows states to count certain state and local health program spending that was in place prior to the waiver toward the non-federal share, and they're authorized under Section 1115

waiver demonstrations. So, for example, Rhode Island can claim federal matching funds for state spending on a tuberculosis clinic and a child audiology center.

While earlier DSRIP programs were primarily led by hospitals, newer DSRIP programs support the formation of provider networks and partnerships that are made up of hospital and nonhospital providers, and Rob will talk a little bit more about this in just a minute.

And while earlier DSRIP projects were typically developed by providers and focused on provider-specific goals, newer DSRIP programs focused more explicitly on statewide delivery system reform goals. For example, many of them include statewide targets for improvements in behavioral health care and also for the adoption of alternative payment models.

This slide is an overview of 13 DSRIP and DSRIP-like programs ordered by the date of approval. If you look closely, you can see many of the trends that I just described. For example, you can see that how beginning with New York, many of the newer DSRIP programs rely on DSHP as the source of non-federal share and have no relationship with prior supplemental payment programs.

And I should also note that in this slide, we've combined California and Massachusetts's initial and subsequent DSRIP waivers into one line.

And now I'll turn it over to Rob to discuss some of the implications of these findings.

* MR. NELB: Thanks, Ben.

So now that we've given you a brief overview of DSRIP, I want to talk now about the implications of our findings for MACPAC's work on value-based payment. Specifically, I am going to review how states have used DSRIP to address some of the common challenges that we've identified in our prior work that emerge across many different Medicaid value-based payment models.

For example, in our prior work, we found that states and providers often report challenges accessing capital needed to make up-front investments in delivery system transformations. We found that states faced challenges designing payment models that will incentivize providers to change their behavior. Providers have reported challenges preparing their organizations to participate in alternative payment models, and providers have also reported challenges addressing social

determinants of health that particularly affect Medicaid and low-income populations. And, finally, it's challenging to evaluate the effects of many of these value-based payment efforts on health outcomes and spending.

To help provide funding for up-front investments, DSRIP provides additional federal funds to providers that are making investments in infrastructure and care improvements.

All DSRIP programs include some up-front funding to providers for meeting program implementation milestones at the start of their demonstration, and during the course of the demonstration, the DSRIP funding shifts towards pay-for-performance milestones.

In our earlier work on DSRIP, we found that states reported challenges financing the non-federal share of DSRIP with intergovernmental transfers from public hospitals that received DSRIP funds. However, as Ben mentioned, we found that the newer DSRIP programs tend to use DSHP funding instead, which means that these states do not have to rely on funding from providers to finance the DSRIP investments.

To incentivize providers to change their

behavior, DSRIP provides a mechanism for states to invest directly in provider-led projects. As Ben noted, one of the reasons states have pursued 1115 waiver authority to implement DSRIP is that states are typically not allowed to direct payments to providers under managed care.

The providers that we spoke with during our study noted the value of working directly with the state on their transformation efforts rather than having to negotiate different value-based payment arrangements with different health plans.

In some of the newer DSRIPs, as Ben mentioned, DSRIP programs are helping to support the formation of regional partnerships of hospital and nonhospital providers, some of which are beginning to take on some of the roles traditionally done by managed care plans, such as care coordination for their attributed population.

During our site visits, we found that some of these provider networks are planning to become formal ACOs in the future and contract directly with health plans, while others envision a role as regional health planning entities that help encourage provider coordination, but will not formally contract with health plans in the future.

Many state and CMS officials that we talked with viewed DSRIP as a first step towards more advanced forms of alternative payment models, such as shared savings.

And some newer DSRIPs, as Ben mentioned, include explicit goals for the adoption of APMs by the end of their demonstration. The provider we spoke with noted how their participation in DSRIP was helping to prepare their organization to participate in APMs by allowing them to invest in the infrastructure that they needed to monitor their own performance. In addition, providers noted that DSRIP was helping their organization adapt to a culture of performance-based payment by gradually transitioning incentives from pay-for-reporting to pay-for-performance during the course of the demonstration.

We found that states are using their DSRIP programs to address social determinants of health in many different ways. Because DSRIPs are incentive payments that are authorized under a waiver, providers can use DSRIP funds to support investments in population health and other services not typically covered by Medicaid.

We found that some newer DSRIP programs are requiring DSRIP providers to direct a portion of their

DSRIP funding to community-based organizations.

We found two different models in play. In Massachusetts, for example, funding is provided to community-based organizations directly as a separate stream of funding, while in New York, funding for community-based organizations flows through DSRIP provider networks and is part of the overall incentive payment that the provider receive.

Finally, because DSRIP programs are authorized under Section 1115 authority, states are required to conduct interim and final evaluations of their DSRIP programs. So far, we have final evaluations from two states, California and Texas, and interim evaluations from three states, Massachusetts, Oregon, and New Jersey.

A summary of the evaluation findings are in your materials. In general, these evaluations show that providers are meeting their milestones and demonstrating some health improvements. However, because of a lack of a comparison group, it's difficult to evaluate whether some of these changes would have occurred without the demonstration.

In addition, the evaluations so far don't include

much data on the long-term cost savings as a result of the DSRIP investments, so we don't have much information so far about return on investment.

At this point, the future of DSRIP programs is unclear. In recent DSRIP approvals, CMS has indicated that it views DSRIP as a one-time investment and has encouraged states to develop plans to sustain their DSRIP activities at the end of their 5-year waiver.

One approach that states are looking into is sustaining DSRIP activities by making changes to their Medicaid managed care contracts.

In CMS's recent revisions to its managed care rules, CMS added a new option for states to direct managed care plans to direct a portion of their capitation rate to providers that are undertaking delivery system reform activities. These are sometimes referred to as "pass through payments."

Arizona's Targeted Investment Program, which was approved under an 1115 waiver and which we characterized as a DSRIP-like program for our analysis, does appear to be approvable under this new authority because the funds are passed through the managed care organizations.

However, some other states and providers that we interviewed expressed uncertainty about how this model would work in their states. In particular, it's unclear whether this model could support all the different types of projects that DSRIP currently funds, such as infrastructure investments and investments in the social determinants of health.

In addition, since CMS regulations prohibit pass through payments from being tied to IGT funding, it's unclear how some states would be able to finance these initiatives.

So this concludes our presentation for today. More information about our DSRIP work is included in your materials, and if there's interest, we can publish these findings in some form.

As Ben mentioned, the main purpose of today's session is to hear from you about where you'd like to focus MACPAC's work on value-based payment moving forward, and to that end, we've highlighted some policy questions raised by our latest DSRIP work to help jump-tart that conversation.

We look forward to your specific feedback to help further direct our work in this area in the year ahead.

Thanks.

CHAIR THOMPSON: Great. Thanks.

All right. I have Sheldon, Marsha, Darin, Toby.

COMMISSIONER RETCHIN: So I'll just kick this off. I really appreciate, Ben and Rob, your presentation and summary.

As an applicant in the DSRIP program when I was in Virginia, I took great comfort from your presentation that there were no guidance rules about what qualifies as DSRIP, so that was very comforting to me. I have now concluded it was probably alphabetical.

[Laughter.]

COMMISSIONER RETCHIN: So this just seems to be a great opportunity for MACPAC to provide a comment to CMS because this is a case where they're pondering, I gather, on what to do with DSRIP programs, and then I'll migrate to the question about value-based purchasing.

It seems to me that DSRIP started off as maybe another opportunity for mitigating the effects of the depletion of pooled funds with the managed care growth, but now has morphed into a pretty cool program and like a Petri dish with the best consequences.

And of all the things that it has provided -- and I'd be interested in others commenting on this -- it seems to me that it's promoting the opportunities for vertical and horizontal integration of safety net. Largely -- and this has been an area where there's been enormous vertical and horizontal integration in the health structure overall. I mean, that's a 10-year story. By and large, integration has only increased the costs of care by consolidating market power, and I'm not suggesting that any systems did that for that reason, but it has increased the cost.

I think this is an exception. So that the safety net consolidation has had the benefit of actually getting providers ready for alternative payment models. That is, before you can have ACOs, you need to have O's. So I think DSRIP has played a great role in the areas where it has promoted that, maybe in Texas and New York are great examples. It doesn't seem a program where there's been abuse. That, actually, the funds have really catalyzed this experimentation, and I think maybe is a lead for us to get into value-based payment models in Medicaid.

You know, I've been a little surprised at the amount of innovation in value-based payments in Medicaid.

As a safety net provider, the conclusion always is "Wait a minute. You're going to pay me 40 cents on the dollar, and you want me to provide quality metrics? You want to change the infrastructure and a host of other things?" So, yeah, providers that a third of whom don't even participate and you still want to do that, and I think this is a mechanism to facilitate that.

As I read it, I do think the opportunity to publish the results from the NASHP study and site visits and then to make a comment. I don't know how you do this. You can't do a recommendation, I guess, but I think this is an opportunity to maybe persuade CMS to continue the program.

CHAIR THOMPSON: Marsha, Darin, Toby, Alan, Kisha.

VICE CHAIR GOLD: Like Sheldon, I found the DSRIP stuff interesting, to see this new level, and I'm in favor of getting the descriptive information out.

Where I'd like to see the Commission work, when we're describing this stuff, I'd like us to up it a level. The question is, What is value-based payment? And if you look at it, the states historically can pay providers or

they can pay a managed care plan. It's been historically fee-for-service, not very value-based, or the managed care plan, the idea was they would somehow manage to get value out of that, and they may or may not have. And dollars for providers to develop the infrastructure to appropriately participate with health plans have been limited, and that's always been a constraining factor.

It seems to me that -- and this is very consistent with MedPAC's policy, I think -- is that what we're looking at is -- you can't look at DSRIP, and you can't look at value-based payment and fee-for-service separate but not paying attention to capitation because capitation is one of the main value-based tools. And then the question, if you have capitation, is how do the providers' organization themselves under that, or how do you work in the fee-for-service system? And markets are different, and states are different. So, in some places, you're going to have a very capitated system; others, you're not going to have a capitated system.

But it seems like the Commission might, as a general principle, have a view that what we're looking for is how best to encourage -- use payment rates, whether it's

through capitation or fee-for-service to encourage coordinated value-based care that results in the best outcomes or however one wants to say that.

And then within that, DSRIP is more a means than an end. It's a way to get money into the system to do certain things, and I think if we look at it in terms of general goals, we may not get as lost in does this provider and that provider and then how does this relate to the managed care. We're trying to encourage a goal that its execution is going to differ across states and across communities because the provider structures and preferences are different in those places.

And I'll be glad to talk to you more if that doesn't make sense, but it's been what's missing when I've looked at a lot of these. And I think it might help us put together these fee-for-service payment things with this capitation system, which is quite large, over a large sector of the program.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: Yeah, thank you for this. We used to say when I was still at State, we all talked as Medicaid Directors got together and everybody was

interested in DSRIP, nobody knew what it was, but they saw there were a lot of dollars behind it. So it garnered everyone's attention.

You know, in here it's discussed in the context -- and I do agree with the prior comments that it seem like it's evolving and taking a finer shape of what's behind it. What's unclear to me is, one, how the amounts are determined state to state, that that seems more fluid, less structured than, I think -- the other thing, we're implying that DSRIPs or it's at least being suggested that DSRIPs are a means in order to allow a system to change to value-based purchasing. Yet we see states out there, several states that have actually probably as aggressively if not more aggressively moved to alternative payment models, and they had not received a DSRIP. So the question is whether or not that's a necessary mechanism or it's a complementary mechanism. Does it help speed that process of transition up? But, also kind of as a sub-point to that, how does -- in some cases, let's think of like PCMH as a great example. In a lot of PCMH models, there's funding embedded within the PCMH model to do some of the process and infrastructure changes that are needed at a provider level. And I know in

some of these states that have DSRIPs, they also have PCMH models, and how these things overlap and fit together, it would just help give greater clarity and I guess further refine really the true purpose and benefit of DSRIP compared to maybe other approaches.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: The one policy question that I think we need to focus a little bit more is just the sustainability within -- outside of DSRIP or 1115 and how are states bringing back this idea of, you know, value-based and managed care and the intersection with providers, how and is that really happening? You know, I think just the view that I've seen is a lot of times it's still just happening in isolation, and the expectation is these will continue. Yet we have the conversation we had earlier, just to overlay financing and reform, so what is being done to prepare at that delivery system level to really sustain these in a way that it is not through 1115.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: You know, my view is consistent with Marsha's and Darin's, so I won't repeat it. I think this is really important work. I think its value

is primarily in context rather than in isolation. So it's how do these initiatives relate to the broader value movements, whether it's PCMH, which I hadn't thought of but certainly the managed care side. The commercial side, I mean, whether the metrics being used have consistency within Medicaid and other payers. It does seem to me like a lot of these are -- the outcomes are process outcomes; whereas, much of the value-based movement is more outcome -- you know, end-of-the-line outcome measures.

So I think at this stage I'm more interested in understanding how these efforts align or do not align with other efforts that are also very much in flux designed to achieve value than try to figure out the -- or even make recommendations about the exact nature of what they should be.

CHAIR THOMPSON: Kisha.

COMMISSIONER DAVIS: Thank you, and I agree with a lot of what has already been said in terms of this just being an area that we certainly want to move to and explore a little bit further.

My question is along the lines of really thinking about how this trickles down to providers and what the

potential implications are on network adequacy, especially thinking about sustainability and scalability for this program. A lot of them have been done in more pilot projects, and so do you create winners and losers among the providers who are providing this and aren't able to get the systems in place to be able to do it more broadly. So just thinking about that as we go forward.

CHAIR THOMPSON: Stacey.

COMMISSIONER LAMPKIN: And I'm not disagreeing with anything I've heard others say, so maybe this is just a little bit of a different way I'm thinking about it.

I think there's a lot of great stuff that we could do and add here, and there's one question in particular that piques my interest. I wonder if there is a way that we can contribute by addressing the question as to whether there are types of investments in infrastructure that is more efficiently done by the state on a systematic basis versus through managed care organizations and the states that are so largely managed care now. Like which kinds of services, investments, and efforts fit better at the state broad overlook level and which ones done by MCOs? Because where the waiver pools seem to have value to me is

if they can help states address those systematic investments. And if we see any themes there that we think can help CMS think through that or things that we have to add, that seems like value. And I think there's an intersection with that, and the question that you posed about how do the current managed care regulations affect states' ability to pursue these goals, because I think there's -- if there's a body of effort that we think is more efficiently done through the managed care organizations, does the regulation provide states and actuaries and managed care organizations the flexibility that they need to do that efficiently? Or are there efforts that need to be made there?

CHAIR THOMPSON: Thank you, Stacey. Chuck and then Fred and then Martha.

COMMISSIONER MILLIGAN: I agree with the comments that have been made. I think to me part of it is context setting. I think for a lot of people there's still a view that it's the first generation DSRIP, which is, you know, supplemental funding for the sake of supplemental funding. So I think context setting about outcomes and communicating and disseminating is a good thing.

I think, you know, as I've watched kind of the evolution of DSRIP, I think back to DSH and other things where, you know, there are the high DSH states and the low DSH states, and it's sort of disproportionately utilized opportunity. And I think that contextually, you know, the next time that there are efforts to do Medicaid reform at the congressional level, a lot of this is going to be part of that conversation about, you know, equity across states. And I think -- so to some of the comments.

I think explaining more clearly how the funding levels were set and how that fits into the context of how we got to where we are in terms of different state opportunities, different state amounts, and equity across states when there's federal health reform conversations, I think that that's going to be important.

And I do think to whatever extent we can illuminate this issue -- and, you know, Darin gave one example about PCMHs. I want to give a different example about the Section 2703 health homes. There are a lot of different interventions that can try to take credit for an outcome that we're observing as a good outcome. And I think trying to tease out how to identify the effectiveness

of some of these interventions that are happening at the same time and contextualize it with some of the comments that have been made earlier I think would be helpful.

CHAIR THOMPSON: Fred.

COMMISSIONER CERISE: Agreeing with the comment, this is definitely something that I think we should pay attention to. It seems like there's some fundamental disconnects that ought to be addressed. One is the CMS expectation that these are pilots that at some point will pay for themselves and then we'll be able to continue, because if you look at the projects, clearly a number of them don't fit into that, a lot of access and things like that that are good projects but that aren't going to end up paying for themselves. They pay to expand coverage or access.

But, in general, there are so many of these projects and so many measures that states -- and I'm sure CMS has trouble keeping up with this, and, you know, if we could do something to try to get some order and simplify. You know, Medicaid tends not to be a great payer, but then to Andy's point, when you add up all the supplemental programs, it's not such a bad payer a lot of times. And so

can you look at the projects that have proven to have value, distill some metrics and some meaningful outcomes that you want from the program, and then perhaps also look at the issue of do states administer these or do the MCOs?

I could tell you, it's very difficult to match source of funds, so, you know, where you're generating your state share from and then multiple projects through multiple MCOs, then who's measuring those outcomes and determining whether that IGT actually turns into a payment or not. And so to sort of simplify what you're looking for and also to the extent that states can set priorities and simplify how you administer that program I think would prove to be beneficial in a program, again, where oftentimes you have trouble recruiting in providers.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: I was really interested in the DSRIP information, and I'm glad to hear of the next generation of DSRIPs.

My question -- and I'm struggling with how to ask it -- is more fundamental about time horizons in terms of performance measures, and, you know, what we expect systems to be able to pay for -- you know, pay for themselves over

the short term versus the long term. And I wondered if there's a role for the MACPAC in terms of maybe differentiating time horizons in performance measures, because obviously we need to be able to pay for the system, but we also need the community providers to have the incentive to put the resources into the prevention and the up-front measures, the social determinants, the pre-diabetes screening that's going to keep people from end-stage renal disease. And, you know, that is a big sort of system question, but is there a role for the MACPAC in distinguishing time horizons in terms of performance metrics?

Sorry, it's a thorny one, but it's something that I've thought about a lot.

CHAIR THOMPSON: Let me ask a couple of questions, and Kit Gorton wasn't able to join us at this meeting and sent some thoughts and questions on this which somewhat paralleled my own.

It sounds like we have a little bit of a consensus that we'd like to see this conversation in the larger context of value-based purchasing and it's just one way to make investments and there are other ways in which

the Medicaid program can assist providers in navigating this transformation.

One question is: What do we know about SIM? So the SIM grants were supposed to be oriented towards this idea of not Medicaid living on its own, going its own way, but really working in a multipayer context to support some of these initiatives. And I think, Alan, this kind of is your point, too, or one of your points, which was, you know, is Medicaid in a stream by itself, making its own investment irrespective of what other payers are doing? Or is it augmenting signal strength from other payers or working in concern very deliberately and up front with other payers? What do we know about that?

MR. NELB: Sure. So Washington is probably the best example. Their new DSRIP, Accountable Communities of Health, actually came out of their SIM project, so SIM established these accountable communities for health, and then DSRIP was a much larger investment into helping sustain those activities.

Other states we talked to had SIM projects that were going on sort of separate from DSRIP, so that gets to your point that some of them are aligned and then some of

them aren't. But it's definitely a question we asked states.

CHAIR THOMPSON: And I just wonder if -- I mean, to the extent that we're making investments in effectively a provider system, and that provider system is supporting lots of different people in lots of different circumstances, including outside of Medicaid, there's the question of what responsibility should Medicaid have and how should it operationalize that responsibility alongside of others so that it isn't the only investor, if you will, in the provider system? Darin?

COMMISSIONER GORDON: Yeah, and we've seen this -- this gets back to the point that was being made earlier about the disconnect at times between Medicare and Medicaid, because a lot of states using investments and moving down the path of some of their programs and then, lo and behold,
CPC+ comes on the scene and people are like, okay, I've been working two years on this. How do they align? Do they align? Do I need my plan to be more consistent with that one? Does it allow for additional investments from another payer source to help support providers in this

transition? You know, some of that can be planned, and some you're having to react to. But I do think it's something we should look at.

CHAIR THOMPSON: Marsha.

VICE CHAIR GOLD: Yeah, I think that's a good question, and some of the -- in some states the providers and Medicaid overlap other providers more than others. So coordination is important, but probably more important where there's market share that is not distinct. And there have been some efforts, some of the multipayer managed care organizations -- medical home efforts that do that.

One of the things -- and this is what I think is coming up. I mean, after the ACA, there was a lot of interest. How do we get the delivery system to change? And there was a lot of money thrown at it in different ways to do it, some of which is more coordinated than others.

I think there's a recognition that there needs to be some investment in infrastructure and that especially in Medicaid, that may be hard; in the private sector, you have to do it -- unless the government comes in with some money somehow, the providers don't have it or the plans may not have it. But how this all -- we're not going to come up

with a clear answer on how all these things relate. But I think part of what a lot of us are saying is we need to recognize that this is an effort to help build that, and there's these different ways, and if -- the one thing that troubled me in some of the DSRIP things is: How do we continue it or should it continue? I don't know. I mean, to what extent does the delivery system need to stand on its own at some point having been invested in? And to what extent not? Is it a time frame issue, or is it just this isn't going to be managed? And how far can you push a delivery system to become a system and it will be different in different places?

So sometimes we can't solve a problem. We just keep putting more layers of cost on top of it, and I worry a little bit about that. And so that's one of the reasons I was thinking that the more we can conceptualize what's behind a lot of these and how they relate in context to others is important.

CHAIR THOMPSON: So a couple of other points, too, just picking up on some of the threads. One is you talked about social determinants of health. We talked about this in the earlier session. We've been talking

about this at various points. Do we have any information from these efforts or others about which social determinants are more important to address? Are they equally weighted? You know, what do we know about that? I have a general -- I think everyone understands the importance of some of these issues to the need for services and the expense associated with those services and the quality of life that results from addressing some of those issues later rather than earlier.

But Marsha made the point in the last session about, you know, where do we draw some of these lines between what Medicaid would be responsible for and what others should be responsible for? Fred, I think that was a little bit of your point as well in terms of how do you create a stream of funding to support solving for those problems rather than the immediate medical expense.

So I think if we have anything to add to that conversation in terms of understanding where the Medicaid investment -- again, some of my question has to do with what Medicaid should be responsible for and how it should make investments versus where Medicaid should rely or work with other payers, other sources of funding, other

responsible agents and agencies to try to address some of these questions.

And then is there any kind of special consideration for the provider communities serving Medicaid beneficiaries? Are there certain providers who are going to need some special assistance from the Medicaid program that are generally serving Medicaid patients solely or in a major way who will need some specific assistance in order to be able to succeed in a value-based payment environment? Who are those providers? And are they getting attention through either some of the rate-setting activities that we're talking about or through DSRIP or through other kinds of steps that programs are taking? And, you know, this sort of gets, again, back to the question of, you know, were we diffusing some of these funds too broadly when there really is a special case for a special group of providers doing certain services for certain populations that we really should pay very specific attention to? I think that would be worthy of consideration as well.

Fred, you wanted to jump in?

COMMISSIONER CERISE: Real quick, just to clarify, too, because we're talking about different payers.

You've also got the uninsured in here, too, which is another reason why many of these projects can't stand on their own after you've sort of set them up, because you don't have a natural payer to sustain after you've made your improvements, and that gets lumped into DSRIP as well.

CHAIR THOMPSON: Well, and that's a little bit of distinction between the programs that are being supported through DSRIP, right? So there is a certain set of programs that are about changing -- you know, that are basically practice redesign, right? And so I'm trying to invest in helping you change the way that you practice, and presumably that has an endpoint, though it change is perpetual and there will always be improvements that people will try to seek to make in that way of developing practice.

There's also disparate projects that are basically just about serving people, right? And so maybe there's some better distinction that we should be making between those kinds of projects for the purposes of understanding sustainability.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: I have a very simple data

question, and this is my interest. So what is the feasibility of obtaining data about DSRIP programs both in what performance metrics are being utilized in these programs and to what degree are the providers meeting those metrics. So, I mean, value-based payment is supposed to be conditional. It's not like everybody gets a blue ribbon. So is that kind of information, like who got it, who didn't, those kinds of things?

MR. FINDER: Yeah, some of that information is included in the state interim and final evaluations in terms of sort of aggregate numbers of how many providers met targets and what targets were met. And, generally, these payments, they are -- you can tell what they go for, whether or not providers have earned them, and so there are data out there that we could try to look into to get a better sense.

COMMISSIONER BURWELL: And is there uniformity in the metrics? The metrics are, in essence, the definition of delivery system reform, were they not?

MR. NELB: Yes, yes. So there are protocols that define the different metrics, and so we could catalogue them and look at them, kind of similar to what I'll present

this afternoon, what we did with waivers in general. We could do a similar thing looking at DSRIP projects and sort of what measures they're using for different projects and how well that aligns with other payers.

COMMISSIONER BURWELL: That would be of interest to me.

MR. NELB: Great.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, but I just want to add to that. Because these are localized projects that providers are sort of defining, they're doing different things, and so there's a whole range of performance metrics that we have information about whether they're meeting those or not. But since they have different sort of targets based on, you know, what the providers thought that they could do, what the needs are in the community. So it does vary quite a bit.

CHAIR THOMPSON: Marsha, go ahead.

VICE CHAIR GOLD: Well, just I was wondering whether someone else has done it or how feasible it is to look state by state at where the DSRIPs are, where the medical homes are, where the whatever's are, and even a little bit about whether they talk -- I mean, they could be

having different goals with different providers, but some way of understanding how this fits together. I think it relates with Penny's initial question about the innovation grants. I mean, what are all these things buying in different states? And it gets complicated because they may take place in different communities and with different providers. But I don't know if you can understand it without looking at how it comes together in states.

MR. NELB: NASHP does have a map on their website with some of these different initiatives, and it's something we did ask the states.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: Yes, when I hear that, I just get fearful we're going down a rabbit hole because this is what -- from a plan perspective, there are also -- whether it's because the states are requiring them or not, are doing value-based payments, are doing social determinants, are doing -- so, you know, we have to -- this is one piece of a broader -- you know, puzzle, whatever you want to call it, and the question is how -- to me is really whether it's the sustainability or the integration, you know, are they coming together? Or are we having these

silos and everyone's doing it? And then, you know, again, back to if one falls apart, we lose the money. How is that to sustainability of the system?

VICE CHAIR GOLD: Has anyone done case studies of selected states or markets within states as to how all these pieces fit together and whether they're -- how it affects the providers and whether they're falling apart, whether they're working in synergy or against it? Sort of Toby's question. It seems to me that's a cross-cutting question if people haven't looked at it, but I won't find the same answer in different places. Because, Toby, I get concerned. I mean, how does it look at a plan level or a provider level? You've got 18 different things coming at you at different times that people want. To go in a direction that you care about, that's important, but are they working together somehow? Is there still a rabbit hole?

COMMISSIONER DOUGLAS: Yeah, I don't know how to answer -- I mean, this is a hard one in terms of evaluation, so I don't -- it's descriptive and it gets to, I think -- everyone said the right questions, but I don't know where -- I'm struggling on this one on where we go,

unless you take it up a level around value-based purchased, I think that's the best question around, value-based purchasing, and then the intersection with sustainability if, you know, we're looking at potential financing reform of how these types of programs fit into it.

COMMISSIONER GORDON: I do think -- I mean, we do have to be careful because you can chase down an infinite number of rabbit trails with this. But I do think it is helpful to be looking at some of the things that states are doing with their SIM, what states are doing with DSRIP, you know, the different approaches they're doing. They're obviously a different scale, considerably different scale, different expectations under SIM, in some cases with regards to time period and the use of the funds in the DSRIP. But I don't think we have a good handle on that, and I think that's probably a good place to start. But you could go to plan level led initiatives, and that's where -- I mean, we could get lost. But I think at least understanding how those all fit together and promoting or furthering alternative payment models, that would be a good place to look.

CHAIR THOMPSON: One last point that I wanted to

raise, which is I don't quite follow -- and I just may not understand -- the argument about if you didn't have DSRIP or you didn't have a way of making some of these investments through grants or something else, that you would look to plans and you would move the money into plans, how is that -- it's sort of a little bit of what you're asking, Stacey, sort of like what do states do, what do plans do, what do providers do?

But is there -- obviously, somebody's thinking it's better in one place versus another, and can I just try to understand what that thinking is?

MR. NELB: Sure, I can try one more time. So it's less about having the money, so it's sort of like once you have the money, the question is “Is it better to invest in a data system at a provider directly or a particular project, or to put that same amount of money into the rates that then the plans will negotiate their own value-based payment arrangements with the provider?” And so getting at Stacey's point, you know, states trying to make this decision about sort of what types of things they wanted to invest in at a statewide level with DSRIP versus encourage their plans to do.

CHAIR THOMPSON: Okay. So that does seem to me to be something that was worth teasing out and talking about. I mean, I've heard the argument from states and providers that it's better for the states to do certain kinds of investments in the provider system so that plans are able to then contract on a value-based purchasing basis with those providers. But if plans are responsible for making the providers ready, that it becomes a fractured conversation again about different plans making different kinds of investments for different purposes. And so there's some unity that gets created when the state decides that it's going to help invest in the delivery system, and it's going to make the delivery system ready to be successful in working with plans on a value-based purchasing basis. And I think maybe there's some kind of framework that we want to think about there that could also help us understand and make recommendations about the uses for something like a DSRIP stream versus where you need to be augmenting rates and how to address some of the rate issues that, Chuck, you brought up in the last session, you know, in terms of what gets recognized in those calculations.

VICE CHAIR GOLD: Yeah, I think one of the reasons it gets complicated -- and you were pointing out how to sort it out a little -- is that if you give a plan a set of money to be accountable for delivering a set of care, they have to develop a delivery system and contract with them and pay them. And so some of these things can inadvertently disentangle the managed care -- you know, the integrated, capitated structure without meaning to because you've taken -- like if the state just tells the plan that you have to do it this way and you have to do this, it can get complicated.

On the other hand, there are providers, especially safety net ones, that are heavily dominated by poor and uninsured who don't have the money to prepare, and there, there is an argument to be made that there may be -- the state may be a better one to finance building infrastructure without the plan having to do it, but setting that up so that you're not undermining the capacity of the plan to also manage its delivery system while you're doing that.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: But on that point -- and I

think this was what you were hinting toward -- is that if you have multiple -- every state has multiple health plans, and most -- there's a lot of overlap in their networks, and we experienced this back in 2009 and 2010. If everyone takes their own approach and they are all trying to invest in helping the provider be prepared for their own individual model, you don't get anywhere.

And so when you get into this about what's the state's responsibility -- or looking at these different models, are we clear on what would be best, that's the state's responsibility versus the plan's responsibility, just understanding some of those dynamics, that some of that has played out out there. Some states are still experimenting in that area, but it would be probably worth our while to look at that and the lessons learned there, because that would help inform --

VICE CHAIR GOLD: Yeah, and CPCI --

COMMISSIONER GORDON: -- how that funding is used.

VICE CHAIR GOLD: And there are a lot of places where the plans have been at the table, too, with the states, and plans will agree on common measures, and that's

one way of trying to make...

CHAIR THOMPSON: And I also think that contributes to the innovation fatigue that providers feel, that plans feel, that states feel. You know, I was really struck by the conversation in the last session about we should probably focus on fewer things and make them bigger in our minds about what we're trying to achieve. So, I mean, some of this is also about how does this get organized in a way to focus efforts on the things that are most important around the parts of the delivery system that are most in need to support this program since it's this program's investments that we're talking about.

So, Chuck, I'm going to let you have the last word.

COMMISSIONER MILLIGAN: Thanks. So I think if we want to do something where there's a distinction between the state role and the plan role, I think the more important distinction is who sets the requirements and who sets the metrics rather than who pays for it, because there are situations where the state dictates to all of the health plans to do something in a uniform way that the state sets the rules and sets the metrics. So the focus

ought to be that, not who pays for it.

CHAIR THOMPSON: Good point. Thank you.

Thank you, Ben, thank you, Rob. Much appreciated. As you can see, we'll be at this for a good while to come.

PARTICIPANT: Forever.

[Laughter.]

CHAIR THOMPSON: All right. We're going to turn to Medicaid enrollment and renewal processes.

[Pause.]

CHAIR THOMPSON: We have Kirstin and Martha.

MEDICAID ENROLLMENT AND RENEWAL PROCESSES

* MS. BLOM: Good morning, everybody. Martha and I are going to walk through Medicaid enrollment and renewal procedures today as part of MACPAC's work on program efficiency.

Our presentation will include a review of the changes in the ACA that it made to these procedures. We'll talk about current enrollment and renewal policy relative to pre-ACA policy and potential areas for future work.

Both states and the federal government have an interest in improving the efficiency of the Medicaid

program, including the procedures that Medicaid uses to determine eligibility and then enroll and renew eligible individuals, and we have ongoing work in this area.

The ACA passed in 2010 and made some significant changes to Medicaid enrollment and renewal procedures that were designed to simplify and streamline the process. The expectation at the time was that states would automate their application procedures, integrate them with those of the exchange, and retire outdated legacy eligibility systems.

There was also an expectation that more eligible individuals would successfully enroll and retain coverage, that errors in determining eligibility would decrease, and that eligibility determinations would be completed more quickly and would cost less.

The changes that the ACA made took effect in 2014, and implementation got off to a rocky start. For example, the ACA's vision of a No Wrong Door approach to enrollment did not work smoothly at the outset. No Wrong Door was designed so that regardless of where an individual applied, that he or she would be determined eligible for the appropriate program, either Medicaid, CHIP, or the

exchange.

But, instead, for example, many individuals had to first apply for Medicaid and be denied coverage before they could apply and buy a qualified health plan on the exchange.

Now that several years have passed since implementation, it might be a good time to review how the process is working. Are the changes meeting their intended goals? Could additional changes improve program efficiency, such as additional streamlining or even the reintroduction of certain policies that the ACA removed, such as asset tests?

In this section, we're going to compare current enrollment and renewal policy with pre-ACA policy by looking at those procedures in these buckets. We'll explore differences in enrollment and renewal between MAGI and non-MAGI groups in a post-ACA world and provide some context around why those differences exist and potential opportunities to align them.

Before the ACA was enacted, financial eligibility was determined based on the methodology used in the cash assistance program that most closely related to that

individual's status, such as Aid to Families with Dependent Children.

Medicaid adopted the methodology of that cash assistance program for that individual. It was a complicated process that included a complex network of deductions and disregards for things like earnings and child care.

The ACA set out to simplify that process and established modified adjusted gross income, or MAGI, and federal tax rules for counting income and household size. This approach was designed to align Medicaid income eligibility with eligibility for subsidized coverage on the exchange.

Only certain Medicaid eligibility groups fall under the MAGI system. They are the non-elderly and non-disabled, including children, pregnant women, parents, and members of the new adult group that was created under the ACA. Medicaid populations not under the MAGI system are primarily the elderly and disabled, including dually eligible beneficiaries and others that are listed here.

The ACA removed the asset test for all MAGI populations, but states can still impose this test on non-

MAGI groups. States have actually had the option to eliminate the asset test for certain groups since the '80s, and a lot of states did so. Before the ACA was enacted, most states had already eliminated the test for pregnant women and kids, and about half had eliminated it for parents. The test has often been cited as burdensome for both states and individuals.

Today, as I said, states can still impose this test on non-MAGI populations, and for context around the differences between the MAGI and non-MAGI groups in this particular area, there has been a longstanding concern among both state and federal policymakers that individuals in need of expensive long-term services and supports would seek to transfer their assets to their children or others in order to become eligible for Medicaid.

Because some subsets of the non-MAGI population are more likely to have assets and more likely to need LTSS, the level of state interest in aligning this policy between MAGI and non-MAGI groups is unclear.

Prior to the ACA, many states used applications that were specific to an eligibility group, such as children or pregnant women. One analysis identified 85

different printable Medicaid and CHIP applications in use pre-ACA.

The ACA established a single streamlined application that could be used to apply for Medicaid, CHIP, or the exchanges. States are now required to use this application for MAGI groups but for non-MAGI groups, states can use this application and attach supplemental forms, which they would need to do since the streamlined application doesn't include all the questions needed to determine eligibility for a non-MAGI person, or states can use a separate non-MAGI application.

After the ACA, states cannot require a face-to-face interview at application or renewal for the MAGI population, but they can still require a face-to-face interview at renewal for non-MAGI groups.

We don't know how many states currently have such a requirement for the non-MAGI population, but in 2002, we know that 18 states required face-to-face interviews for the elderly and the disabled.

Again, for a little bit of context here, some non-MAGI enrollees might see a face-to-face interview as a preferred option because it provides an opportunity to

receive assistance in filling out the application. Others might not have access to an online application or might have difficulty hearing well enough to fill one out over the phone, but enrollees with limited access to transportation would probably see a face-to-face interview as a burden.

Eligibility verification is not required for people who are automatically eligible for Medicaid because they are enrolled in another federal program, such as the Supplemental Security Income program or people receiving Title IV-E child welfare assistance, but for others, states are required to verify eligibility.

Historically, the obligation to do this was placed on the applicant, who often was required to provide paper documentation to prove things like age and income, but the ACA shifted much of that burden to states to try to simplify the process and reduce the number of errors, such as determining someone to be eligible who was not.

States still verify citizenship, immigration status, Social Security numbers, but must accept a person's self-attestation for things like pregnancy and may do so for other nonfinancial eligibility criteria like age.

Also, states are required to rely as much as possible on electronic data.

Redeterminations are designed to account for changes in an individual's circumstances, such as income, which could mean that the individual is no longer eligible for the program. Redeterminations might also catch mistakes in eligibility determinations.

Post-ACA states must renew eligibility no more frequently than every 12 months for MAGI populations but can choose to do so more frequently for non-MAGI.

To renew coverage, states first attempt to confirm eligibility based on available information, which is known as administrative or ex parte renewal. If a state can't confirm eligibility using available data, it has to use a pre-populated form rather than asking the individual to resubmit the information that they submitted at the application.

But this is not true for the non-MAGI population. In that case, the state can choose to use the pre-populated form or not to use it, and the individual would have to resubmit their information.

For the non-MAGI, the non-MAGI population might

be more stable than the MAGI population, both in terms of financial eligibility criteria like income and nonfinancial eligibility criteria like disability, which might make a pre-populated form a potentially effective tool for improving program efficiency in this area.

States have a number of other options available to streamline enrollment and renewal, including presumptive eligibility. States can allow qualified entities to determine eligibility for MAGI-based groups. Hospitals can also do it. States have express lane eligibility, where they can accept determination of income from another program, like SNAP for children, and they can extend eligibility continuously for 12 months for kids.

States must meet certain timeliness and performance standards, including applications and eligibility determinations. States are also required to provide three months of retroactive coverage, if a bene received a service and would have been eligible for Medicaid at the time that they received that service.

So after walking through the details of some of these policies around enrollment and renewal in a post-ACA world, this table summarizes the key differences that exist

between MAGI and non-MAGI groups, some of which may be policies for MACPAC to explore further in the future.

And with that, I'll turn it over to Martha to talk about potential areas for future work.

* MS. HEBERLEIN: Thank you.

So, as Kirstin mentioned at the outset, the changes enacted under the ACA were designed to streamline and simplify the process for enrolling and renewing coverage for both individuals and the states, but at this juncture, the Commission may wish to consider whether or not the current processes are achieving the goals as laid out in the ACA. So we have laid out in your materials some possible areas for future work for the Commission.

So in terms of reducing barriers, both on the state and beneficiary side, as Kirstin mentioned, initially No Wrong Door approach faced a number of hurdles, including a lack of integration between exchanges and Medicaid. However, later the process seems to have improved, and the Commission may want to take stock of how No Wrong Door is working and whether or not coordination issues remain to be a concern.

You may also want to examine how states have used

their enhanced federal funds to upgrade their systems and how those systems are integrated with other programs, including SNAP and TANF and other human service programs.

So while the use of available data to confirm ongoing eligibility is not new, as Kirstin said, the ACA put greater emphasis on this approach. Most states are now processing automated renewals, and the Commission may be interested in gaining a better understanding of the effect of this process and whether or not it increases the efficiency and eases the burden on states and beneficiaries.

Finally, with a move to MAGI for most populations -- or many populations, the definition of income eligibility changed, as states must now use tax-based definitions of household and income.

Widespread concerns regarding errors in determinations have not been reported, and recent studies have suggested that states may, instead, be failing to maintain complete records of verification and face IT security risks. There's a number of ongoing studies sort of looking at this, and the Commission may have suggestions on what we may add to these ongoing oversight efforts.

Churning refers to the phenomenon of individuals transitioning between coverage sources, and shifts in coverage may not all be detrimental or inappropriate; for example, when an individual shifts from out of Medicaid to employer-sponsored coverage because they secure a job. However, frequent changes in coverage can negatively affect health, increase cost, and place unnecessary administrative burden on both states and enrollees.

So enactment of the ACA include a number of changes that could affect churn. For example, new sources of coverage created new risk points for churn, while on the other hand, state requirements for a 12-month renewal period and a greater alliance on electronic data sources, were thought to decrease the administrative burden at renewal and, therefore, lessening churn.

In order to gain a better understanding of the extent of churn as well as the reasons why individuals might transition between coverage sources, MACPAC undertook two studies related to churn.

Most of the prior work looking at churn had relied income eligibility as a proxy for Medicaid enrollment. However, income changes may not necessarily

translate into coverage changes. For example, individuals may not immediately report their changes income. States may not react on those changes, and depending upon the eligibility threshold and income accounting rules, those changes might not actually affect eligibility.

So the goal of the analyses that we undertook was to provide estimates of churn that were based on a more direct measure than prior research by looking at reported coverage changes.

So in 2013, our work found, using the SIPP and preliminary CPS data that the churn rates among adults range from between 5 to 8 percent. These estimates are lower than the prior studies, typically, that I've mentioned, that used income estimates, with churn rates that range between 20 and 35 percent.

The studies conducted for us found that most enrollees leaving Medicaid become uninsured, and few resume to Medicaid within the year. Of the smaller shares that churn to other coverage, most churn to employer-sponsored coverage.

So these findings may be useful to the Commission as they consider how to promote efficient enrollment and

renewal processes and the continuity of coverage among eligible enrollees.

So another area of potential focus for the Commission may be barriers for non-MAGI populations. Kirstin outlined the differences between many of the procedures, and in general, the changes enacted under the ACA were designed to streamline and simplify the process for both MAGI and non-MAGI populations, but not all of them applied. And, in some cases, implementation may have been delayed as states put their focus on the MAGI populations and may now be turning to the non-MAGI groups.

Furthermore, as Kirstin mentioned, the complicated enrollment and renewal procedures have been cited in the past as a reason why non-MAGI populations do not access all of the services for which they are eligible. So a simplified procedure, such as removing the option for face-to-face interview or requiring the use of pre-populated renewal form, may be of particular relevance to this group.

Finally, Congress, CMS, and the states have revisited some of the changes made in the ACA as well as some other Medicaid procedures, suggesting that states

should regain the flexibility to establish asset tests, more frequent renewals, and not be required to provide retroactive eligibility.

For example, in a March letter to Congress, four Republican governors included a request for states to once again have the option to impose asset tests for the MAGI population when discussing larger federal Medicaid reforms.

Both the House and Senate versions of the ACA repeal bills altered the required 12-month renewal period, and they also changed the provisions related to retroactive eligibility. So Commissioners may wish to weigh in on the merits of these changes.

So, with that, there are a number of options for staff to pursue future work. For example, we laid out some ideas for potential recommendations, such as a requirement to use a prepopulated renewal form for non-MAGI populations. The Commission may also wish to provide feedback on other changes, as Congress and CMS are still actively debating these options. Staff could also expand on the descriptive work we've done on federal requirements and state options related to Medicaid enrollment and renewal procedures and describe a particular policy of

interest in more detail.

Over a longer time frame, Commissioners may have areas in which they want to see additional analytic work, and if that is the case, please let us know if there are particular data points or information that you may find compelling as you think about that.

So, with that, we look forward to your discussion and guidance.

CHAIR THOMPSON: Thank you very much.

We have Chuck, Martha, Alan.

COMMISSIONER MILLIGAN: One of the comments I wanted to make -- this is great work -- there's something I think that also needs to be highlighted that wasn't really drawn out in some of this.

When the Affordable Care Act was passed -- and I think the view at the time was that all states were going to be required to do the Medicaid expansion -- I think part of the thought process with MAGI was there would be uniform standards across states, and so there wouldn't be migration, so to speak, of individuals seeking eligibility in one state where they might not have eligibility in their home state, and that there would not only be uniformity

within a state about how exchange and Medicaid are calculated, but there would be uniformity across states. I think that that aspect of MAGI is an important thing to just note.

And related to that, I do think that the state variations about other eligibility categories around even how disability is defined, you know, the 209(b) states and all the rest of it, how LTC, the NF level of care is defined in terms of income levels and all of that stuff, and never mind kind of the functional assessment part of the variation state to state, I think it doesn't as readily argue for the same kind of a treatment as MAGI because MAGI was specifically intended to be a more uniform national model for a variety of reasons.

So I think that drawing out that cross-state, not just cross-programs within a state, element of this needs to be developed before we start talking about uniform requirements or uniform process.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: I am particularly interested in the enrollment and reenrollment on the issue of children in the current opioid epidemic. We're seeing

children that are raised by grandparents, by family members or neighbors who don't have legal custody. So we're seeing children in our school-based centers who are eligible for Medicaid or CHIP but aren't covered because of some chaos in their lives.

So I'm curious how states are handling the issue of children that are -- and we've really got a whole generation of children that are not being raised by their parents and how is that affecting enrollment and reenrollment.

CHAIR THOMPSON: I think that's a really important thing to examine. It sort of connects again back to what Gail was talking about in terms of the turbulence in the lives of some families, both in terms of family composition, which affects eligibility, but also in terms of income. And I think it would be -- when we saw some of the data that you presented about churn, I wonder how that looks in terms of both state variation, because of the issue that Chuck mentioned, but also the situation that certain families find themselves in. So are there particular kinds of families and individuals who part of the idea of simplifying and promoting more access to the

eligibility systems and making things more streamlined and taking the burden off of beneficiaries was to avoid losing people in the system who really were eligible, just because they had paperwork and paperwork couldn't find them, and they didn't know how to follow up with the paperwork or because of other things that were happening in their circumstance.

So I think trying to sort of peel away how this looks to some particular families and individuals under stress and who are dealing with a lot of change in their lives, I think would be very useful.

Alan.

COMMISSIONER WEIL: So I have three comments and thoughts on this really important work. The first is, as I remember it in the early days post-ACA, with the tight timelines, there were states that went more towards, we've just got to get the health part of this figured out, and states that wanted to do a more integrated approach with social services.

I don't think this is just about the No Wrong Door issue. So I think it does seem like now is a good time, from a sort of standing back and looking perspective,

to say, how is the integration with other services working out, now that there's been sort of enough time for those systems to settle down? I have not seen that issue examined closely in a while. I think the time is right.

Second, the role of administrative burden and cost around eligibility systems redetermination, determination, I think we've talked about it a lot but, again, with the federal proposal that increased the frequency of redetermination and now waivers that are coming in with new requirements, I think it would be a good time for us to focus -- refocus attention, because it's happened before -- on the fact that there's a tradeoff between how much you try to prevent a person, you know, one person who might not be eligible from getting services, how much it costs to do that, the sort of cost benefit tradeoff. Because I think we are in a world where, to be blunt, the pendulum is swinging in the direction of more interest of those kinds of barriers, and we now have data about what's happened when we shift in the other direction, with respect to enrollment, with respect to administrative burden.

My last comment is on churn. This is -- I don't

want to just -- I don't want to nitpick here but I want us to be careful, because, again, I think this is a really important topic. When we published, in 2011, I think it was the first analysis of churn in the ACA, coauthored by our former Chair here at MACPAC, that was before the court case that made Medicaid expansion not mandatory. And so churn, in the initial analysis, was shifting from one type of coverage to another. Now, of course, there are a lot of people who lose coverage.

I also think churn is not one transition; it's two. Churn is leaving and coming back. That's an unnecessary disruption. If someone's circumstances change and they move from A to B, I'm not saying that's not consequential.

I guess what I'm trying to get at is I think if we're going to do more work in this area we have to be a little bit more precise, and the data you present are, but the language, I think we're losing the language even as we're adding now longitudinal data and using administrative data instead of just estimates based on -- or not administrative data; that would be great -- but using survey data on coverage as opposed to just survey data on

income, which is where the original estimates were done.

I think because there are now significant gaps in coverage, it would be helpful to step back, now that you have the new findings. It's not just that the numbers are lower than we initially thought. It's that the nature of churn is different than what was originally envisioned because some churn is loss. It's that very few who leave come back on, which means it's not really churn; it's loss of coverage.

I would encourage thinking a little bit differently about the topic than we did in 2011, when the first estimates were put out.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: Yeah. Along those lines, I mean, we think about the churn and we think about, you know, the recertification, whether it's 6 months or 12 months, and we think about that as if all populations are the same. And I would just be interested, along the lines of what you're talking about where people are actually coming off and then they're coming back on, there are certain populations that I would believe that their being on the program, nursing home-eligible individuals, HCBS

members for example, that you might even make an argument that you shouldn't have to do that every 12 months because that population, by the nature of what those categories of eligibility are, and kind of the pathway in which they entered, they are less likely -- their income situation is likely not change frequently, or some other criteria -- their age change, like in some of the children's categories where you will move but you know that well in advance when that's going to happen.

But maybe there's some categories that the data would argue that, to reduce some of the administrative hassles and some of the challenges for the members themselves, that maybe you can make a case that you shouldn't have to do that but every two years, or maybe even longer. But I think the data would bear that out and I would be interested in seeing that.

CHAIR THOMPSON: Toby, then Marsha, then Brian.

COMMISSIONER DOUGLAS: A couple of thoughts. One, on the administrative renewals, I think it would be really interesting to do just a little deeper dive on the state variation. Just seeing, you know, the use of ex parte as, you know, your initial looking at some of the

other work on this, there is very big difference on the use of data sources versus requiring a pre-populated form, and it would be interested in why, a little bit more on the state levels, why that variation is occurring, and to what end in terms of outcomes.

The other is just, you know, on the flip side, is the administrative, or rather the fiscal admin change. What have we seen? What are we learning on how this has changed from a state admin claim, given this is -- part of this was about streamlining the process and really reducing the intensity of the labor, the work, on states, and, in many cases, counties? Has that occurred? Has the vision of moving to more IT systems led to less administrative costs?

And then the final piece is just kind of, again, a little bit from where I stand. But you see on the exchange the ongoing interaction, month to month, with the premium and plan relationship really keeps some of the retention. What are states doing on, you know, using plans to engage and help with that retention versus kind of an isolation doing the re-enrollment on their own?

CHAIR THOMPSON: Marsha, than Brian.

VICE CHAIR GOLD: Yeah. This piggybacks a little bit on one of Alan's points, I think. There's a lot of specific detailed eligibility policies in here, but maybe one of the things I'd like us to think about doing is maybe connect some of them to their underlying motivation. And the one I'm most interested in, because it's changing, is the efforts that, over time, have been to try and get people in, keep people in, reduce people losing temporarily and go out, and the continuity of enrollment. And there's a history of policy that was going on through there and through express eligibility, and I agree with Alan that some of the current bills and some of the waivers that have been sought seem to reverse those.

And I think that it would be analytically very useful to look back at the motivation for those initial policies, to make it easier for people to stay in and to reduce the burden on states -- What happened when? What was done? What the effects have been? -- and put these new policies in context, potentially with the Commission even coming up with a, you know, a statement, a recommendation that, you know, that there could be some bad effects to some of these changes, or whatever we decide would be the

right formulation. But there's enough change there that I'm a little concerned that some of the gains that have been made over the years will be lost without as full an accounting for the rationale behind the original policies as there might be.

CHAIR THOMPSON: Although the idea of change has its own rationale too, right? I mean --

VICE CHAIR GOLD: Change?

CHAIR THOMPSON: Well, to the extent that people are proposing to do something different. They are doing that because they have their own rationale for wanting to focus resources and make sure that the, you know, people's eligibility is maintained in an accurate fashion, and --

VICE CHAIR GOLD: Yeah, but I think that --

CHAIR THOMPSON: -- that they're focused -- you know, I mean, so I'm just -- my point is simply you can explain the rationale for the policies as they have been developed and implemented through ACA, but then you also have to acknowledge that the rationale for changing those policies exists at the top.

VICE CHAIR GOLD: But it goes way before the ACA. I mean, a lot of these things are with CHIP and Express

Lane Eligibility, with managed care, and not having people cycle on and off. I'm just not -- there may be a rationale but I'm not sure that the tradeoffs have been articulated, and I don't know where the Commission would come down, personally. I'm concerned with those. But it seems like there's some value in sort of looking back, analytically, at what the tradeoffs were, why the policies developed as they did, and what the rationale is now, and what the effects might be, and see if we think we should do, you know, anything.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: On that point, are you like suggesting like, as folks, for example, have managed care, as again, to only increase, asking the question or looking at the data whether or not a more frequent determination actually is not helpful in that scenario because -- I mean, I'm trying to get a --

VICE CHAIR GOLD: No. My concern is just there's a lot of evidence that the more often you have people recertify it adds a lot of costs and you lose people in the process who may still be eligible but just don't come in. And if they're in managed care they may get out of managed

care. And --

COMMISSIONER GORDON: The reason I asked, I mean, when we admitted managed care 20-some-odd years ago, I mean, we were making the argument not to do it more frequently, because if we didn't have the person for a long enough time to impact their care and they turn on and off -- you can't manage care when someone is bouncing in and out, because of other processes and everything like that. And I was just wondering --

VICE CHAIR GOLD: Yeah, that is one of the rationales that's been there.

CHAIR THOMPSON: And I wonder if, to that point, is there anything around people who lose coverage as a result of redetermination, or as a result of the ongoing requirement to continually assess if there are external data available, indicating that a change in eligibility has occurred? Are those people people who are losing coverage but could come back into the program? Sort of to Alan's point, are they losing but the -- and maybe, according to strict interpretation of the eligibility policy, they are no longer qualified, but their circumstances will always sort of jump around, such that they could come back into

the program, and if so -- but they don't because once having lost that point of contact they're not coming back into the system?

Go ahead, Anne.

EXECUTIVE DIRECTOR SCHWARTZ: I just wanted to comment on sort of two things here. One is in thinking about policy and, you know, for the Commission, if you get to a point to make recommendations, the issue is sort of where do you prioritize in this balancing process. And there are certain things that were prioritized in the ACA, for a variety of reasons, that are rated lower by some of these newer proposals.

The other is there are mixed messages in the current policy as it exists. So you're not supposed to be doing a determination more than every 12 months but you're also supposed to be continually reviewing changes in information. So how do you square those things and how do you square those things from the perspective of burden on the state, finding people who shouldn't be on the program, kicking off people who will come back on the program?

And so I think that's potentially another area of clarification, and that clarification, how that

clarification comes about depends upon sort of how you prioritize among these different goals.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: I'm sorry, Penny. I don't mean to keep jumping in at the end when we're kind of winding into it.

So I think it's a useful distinction between sort of just the administrative operational pieces of it, that sort of Toby was alluding to, from some of the policy implications of some of this, because -- and, Marsha, I hear what you're saying. I think that there's a lot of emphasis, also -- we're seeing, in waivers, and we'll be talking about it more, around personal responsibility, and, you know, as states are thinking about premiums the states are thinking about other things, I think there is an underlying personal responsibility element to recertification, like, you know, coming in or doing that, or doing that online once a year is a reasonable expectation. I think there are other arguments in the other direction.

I just think that those policy issues, where there's a lot more federalism and all of that going to get

invoked, are separate from some of the administrative simplification, operational simplification, reduction in cost, and I just think that not comingling all of that might be a useful frame to always keep in mind.

CHAIR THOMPSON: I think that's a good point. Brian.

COMMISSIONER BURWELL: So I have two things. If we're going to do further research on this area I would strongly recommend using administrative data to look at churn, rather than -- I mean, just the data here is based on survey data and there's actually been work that's done that when you ask people "are you eligible for Medicaid?" the answers are not very -- there's a lot of error in the response. Because a lot of it is, you know, Medicaid programs have different names now, and it's like if they say, "No, I'm part of Hoosier Plan" or something like that.

So I'm a little skeptical of survey data. I think we do have good -- better administrative data available, and there are generally monthly flags around enrollment of beneficiaries. So I think you can do some good analysis around turnover, using that source.

My second issue is we haven't talked about

eligibility for long-term services and supports. That's a whole different world. It's a very complicated world. I've done a lot of work in my career around that issue and asset transfers, et cetera. I'm not opposed -- I just want to be clear -- I mean, I think we can make a decision. We are going to focus on eligibility enrollment for the MAGI population, not the non-MAGI population, and not take on both. But I just wanted to be -- make it clear that we have made that as a decision. If we go into LTSS, that's a lot of work, and there's a lot of variability across states, and there are a lot of different policy issues related to that.

For example, eligibility for LTSS, because it requires a review of your total assets, takes a long time. I mean, some months it's more than six months' average for an eligibility determination to be made. What happens to those people during that six-month period is kind of an important policy issue. A lot of people go into nursing homes because the nursing homes are willing to accept the risk for that period of time, rather than an HCBS provider.

I'm -- you know, I'd be all for working in that area, but I think it would be hard to do both at the same

time.

CHAIR THOMPSON: So are you suggesting that for the non-MAGI population that delays in application are promoting institutionalization?

COMMISSIONER BURWELL: Yes, they do, in some cases. But that's just one issue.

CHAIR THOMPSON: Right.

COMMISSIONER BURWELL: There's a million issues related to LTSS eligibility. I mean, that includes both a functional component and a financial component --

CHAIR THOMPSON: Right.

COMMISSIONER BURWELL: -- and then how those two are --

CHAIR THOMPSON: And who does it.

COMMISSIONER BURWELL: -- you know, integrated. And also there's an MLTSS issue, because if you have a state program where people are supposed to pick a plan, how do -- what does the state -- you know, what's the policy while eligibility is being determined, in regard to plan selection? Or do you have a fee-for-service program for a while? There's all kinds of interactions on that side of the program.

CHAIR THOMPSON: I wanted to ask Kirstin and Martha, can you respond to the question about administrative data that Brian brought up?

MS. HEBERLEIN: I can try. So I think there's sort of pros and cons with doing it with either. The reason we chose to use survey data is because part of the reason for the study was to find out where people go, and the Medicaid -- the admin data will tell you that they left Medicaid but it doesn't tell you where.

To use the admin data, on the other hand, might get us more at some of the reasons for churn, depending upon the state systems. You know, some are better than others, as with everything in Medicaid, there is variation by state, and some have flags for, you know, they were no longer eligible, they didn't file their paperwork. And so you can get different things from different sources, but part of the reason we wanted to use the survey data was to find out, you left Medicaid and where did you go.

COMMISSIONER BURWELL: I wasn't arguing that administrative data is better. I just think it's good to look at a variety of different data sources when looking at this issue.

EXECUTIVE DIRECTOR SCHWARTZ: And also, Martha, in terms of the administrative data that are routinely available to us, they're not available yet for the time period that we're interested in. We don't have state-level data. We have the MSIS data, and we don't -- we wouldn't have the right time period yet.

COMMISSIONER BURWELL: I thought we were one of the early utilizers of T-MSIS.

EXECUTIVE DIRECTOR SCHWARTZ: We are but we are still in a testing mode with that.

COMMISSIONER BURWELL: We're not allowed to publish it.

EXECUTIVE DIRECTOR SCHWARTZ: No, we're not. No.

CHAIR THOMPSON: I wonder if I could just ask the Commissioners to just weigh in on this question about looking at the non-MAGI versus MAGI populations, in terms of -- go ahead, Marsha.

VICE CHAIR GOLD: Well, I just -- I mean, I think the policy issues right now seem to be focused on the more average populations. There may be issues that are important there, where the changes seem to be occurring, is around -- I think the right word is MAGI. I'm not an

eligibility expert. So that's where I was interested in, because that's where there was the most -- I mean, the people who are -- you're talking about, Brian, they don't usually come on and off once they get on. They get on and then they're on. The others are -- there's a lot more activity in the MAGI.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: I think the continued focus on MAGI is the right focus, because I also think that's where we are seeing a lot of the 1115 demos around Medicaid expansion adults and all of those with federal discussions.

CHAIR THOMPSON: Right. Okay. And I do think that the later conversation needs to be connected to this one, in the sense of what are beneficiaries being asked to do and how do they interact with the program in order to maintain eligibility in general, and sort of this larger question of how does that fit within some kind of an engagement model and who should be involved in that. I think that's part of the way to think about this.

I just also wanted to pick up on, Alan, your point about integration, and I think that that's a place

where there could potentially be some specific recommendations. I know that one of the -- it was certainly true that there was a desire to phase some of the steps from MAGI, non-MAGI, and then other programs, as people were attempting to implement these changes associated with the ACA, and take advantage of the funding that was being made available.

The last piece of that, that integration piece, is somewhat still challenged by different rules and different programs about how to count income and how to define families, and I think that we should think about that. And while I'm conscious that we are not here to solve problems for other programs beyond Medicaid and CHIP, I do think to the extent that that impedes that kind of streamlining and integration, that we should be pointing towards possible ways to address that.

COMMISSIONER DOUGLAS: Just one more. I do think it's still this issue of whether the IT systems really was kind of the panacea to --

CHAIR THOMPSON: Yep.

COMMISSIONER DOUGLAS: -- you know, reducing the administrative costs --

CHAIR THOMPSON: What kind of efficiency the relief got, yep.

COMMISSIONER DOUGLAS: -- and dealing with program integrity, because I don't think -- I think, you know, this issue of -- the idea is that rather than having to do labor-intensive program integrity it was doing data, data, IT systems, and is that coming to fruition needs to be --

CHAIR THOMPSON: Yeah, I agree. I didn't mean to suggest that that wasn't part of the -- what we should be examining. I think that issue about it's almost -- the cost of customer acquisition, if we think of that in a commercial sense, and how to maintain that, and then that issue of accuracy, which is not unrelated to some of the other things that we've been talking about, from a policy standpoint, because accuracy is always judged against the intention and the policy, right, so that if you decide that you're accepting a continuous enrollment over 12 months, then regardless of any changes in those 12 months, that's an accurate enrollment, right?

COMMISSIONER GORDON: But I think as Toby is point out, as a lot of folks, as you put up these systems a

lot of the vendors that could offer those systems actually -- there was a lot of assumptions early on that it would be tremendously reducing the administrative -- the actual personal involvement --

CHAIR THOMPSON: That's right.

COMMISSIONER GORDON: -- and executing --

CHAIR THOMPSON: That's right.

COMMISSIONER GORDON: -- the application. And as that evolved people were recognizing --

CHAIR THOMPSON: That's right. That's right.

COMMISSIONER GORDON: -- it wasn't a system that eliminated those things. So that's kind of what I've heard you suggesting that we should look at.

CHAIR THOMPSON: Martha, you were trying to jump in?

COMMISSIONER CARTER: Another way that -- to consider churn is not just the people who fall off coverage but the people who change within the system. You know, I'm a lot closer to the ground than some of you policy folks, and so we see people jumping around between different managed care products, and I'm curious if anybody has taken a look at that, the rate that that happens, and the

inefficiencies to the system that that causes. As we talk about quality measures we've got -- especially in a state that doesn't have an integrated system for tracking their quality measures, everybody has to start over when somebody goes from this managed care program to this managed care program. Maybe they moved to a different part of the state so they had to switch, or whatever happened in their lives. You know, from my level, we see that actually as a fairly large problem.

CHAIR THOMPSON: That's something that we can circle back to when we talk about managed care issues later. Okay.

I think it's time for some public comment. Do we have any comments from the public?

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Okay. We will reconvene then at 1:30 p.m.

* [Whereupon, at 12:11 p.m., the meeting was recessed for lunch, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

[1:37 p.m.]

CHAIR THOMPSON: All right. Sorry for the delay. We were just a little bit late running. We are going to go ahead and kick off the afternoon session with a session on state flexibility and program accountability with Moira.

STATE FLEXIBILITY AND PROGRAM ACCOUNTABILITY: FRAMING WORK FOR THE 2017-2018 REPORT CYCLE

* MS. FORBES: Thanks, Penny.

So over the past two report cycles, the Commission has spent a lot of time examining issues relating to federal financing flexibility, and this session we're going to -- actually, this whole afternoon we're going to be introducing related area of work for the upcoming work cycle, which is state programmatic flexibility and accountability.

So when speaking of federal and state Medicaid program responsibilities, they can be described roughly as follows: Federal law creates broad program requirements ensuring that federal dollars are used for statutory purposes, establishing consistent minimum eligibility standards and benefit across states, ensuring enrollees

have access to timely and appropriate services, and ensuring that federal funds are used for the proper and efficient operation of the program.

And then states have flexibility within these federal parameters to make a lot of policy and operational decisions, including determine who's eligible for the program, what services are covered, how much providers are paid, and how the delivery system is structured and operated.

Over time, states have made a lot of different choices using this flexibility. MACPAC has been cataloguing a lot of these differences and developing our compendia of state flexibility decisions. We've published fact sheets on eligibility, enrollment and renewal procedures, benefits and provider payment, and we have some additional pieces still coming. Those are all on the website.

Because we're looking at both the design and operation of state programs and there are all these different requirements and parameters, this effort will incorporate multiple work elements which we'll begin to discuss this afternoon, but then we'll continue over the

fall with additional pieces of research to come.

So the purpose of this introductory discussion is to give you an overview of our planned work and to share with you our understanding of how we see this work. We want to make sure we're using the right words and the right concepts to tie these threads together, so staff would like your feedback on our overall approach. And so I'll go through that quickly, and then myself and two other staff people will discuss the first three research projects.

So states are requesting additional flexibility for different purposes and different reasons, and we've sort of loosely grouped these into four buckets. We do love our buckets.

The first is loosening federal requirements related to who and what must be covered, such as 1115 waivers that would permit work requirements or time limits on coverage. Congress has also considered some statutory changes in this area.

The second is removing perceived barriers to innovation and delivery of services. The administration is currently reviewing all aspects of the managed care rule that was finalized in 2016. States have asked for changes

regarding the pass-through rule, the IMD exclusion, FQHC payment, things like that.

The third is changing processes for the approval of state plan amendments or the approval or renewal of waivers. These are perceived to be outdated, slow, and arbitrary. Some of the suggestions have been around converting waiver authority to state plan amendment authority, creating a path to permanence for certain waivers, or allowing states to receive fast-track approval for waivers that have been approved in other states.

And the fourth bucket is reducing data collection reporting perceived to be onerous, duplicative, not useful for decision-making, or more focused on process instead of outcomes to see if there are ways to streamline or prioritize data collection to facilitate evaluation of innovative designs and facilitate cross-state comparisons and improve program management.

We're also looking at federal policy options for allowing states greater flexibility. CMS can waive some but not all statutory requirements through demonstration waiver authority. The Trump administration has indicated support for allowing states greater flexibility through

statutory and through administrative changes. Different proposals to constrain federal financing through per capita caps or block grants have also promised greater programmatic flexibility, although the actual legislative proposals that we saw earlier this year seem to offer more flexibility under block grants than under per capita caps, and some even proposed new requirements for states.

There are a lot of ideas under discussion at the state and federal levels right now. So some of the Commission's work in this area may be discussing specific proposals or actions while in other cases the Commission may want to approach the issues more broadly in a context of just how you think the program should be run.

So over this report cycle, the Commission will examine issues in many of the areas in which states have requested additional flexibility. We've highlighted six pieces of work -- I have to work on my PowerPoint skills.

[Laughter.]

MS. FORBES: Sorry about that. Bull's eye.

So the first three are the three that we'll talk about today: design and implementation issues associated with certain states 1115 waiver requests such as imposing

work requirements, drug testing, and creating length of coverage limitations; key accountability elements of the 2016 managed care rule now under review by CMS; and information being collected for monitoring and evaluation of Section 1115 waivers.

At subsequent meetings we're planning to present on several additional pieces of work, including follow-up to the March 2017 meeting discussion on 1915(b) waivers, including considerations for determining when waiver authority will be converted to state plan amendment authority and under what conditions; findings from other states regarding implementation issues associated with 1115 expansion waivers; and information to consider streamlining of authorities such as creating a pathway to permanence or identifying the conditions under which one state could be approved for a waiver that is being used by another state.

As I said, these pieces of work are different in terms of where they could land. Some could lead to specific recommendations. Some could be about how the Commission responds to a specific administrative or legislative action. Some may just be useful discussions for illuminating the broader issues. But we did want to

provide the context for these upcoming sessions and get your thoughts about this general area of work.

So, with that, I just want to open it to discussion. Staff is interested, before we get into the specific projects, about hearing what the Commission thinks about this area.

CHAIR THOMPSON: Okay. Open it up. Toby.

COMMISSIONER DOUGLAS: I like your PowerPoint. It's good.

On the design on 1115, the one thing we can think about from this morning, just around the intersection between 1115 and 1332 and just some of the design considerations around budget neutrality across those, would be something to just think through.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: I know we're going to get into more specifics as we go on, but I think it's going to be very important that we get very specific, because my sense is that when we talk about this at a high level, it really doesn't have enough depth to tell us -- I mean, you mentioned sort of the federal guard rails, and there's an issue of if you knew the specifics, you would understand

whether you thought this was appropriately a congressional decision or this is something that should be within the context of CMS and/or the states. Okay? But until you get to the specifics, you really cannot, I think, make an assessment. And so the idea of having sort of procedural or process sort of standards that are not tied to specific authorities I think isn't going to work. I think you're going to have to sort of identify the authority that you're talking about and then say here's an appropriate process standard.

The example that keeps going through my head as we talk about this or as I read about this is what's in the ACA with respect to the Centers for Medicare & Medicaid Innovation, the fact that something can become a permanent part of the program under certain circumstances. And I think there, there was congressional deliberation to put that into the program, and it seems to me that there's something -- what we're talking about here is maybe something analogous. There's consideration of what this might entail. There's a set of guidelines as to when it may be allowable. And then it can be sort of implemented without sort of congressional action.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: Yeah, I think diving into the details is going to be important and helpful. I'm very comfortable with this. Let me just follow up on Bill's point and then make one slightly -- a slight variant on it.

I want to strongly agree, I think it -- we even heard it from the presentation this morning. It's just a little bit too easy to say -- no criticism of anyone. I've said it myself. It's a little too easy to say this is a balance and we have to strike the balance, and everyone kind of knows that, but it doesn't help.

I think the CMMI example is very unusual and somewhat problematic, and I think we're going to have a hard time finding examples like that. But, Bill, I appreciate the thought.

The broad comment I want to make is that I think this agenda situates itself between two functions that I think are fairly different for us and both important, and we're going to have to blend them both. On the one hand, there really is a technical element to this. You know, how do we streamline, how do we reduce burden, things like that that are pretty easy. But there's a very strong

ideological element to this, particularly in the first grouping of the waivers around work requirements and the like. But even when it comes to things like enabling a waiver to become permanent or enabling one -- I mean, I was staffing a governor 20 years ago, and it was NGA policy that if one state got a waiver and it worked, every other state should be able to do it. So this is not a new idea.

But those kinds of policies, once they go beyond just sort of the general concept, raise huge issues of trust and accountability and how much faith you put in the federal bureaucracy, how much you put in the state bureaucracy, and how much you put in the political processes at that the state and federal level.

So I think our challenge is going to be weaving some really good analytics, which you all are terrific at, particularly around things like identifying burden and doing case studies and things like that that can focus in on where the administrative burdens are. But I think we're going to have a whole different challenge ahead of us when it comes to figuring out some of these more ideological -- I don't have an answer for it. I just want it to be in our minds as we're entering this.

CHAIR THOMPSON: Yeah, I agree. I think that we've got to narrow this somehow to some practical realities of how states seek and receive these authorities. One question is we seem to be all about waivers, but states exercise a lot of flexibility and have a lot of burden to exercise that flexibility under state plan authorities. And sometimes the process of getting the state plan amendment approved is as onerous to a state as getting a waiver approved, depending on what the nature -- I don't know if you would agree with that, Toby or Darin, you know, that -- or, yeah, Chuck. So I'm not sure -- I mean, I'm not sure that we should entirely think of this as waivers.

The other piece of this is that you can -- there's an element of this which is about what do states have to fill out as a form or as a request that you can kind of wrap your head around and grapple with, but another part of this that has to do with what are the questions coming from the federal staff to the state staff? And what are those questions about and what are they intended to understand and what are the revisions being made by the state staff as a result of that? When we account for what happens in a process, there's just an awful lot that

happens that is people talking to other people and people making changes and people rethinking something. And I don't know how we get involved in that and get close enough to that question to have a whole lot to offer about how that six months' worth of conversation could have been two months' worth of conversation. So I just --

COMMISSIONER DOUGLAS: Or not at all [off microphone].

CHAIR THOMPSON: Or not at all, right. Yeah. So, again, no answers to that, but just sort of thinking about the fact that some of what people find onerous or burdensome or irritating or frustrating isn't what's written in a regulation or in a form, but has to do with that kind of conversation that takes place. So I'm just a little skeptical that we're going to have a whole lot to be able to offer on some of the administrative process in terms of where the opportunities for a little streamlining could take place.

So we have Darin and then Chuck.

COMMISSIONER GORDON: So as an operator for 20 years in a state, I will always advocate for some state flexibility and ways to make it more effective and

efficient. I was looking at the one on the slide you were real happy with, with the bull's eye. The very last item there was streamlining authorities and things. It just made me think, there are obviously things that can be done, and I think you are right that some of those things are going to be easier to identify. Some of it is just the way -- how it's carried out in practice, which is a little bit more complicated.

But there are things -- and I think it would be helpful looking at this. There are some things that even states can do to reduce some of that administrative complexity, and I'll give you a great example of that. And I've been a big advocate and promoting it to every state I can talk to. We had several 1915 waivers and our 1115, and as we were looking at where we go with MLTSS, for example, we were quite insistent to not do that through a variety of 1915 waivers. We had sufficient authority under the 1115. We wanted to do it under the 1115. And the thought process there -- and other than a legacy 1915, we moved almost everything to our 1115 -- is to have single reporting time periods, single phone conversations with CMS on updates. We reduced how much time we deal with managing a litany of

waivers and times we spent on calls and different reporting requirements and expectations. It saved an enormous amount of time.

And so I think it would be helpful to absolutely get on the path of looking at the things that can be done from federal expectations, but also looking at some of the things states can do to reduce some of the administrative activity so they can focus on some of the more transformative program initiatives that they're looking at.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: Just a quick comment. There's some part of this that is just not ever going to be calculable, and the reason I wanted to jump in, Penny, is when you were talking about state plans and waivers and how they can all feel onerous in certain ways, there is an element where, from the state perspective, people at CMS superimpose their policy judgments, even where there's authority. And that is going to never be something we can discern, but it's very real. And so I just want to make that comment out loud and not just in my head.

CHAIR THOMPSON: Anne, you wanted to jump in.

EXECUTIVE DIRECTOR SCHWARTZ: I wanted -- just

something for you all to be thinking about, both this afternoon and in general, there is work that can be done in each of these areas that would lead to some very specific concrete action steps or recommendation to somebody to do something. There's also work here, I think a lot of these areas are -- a lot of people have said the top lines of them without discussing beneath that, and to the extent that you think some discussion of those things has some value in helping sort of illuminate why that is or what the -- you know, what the challenges are in sort of moving beyond it, that is of value as well. I feel like that's a lot of what we did around some of the design issues on the financing stuff last year, which I think you all seemed to think was a value, even though you didn't come out and make a recommendation on that.

So just as you go through these sessions, sort of think about, you know, just because something is difficult doesn't mean that we might not be able to make some kind of contribution. So we could think about how that discussion could sort of further the public discourse.

CHAIR THOMPSON: Marsha.

VICE CHAIR GOLD: Yeah, I guess my only -- my

contribution here, I think, is to ask us what our goal is in this area, because to me when I've looked at it, it's very broad. And I was trying myself to figure how we can be useful, and it seems like there's two separate strands of concern. One, which really affects more the first type of state flexibility, federal requirements, and to who and what must be covered, are some real differences of opinions across states and parties about what the Medicaid program is and to what extent it should statutorily be changed. That's a big policy question. I don't know -- you know, that one makes me nervous, and I don't know quite whether we want to take that on or not, because it's a policy judgment.

The other is the complexity of the program, which is really -- many of us who have studied or participated know, I mean, it isn't even intended. Things just get complicated because one thing leads to another leads to another. I mean, my best example, which isn't Medicaid, is HIPAA, which everyone thought was great, and we've killed a thousand million trees so that every time you go to the doctor you have to sign a form saying you've reviewed whatever that plan is that's somewhere. And it was with

good intention.

And so I think there is a lot of that frustration that I hear from states and others, but unless we were focusing on a specific area that we thought was a particular problem, I don't know how we contribute to that area.

So I'm trying to think of what the realistic goal -- what would we want to be our outcome of looking at this and what do we want to fix.

CHAIR THOMPSON: I do like, Toby, your idea about trying to think about 1332 waivers in this context. I think that makes sense, and, you know, could be a helpful contribution to kind of thinking about how to move forward to combine some markets and think more broadly about a pool of insurance.

I think, you know, we're going to talk about monitoring and evaluating the 1115 waivers. That's certain an area where I think there's a lot that we could potentially say fruitfully, but it's also one that, in the end, is going to end up being about what data is available and how quickly can it become available and how definitive are results, and if they aren't definitive then whose

judgment basically rules the day.

So I think those are things that are potentially useful here. But in the end I do think we have to decompose this to some level in order for it to be useful. I was originally not excited about the 1915(b) work about trying to look at the possibilities for converting that authority, but I've actually come around on that. I think that's useful to do, because it's getting down to kind of a level of, you know, where is there some opportunity to kind of streamline some of these authorities.

One question that I have is, so do we have, or have we done in the past some work on where states across the board have exercised certain authorities under different, at least, waivers, for long periods of time, where we -- I'm just thinking about the pathway to permanence question. Are there some specific areas that we should be looking at specifically with an idea to recommending some permanent pathway for states to exercise those options?

MS. FORBES: So that's what we had some work done a few years ago and staff have been systematically going through and adding to that and collecting that. So that is

part of what we'll be bringing. The path to permanence, actually, I would say of the various projects listed on that slide, the piece of work I think that we could probably use the most guidance from Commissioners on what would be interesting and helpful to you would be the path to permanence and the what is used in one state applies in others. As Alan said, this is the perennial question. So, what's the thing? What's the evidence we could bring that MACPAC could maybe add to that conversation?

So if any of you have ideas about what we could bring, what we could go through and find and collect and present that you think would add to that conversation, let us know. I would say we have a lot of spreadsheets and tables and things we've been compiling, but that's the piece that we are the least -- have done the least work on and could use the most guidance from you on what you think would be helpful.

CHAIR THOMPSON: So do we think that we have an understanding about where states have exercised some of these authorities for long periods of time, alongside evaluation results that tell us that they were successful, or at least not harmful, that could be --

EXECUTIVE DIRECTOR SCHWARTZ: I think one of our biggest challenges here is especially in states that have had longstanding 1115 waivers and had those renewed repeatedly is most of those waivers -- there's a chunk of that that's new in each iteration, and a part of that that is not new and is actually not different from other things that are being run through the program. So the question is, advantage whom in that situation? You know, does it help or hurt the state to have everything continued to be run through the 1115 or not, and that's -- I think that's sort of a subjective kind of conversation. It's not really a data conversation.

CHAIR THOMPSON: You mean that even if you created a path to permanence, so to speak, it's not very different than having it permanently be part of your 1115 waiver? Is that what you're saying?

EXECUTIVE DIRECTOR SCHWARTZ: Unless, yes, unless there's differences in what you're being asked to report. It's sort of a qualitative question. I also sort of think Arizona sort of complicates this whole thing, and it's like if we could just call the question on Arizona, have the conversation and set Arizona aside, that might be also a

useful thing.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: To make the connection between state flexibility on Medicaid and social determinants of health, because I do think that those two things are going to bump up against each other, the example that I will give, that I know is kind of going on now, is, you know, the restriction under Medicaid, we don't pay for room and board for long-term services and supports. But now states are pushing -- you know, they're trying to push the envelope as far as they can. Well, can we provide housing-related services? Can we provide counseling to tenants about how to be good tenants and sign leases and keep people with substance abuse disorders, you know, in a -- can we help them find housing, that kind of thing. And it just -- you know, it is -- housing is a big part of LTSS.

And I just see the dynamics in CMS, I mean, because they came out with some SMD letter a couple of years ago, and then the legal people decided that wasn't -- it wasn't what they liked so they're trying to retract that. I mean, it just -- I don't know how we play into

these policy decisions. And I guess -- I'm in the camp of those people, I don't know what our role is here, in terms of trying to articulate a policy direction around some of these things, because they do get into kind of fundamental things about what is Medicaid and what is Medicaid not. And is that a congressional thing, or is that an administrative thing? Is it a waiver thing?

CHAIR THOMPSON: And the other part of that question is, even as we think about some of these long-time waivers is -- Bill started us off talking about the CMMI example, where there was sort of an expectation of how things end. You know, things are tried, things are tested, things are evaluated, there is a data point, or multiple data points, and then there's a conversion.

And so also when we think about this it's sort of, as you talk about with Congress, where does Congress step in and say, "We now believe that there's been enough experience in the states that's successful on these different dimensions or areas of the program that we want to convert that now to a state plan authority and an ongoing grant of authority to a specific state." Do we feel comfortable with a perpetual administrative process by

which those things are managed versus some place where it becomes a matter for the Congress to take a look at and determine whether or not certain benefits should be continued or certain benefits should be extended?

Bill, and then Toby.

COMMISSIONER SCANLON: I mean, it's always Congress' prerogative to step in and say, "We have looked at what is happening here and we approve of it and we can make it a permanent part of the program."

I think the issue that we are talking about today is, is there a reason that Congress should enact an authority that is very broad and open to sort of a fair amount of variation, where CMS and states can demonstrate, to their satisfaction, that something should be permanent, because that's different. Again, Congress can come in, at any point, and when they say "this is part of the program," it's part of the program. I mean, that's not an issue.

So I think we are talking about changing the decision locus to the Executive branch, and the Executive branch approving what the states are doing on an ongoing basis. And that, I think, is what the nub of the issue is.

CHAIR THOMPSON: But just to press back on that a

little bit, I mean, it isn't necessarily true that we would need to construct a new authority. I mean, part of this is also about just an administrative process by which there is guidance given to states about an invitation to apply for a waiver, or an easy way in which waivers are granted and a view in which those waivers will be assessed in a particular way in order to establish ongoing authority to continue to operate under that, with less requirement for a particular state to come in and engage in a state-specific process.

COMMISSIONER SCANLON: This is more of a question than sort of trying to counter that. One of the things that I had understood about the 1115 waivers was that there were these elements that continued with renewal after renewal, and there were new elements that, in some respects, justified the renewal, that if you were just to come back with what you did yesterday, that was not going to be renewed, that it was when you were demonstrating something new that then you got an extension. Okay. And it's kind of this --

VICE CHAIR GOLD: Medicare.

COMMISSIONER SCANLON: -- right, yeah. It's this

artifice that sort of -- that allows us to go on, and what we're talking about here is eliminating that, saying that if something is demonstrated as positive, that it can go on without sort of a deadline.

CHAIR THOMPSON: I don't know that as a practical matter it's ever true that a state comes forward and doesn't change anything, but I don't know that it's necessary to change something in order to receive a renewal.

COMMISSIONER DOUGLAS: I'll give it -- I mean --

CHAIR THOMPSON: Toby, and Alan, and Darin, and then Anne.

COMMISSIONER DOUGLAS: -- a couple of points, just to answer -- I mean, well, one, remember we used to have family planning waivers. Those were the same 1115 over and over again. There were fights about that, but that was more about the politics. But those, finally, Congress did create a permanent seat for those.

But, you know, just -- I am struggling with this whole flexibility for, you know, one, because it hits against -- when we talk about 1115 and permanency, it isn't -- it's just around -- it hits against the financing that,

you know, states want flexibility but they also want the financing. So we can't look at, again, some of these issues in just isolation. It's how, again, do we think through all the different pieces of creating a framework that does allow states to have this flexibility they want but balance it with the outcomes but also balance it with the ability to have the right financing. And so if we talk about path to permanency and getting -- that you don't need 1115s, some states are going to say, "Well, wait, we want the 1115 because we wanted the budget neutrality."

So, anyway, I don't know what the answer is but it's hard to really start to get down on the micro level on some of these issues when they are all interrelated.

CHAIR THOMPSON: Toby. No, sorry. Alan.

COMMISSIONER WEIL: So, you know, we've had PACE turn into an option, the whole transition of managed care. We had the HIFA waiver templates. Massachusetts health reform happened in an 1115 renewal because the federal government's attitudes towards the financing mechanism changed.

I go back to where Bill started us. Principles are not -- they're just not going to get us anywhere. We

kind of -- in addition to the data collection analysis component here, which I think is always a very important role that we play, question number one is, are there instances where we could envision a process, just as Bill mentioned, like with CMMI, where if the CMS actuary says an actor has a certain decision to make and we give them authority to do something different. If we wanted to recommend that, that would be a big deal. I'm not saying I'm in favor or we should. But that would be a contribution, to say there should be a mechanism, not a set of principles but there should be an actual mechanism to take things there. Or I think we have to get down all the way into the weeds and say, here is a place where we have observed what's going on and we think it's time for this to move from being in Pot A, where there's all these questions being asked, into Pot B, where, in theory, things are more streamlined, and that could be either moving the 1915 over, the 1115 over, or something to a state plan amendment.

But I think if we stay at the level of “it's a tradeoff”, we don't get anywhere. You either need a process or we need a decision. Otherwise, I'm not sure we move this forward.

CHAIR THOMPSON: And in that latter category, Alan, are you thinking about specific authorities, like the 1915(b), or are you thinking about specific policy flexibilities?

COMMISSIONER WEIL: I mean, I don't -- I think we should consider both of those. How we feel about them, whether we can get consensus is something I have no idea. But I think that the purpose of doing it would be to look broadly.

CHAIR THOMPSON: Darin, and then Anne.

COMMISSIONER GORDON: On the point that, you know, states, when they're doing extensions, they're often modifying their program, I'm sure that's the case in some instances but in my 20 years in doing multiple extensions we actually went out of our way not to make programmatic changes during our extensions. If we were doing something new, we would do it off-cycle, we would go in and do an amendment to the program. But quite often, if you look at the bulk of what our program was, the changes that have been made to it that are not new, like moving things into it, consolidating waivers, were actually things that CMS wanted to change. Some of it was just preferences and

style, what all they wanted to include in it.

But more times than not, if you look at what's undergirding our 23-year-old waiver, it's the same stuff that's been there for 23 years, yet every 3 years I have to go back, and we hit every point, and just why are we doing this, and explaining why we're going to do that, and that's not always helpful for states to be spending all their energy. Again, it's fine if it's new stuff. You need to have those conversations.

But there does come a point that that's not the highest and best use of the time of a state-administrated program to be rehashing something that's been well established. We should be spending our energy and allowing states to spend their energy on what new things they can do to improve their programs, and I think that's at the crux of this and I think there's things we can do to recommend a process. I think principles will be hard but our process or our vehicle by which you can -- that states can have less administrative complexity to administering already challenging programs to administer.

And I will say this. It's not my recommendation but it is a thought. The idea again is every three years

you're having these conversations, and it isn't a quick conversation, and, actually, you start that process at least a year in advance. Typically it's taken me two years every extension, and that takes time off big strategic imperatives that we're trying to implement to improve the care to the people we serve when you do that.

But when you look at that, you could do the path to permanence, which I personally would argue is ideal, or you could extend these time periods as if we think they were, you know, so perfect when they were first established that you have a five-year and then multiple three-year efforts. Maybe you extend the time periods by which you're having to relook at these things. I mean, either one will reduce burden. We keep talking about path to permanence, which is my preferred option, personally, but there are other options to reduce that administrative hassle.

COMMISSIONER BURWELL: How would you do the budgetary part of that pathway to permanence. Some indexing?

COMMISSIONER GORDON: So the reality, yeah, we talk about budget neutrality. Budget neutrality has not been an issue that we've ever had to talk about in the last

23 years. And so the line keeps going up, that we keep -- we are amassing more and more of budget neutrality authority, yet we will spend several months talking about budget neutrality again.

So in some cases there may not be that and then that's a different discussion, but I'm telling you, some of these waivers have been around -- it's long established, this is more efficient than what you were doing before. I can keep proving it again for another 23 years.

COMMISSIONER BURWELL: So it keeps widening?

COMMISSIONER GORDON: It keeps widening.

CHAIR THOMPSON: Because the baseline keeps getting older and older.

All right. So, Anne.

EXECUTIVE DIRECTOR SCHWARTZ: So, the GAO people in the audience are taking notes on budget neutrality.

I just wanted to say, the fact that we are talking about different things means that the staff have to do work to sort of clarify what we're talking about when, and I think different waivers states do for different reasons and we should talk about those differently, so that helps with some of the staff work that we should come back

to with. And I think we can probably reach out to figure out what's the right sequence for that.

But I think this does suggest that you have an appetite for it, even though it's big and hard, but I think we need to get -- sort of take it in chunks that sort of make sense. So I feel like --

CHAIR THOMPSON: Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: -- I'm getting something from this that will help us have a better conversation next time.

CHAIR THOMPSON: Got it. And I think we are agreed that we've got to get down from the 30,000-foot level into some ways of slicing and dicing these issues so that we can say something practically about mechanisms or permanence or policies that really merit specific attention, in terms of changing the way that things operate today.

Thank you. We did go over a little bit on that conversation but that's okay. But fortunately we still have you, Moira, to continue on with managed care oversight.

MANAGED CARE OVERSIGHT

* MS. FORBES: I'm the fastest talker here. All right.

So now we're talking about managed care specifically, and 10 bucks to anybody who finds a problem with these slides.

[Laughter.]

MS. FORBES: All right. So in this session, we'll talk about managed care specifically as a lens through which to focus on some of these issues around state flexibility and program accountability.

So the background materials that we shared with you describe some program design elements that are unique to Medicaid managed care and describe a lot of the existing requirements and processes for managed care oversight and some of the key changes that were required in the 2016 rule.

I won't go over the program design descriptions here. I'm happy to answer any questions you have now or as we go along, based on the information in the background paper, but that was pretty detailed. And I'd rather get to the meat of the discussion.

So this presentation will just highlight some of those key oversight areas and then raise some policy questions for discussion.

So, as we just were talking about, we're reviewing the federal-state relationship and that balance between expanding flexibility and ensuring accountability.

Managed care is obviously a very important area for examination. It plays a large and growing role in Medicaid. It has its own set of federal oversight mechanisms, and CMS has stated that it is specifically examining managed care oversight as part of its review of opportunities to improve federal-state collaboration.

As many of you will recall, the rulemaking in this area is very extensive. Of course, to go through all of that would probably take us days. So the goal is not to discuss the reg specifically but to address the balance between oversight expectations and opportunities for state and plan flexibility.

I will discuss four major oversight areas and summarize the status of the final regulations in each areas as implemented to date.

We tried to include some key details to help

illuminate where the rule is helping ensure that the program is meeting its statutory objectives to protect beneficiaries, ensure the appropriate use of federal funds, and achieve other program goals.

I'm trying to do that on one or two slides, so feel free to ask for more details if that helps.

So managed care, as we've said many times in these meetings, it's the default delivery system in most states. It accounts for almost half of Medicaid spending.

The primary differences between fee-for-service and managed care, in particular, the payment and contracting arrangements, require separate approaches to program management and to oversight.

For example, under managed care, the state delegates provider contracting, utilization management, and claims processing to managed care organizations. So the MCOs, not the state, are responsible for making sure that there are an adequate number of contracted providers and for collecting and reporting claims and encounter data.

As a consequence, Congress and CMS have established statutory and regulatory oversight requirements specific to managed care. These include structural

requirements or processes that states and MCOs must have in place to operate a Medicaid managed care program, such as having a beneficiary support system or an enrollment broker.

They also include ongoing operational requirements, such as the requirement that MCOs conduct an initial health risk screen within 90 days for every new enrollee.

Finally, there are a number of reporting and transparency requirements intended to support oversight, such as the requirement for an annual external quality review of each MCO and for the state to post each EQRO report publicly.

Few specific oversight elements are described in statute. Most are in regulation. The first rule was published in 2002, and it was updated in 2016. The 2016 rule reflected the increased use of managed care in the states, including greater enrollment of more complex populations. It added new provisions and greater specificity to existing requirements, particularly in the areas of payment, access, quality, and program integrity. It also created additional mechanisms for ongoing oversight

and more reporting by states and MCOs.

The Commission discussed changes to program integrity at length last spring that culminated in a chapter, so I will just go through the requirements around payment, access, quality, and reporting here.

A key aspect of federal oversight is ensuring that state payments to MCOs are sufficient and actuarially sound. The 2016 rule added to the existing standards. It specified standards and procedures for developing and documenting capitation rates, adds more specificity to the actual soundness requirements, requires states to develop capitation rates so that MCOs can reasonably achieve a medical loss ratio of 85 percent and codifies sub-regulatory guidance, allowing payment flexibility for "in lieu of" services, but also phases out a special payment mechanism for pass-through payments that had been permitted in some states.

Some of the payment provisions have not yet gone into effect. The pass-through provisions are being phased in over the next five to ten years, meaning that pass-through payments are being phased out over the next five to ten years in the states where they're being used.

Medical loss ratio reporting requirements are in contracts that began this July. The first reporting will begin next year, and the rate setting piece of that will go into effect for contracts beginning in 2019.

States and MCOs have raised concerns about the changes to the rate setting standards and the review guidelines incorporated into the new rule. The changes could increase the time to review proposed capitation rates, which could increase uncertainty, particularly for plans looking to contract in the state or for states looking to make changes in the program.

They've also raised concerns, particularly with the medical loss ratio, with the calculation, as the Medicaid-covered populations and services are significantly different from other insurance programs. Many of the changes to the rule were intended to align the Medicaid rate setting guidance with that of other programs, but there are differences between Medicaid, commercial insurance, and Medicare, and some question whether all of the alignment is appropriate.

On the flip side, some provider groups have supported the changes, including the medical loss ratio

standard, and having a lot more specificity and transparency around the rate setting standards.

Another key difference between managed care and traditional fee-for-service is that it restricts patient freedom of choice; that is, Medicaid enrollees' access to care can be limited to providers in an MCO network. Consequently, a key beneficiary protection is that Medicaid MCOs must assure access to an appropriate range of services, to preventive and primary care services, and to a sufficient number, mix, and geographic distribution of providers.

The 2016 rule requires states to develop network adequacy standards and to conduct additional monitoring. By July 1, 2018, states must develop time and distance network adequacy standards and make the standards and the monitoring public. These apply to a number of different provider types, including primary care, specialty care, hospitals, pharmacies, and so on. Plans must also affirmatively certify their networks on an annual basis.

States are required to consider a number of factors in developing these standards, including the ability of providers to communicate with limited English-

proficient enrollees, to accommodate enrollees who have physical disabilities, and the extent to which telemedicine is available.

So this approach continues to defer to states' responsibility to develop provider network standards, while now requiring minimum network adequacy standards for specific provider types. It doesn't establish a national federal standard for network access.

Consumer advocates support the use of state quantitative time and distance standards as an improvement over the prior guidance, although some would have preferred a federal standard.

The statute requires that state Medicaid managed care programs have a quality assessment and improvement strategy. This is a longstanding requirement. The changes we saw in the 2016 rule are requirements that states develop a more comprehensive quality strategy, that they implement a quality rating system or QRS for MCOs, similar -- this would allow quantitative comparison of MCOs on a number of indictors, similar to that used in the federal exchange or the Medicare Advantage star rating system.

It created requirements for states to provide

more opportunities for stakeholder and public engagement, and it also created greater transparency around quality reporting.

Some portions of the rule have already gone into effect, but the effort associated with several of these provisions is anticipated to be significant, and states have been given several years to comply, particularly with the state quality strategy and the QRS provisions. This includes the initial effort to design the strategy and the reporting system, and the annual effort to collect and report on the data have been estimated to create new burdens on states' health plans and on CMS, and so they will not be going into effect until at least 2018.

At the same time, the changes, particularly around the use of stronger metrics to allow comparisons across plans and across states and the use of greater transparency in public reporting and consumer involvement in developing metrics and developing reports have been strongly supported by a lot of advocates in the community.

And, finally, on reporting, CMS has few direct oversight and monitoring obligations in the statute. It's generally focused on reviews of waivers and MCO contracts.

The 2016 rule establishes new provisions focused on CMS oversight of state operations at several different points, including pre-enrollment including the required readiness reviews of new MCOs, ongoing operations including specific requirements for managed care program reporting, and periodic and retrospective activities including more frequent and detailed state reports, such as an annual comprehensive report on each managed care program in the state.

The state reporting requirements incorporate but may duplicate some existing efforts. States already report a lot of things, but in my read of the entire list, I don't know of any state that does every single thing in that list every single year.

States have raised concerns about the balance between burden and transparency and questioned whether CMS has the resources to review the increased amount of data that they've asked states to produce.

Advocates have noted that the transparency requirements will allow stakeholders to more easily monitor program performance, and they also hope that they'll be requesting fewer ad hoc reports from the state.

So that's a high-level summary of where -- just as a reminder, I know not everybody was on the Commission when we went through this rule when it came out -- of sort of where that rule comes down on the sort of balance between trying to increase accountability around managed care and where the perception is of how that improves transparency and accountability, but also the burden on states and the federal government.

As we've said, there is a lot of discussion right now. Our understanding is that CMS is looking at possibly reopening that rule or administratively changing the way they enforce parts of that rule. We don't know yet what actions may or may not be taken.

They are in the process of implementing the rule. Many of the provisions already went into effect in 2016, particularly many of the beneficiary protections and a lot of the provisions that codified existing sub-regulatory guidance. A lot of provisions went into effect at the contract year that just began on July 1. This was to allow states and MCOs time to develop the appropriate payment rates and revise the contract terms, if necessary, although CMS did say that they would use enforcement discretion in

cases where states weren't able to make some of the changes for 2017.

Some of the big new provisions will not go into effect until contract years beginning July 2018 or July 2019, and some of these provisions are dependent on other things. They have to do a separate rulemaking on that quality rating system, for example.

In revising the rule in 2016, CMS noted that its intent was to account for the much greater role that managed care plays in Medicaid, while providing an appropriate balance among state flexibility, national minimum standards, and alignment across programs, meaning Medicare, Medicaid, and national commercial insurance standards.

A lot of the changes codified guidance that was already in practice, but we're now at the point where CMS, states, and MCOs are having to implement a lot of the larger policy and operational changes that were created in that rule. And many of the differences and challenges are becoming clearer. So CMS has signaled that it's taking a close look at the rule.

This creates an opportunity for stakeholders to

revisit not just the individual provisions, but the extent to which the rule overall is balancing these different policy goals -- state flexibility, accountability, alignment, to the extent that that's still a priority and so on.

So we've identified a few policy questions that may help frame your discussion. We don't know yet when or how there may be an opportunity for the Commission to weigh in, but based on your discussion today, we can be better prepared to develop formal comments in the event that CMS does issue a proposed rule, or we can help inform Congress and the administration as they consider broader program changes. We can also identify if there are just areas that we need to look in to further to bring back additional research for you.

So, with that, I would turn it over to the Commission. Thank you.

CHAIR THOMPSON: Comments from the Commissioners?

[No response.]

CHAIR THOMPSON: I don't know if you saw, Moira, there was a GAO report issued yesterday about the oversight of managed care plans with respect to MLTSS that was

released. So I think there were some findings around reporting and the adequacy of reporting, so that was -- I didn't have a chance to dive into it, but I thought that was certainly something that we should take a look at.

CMS did come back with the responses to those recommendations, basically agreeing with the idea of needing to have adequate reporting to oversee MLTSS programs and noting its current review of the regulation.

Do we have any information about states' requests for enforcement discretion or waivers? I think it would be very interesting to know from the state's perspective where they have been having trouble meeting some of the requirements that became effective in July 2017 and where they asked for some relief from the agency. Is that information available?

MS. FORBES: No. That is an excellent question. I haven't seen that.

States were told that they could not get regulatory relief on the provisions that went into effect July 1, 2017, in the areas of the medical loss ratio reporting, the pass-through, or -- there was a third one – actuarial soundness, but the rest of them, there was

enforcement discretion. But I haven't seen any reporting on that or anything in the news clips about that.

But we can certainly ask around.

CHAIR THOMPSON: We should ask about that. I mean, it was, in my view, a pretty typical offer to the states who were having difficulty meeting compliance dates to come in and talk about what they were doing in order to continue to make progress and if there were mitigations that needed to be put in place while that was being achieved and so forth, and so I think it would just be a little bit of a leading indicator on where, if anyplace, states are having just an implementation issue in terms of getting into compliance with those provisions, understanding that a number of the provisions don't come into place until later.

Go ahead, Fred.

COMMISSIONER CERISE: In reference to some of the issues around value-based payment methodologies, quality measures, outcomes and those types of things, we talked about it a little bit earlier, and that is these become complex programs. And you've got multiple managed care plans. You've got state priorities that they're trying to

push, and to the extent that we feel it's appropriate to look at, what are those things that the state may retain to simplify the program and to provide common structure? Because we talked about things like Medicaid ACOs and DSRIP payments and innovation payments and things that you may be trying to do on a state level, but that among a group of local providers, it gets complicated by now trying to run that through multiple managed care organizations. So what could states define as common elements that they would want to do and hold onto as opposed to trying to push like the DSRIP stuff through to the managed care organizations? So, again, kind of that theme of, for simplicity, how do we create some common expectations? Because it does get quite complex for providers to try to comply with -- or to try to manage multiple programs.

You subdivide your population every time you try to do one of these things working through multiple organizations.

CHAIR THOMPSON: And, Fred, are you thinking about that from the standpoint or providers or plans? Because the rule really --

COMMISSIONER CERISE: Both, actually.

CHAIR THOMPSON: The rule, as it was issued, really focused on trying to help plans operate in an environment where they could --

COMMISSIONER CERISE: I think it would be both, and you guys who have done plans can comment. But when you look at the plan, your approach by multiple providers, if there's a state initiative, it's a waiver initiative, a DSRIP initiative, they're going to come to the plans now to try to coordinate, and so you'll get these messages of "You guys work it out and come back to the state with the answer," right? And so it is complex --

CHAIR THOMPSON: "You guys" being the providers?

COMMISSIONER CERISE: Or the plans. Well, the providers and plans, you guys work it out.

And so to try to manage a number of these programs through multiple plans, it certainly is complex for providers, and I believe it's pretty complex for the plans as well.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: So I'll try to respond directly to the three questions.

Having just said that I think it's important we

be specific, I find myself -- and I don't know if this is part of why people aren't raising their hands faster. The complexity of this rule and the number of comments provided in its preparation makes it very hard for me to feel like I have any judgments greater than the collective judgment of all of the people who spent thousands of hours.

I was daunted by the estimate of the number of hours states are expected to spend just to implement this.

From a sort of MACPAC competency perspective, I think going through the rule sort of section by section, as you've done, and weighing in on shifting it a little to the left or to the right or to the front or to the back, I don't know that we have the competency. I feel not particularly competent in that.

So it's hard for me to look at those first two questions and say I can't answer that the rule does it, but I can't also -- I also can't answer that I think we could come together collectively and come up with a better answer. That's my honest reaction to them.

With respect to the third question -- and this goes a little bit to the conversation earlier this morning, and it's a little reminiscent of some of the conversations

we had about CHIP reauthorization and the long-term vision versus the practical reality of what's in front of us today.

So I have no hesitation saying that I think outcome-based accountability is far -- conceptually far preferable to sort of process management.

I also don't think we are anywhere close to having the set of outcome measures that you would -- you know, for the federal government to say to states, "As long as you're holding plans accountable on these 7 metrics or 20 metrics, you can rip up the reg." I just don't think we're there, and so it's not that I can judge every process measure in the reg. But I don't think we're at a place today where I would support or could see us coming up with some sort of completely different approach to accountability from the federal government to the states when it comes to managed care.

So I think this is a big topic, and I'm really glad we're working on it. I feel a little funny. Thankfully, there are multiple segments on state flexibility, and I don't feel as incompetent in the other ones as I do on this. But on this one, I think it would be

really hard for us to sort of go deep in and rewrite the reg.

CHAIR THOMPSON: Stacey and then Peter.

COMMISSIONER LAMPKIN: I appreciated your including MACPAC's letter in response to the proposed rule. I was not a Commissioner at the time and reread it in preparation for this session, and really can't find anything to argue with the way MACPAC tackled it at that time in the context of these questions. The push to greater transparency and oversight is good, and I can speak a little bit more on the rating side of it and kind of how they captured that. And I think generally what the rule does is emphasize some already best practices that hopefully were fairly broadly used, maybe a few things to quibble about, but really not too many.

The review process and having a streamlined rate review process, now that's another question. But that's not the regulation itself.

Network adequacy I think is also -- I happened to be with Florida Medicaid at the time that we revamped our whole approach to network adequacy there, and it was certainly -- it required a lot of resources, but definitely

paid off, definitely worthwhile.

I know nothing about the quality side with respect to where the balance is here. Maybe others are better equipped to do that, but just -- it is hard to know how, if CMS were to revise this, how we would be able to comment with any specificity in some of the areas about where the tradeoff is.

CHAIR THOMPSON: I agree, by the way, in terms of being able to take a look at the comments that came in on the prior rule and to question whether or not we would be in a position -- I mean, on the one hand, I would just say I find it unsurprising that an administration would decide to take a look at this rule, and after having a little bit of experience with some implementation and a little bit of additional commentary, would kind of take a look and see is there anything that we want to change here.

It was a long process to get this rule out the door in the previous administration. That was because a lot of these issues are very complex. It's a lot of judgment calls. You can land in a lot of different places with some of this.

I think some of the areas that may be

particularly under scrutiny in terms of mentioning, for example, the review process for the capitation rate was a big point of conversation, how to make that process work just from a timing perspective.

So, you know, I guess I'm also in a similar place to Alan and Stacey in terms of wondering both how much effort to put into getting prepared for a potential policy change in the new rule versus spending time on other issues that we think will be continuing to be important in terms of managed care. And one of the things, for example, what we talked about earlier today, how do we recognize some of the -- I think, Chuck, you mentioned this issue; Stacey, you too. How do we recognize in the encounter data or in the underlying cost structure what plans are investing to help promote response to social determinants of health or to other aspects of well-being and care for their populations?

You know, it's my view that we should spend more time on those kinds of issues than on trying to anticipate what the federal policy will be or responding to some of these particular matters.

Peter?

COMMISSIONER SZILAGYI: Yeah, I was going to make exactly the same point, not really as eloquently as Alan. You know, and to emphasize, almost two-thirds of all Medicaid beneficiaries would be -- are affected, and maybe 75, 80 percent of children are affected. So this would be no minor thing for us to wade into these treacherous waters and try to, you know, make very specific changes when we're not really expert at that.

And I was also going to make the point that Stacey, that we're already on record kind of supporting this process with Diane Rowland's letter, so I would also favor putting our effort in other directions.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: And, Moira, my apologies again. I missed a lot of this with a work call I needed to take, but I guess -- I mean, I'm agreeing with everything that I've heard since I came back in the room.

One of the just contextual things I want to say to the Commission as a whole is sometimes CMS -- and this was particularly true with some of the access regs and some of that. CMS steps in and regulates and creates a framework because the federal courts -- and Toby has lived

the dream in California about this. The federal courts want to defer to the federal agency around managing the state behavior and, you know, compliance and oversight functions, and so I do think that contextually, for all of us -- and I'm not sure where the new administration stands about all this, but sometimes CMS steps in because if they don't, other federal players will step in, and CMS needs to own the issue, appropriately owns the issue.

And so I just would say out loud for folks that I think a regulatory framework matters -- for CMS to have for all of the kind of quality and access and network and rates and all of that, that CMS needs to own the issue. And I think that that kind of framing statement, if and when we do get around to reviewing a new proposed regulation, is going to matter. So I wanted to contribute that.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: So I don't disagree with, whether or not getting into this is helpful now when the discussion is -- and the administration has been pretty clear that something is going to happen.

I think, though, from the perspective -- just so my position is clear, because it sounds as if we're saying

that the decision is whether or not CMS oversees managed care or they don't. And I don't think that's what's intended, but that's some of what I've been picking up. The question is whether or not they got it right. And, you know, as I was president at NAMD, we wrote a very long, lengthy letter on behalf of all states, all members, that there were places they didn't think that they got it right.

We talked about throughout this day how complex this program is, and so not because of ill intentions that you don't get it right, it's because of the incredibly vast complexity of the program. Did you strike the right balance? You know, that can be debated. But I don't think the question is whether we should dive into all the different ways that someone could reconsider those actions, because we could spend a lot of time guessing what those things might be, but waiting to see kind of where that goes, and then maybe weighing in on those things. But I don't think it's a question -- at least the perspective of the states that it's continued even after since I've left, is whether or not the balance was struck right in the oversight of managed care and the way that it's being carried out. I think that's where there's the state -- I

guess the issues which the states have laid out there. But trying to, again, guess where that goes would be hard to do at this point.

CHAIR THOMPSON: Go ahead.

MS. FORBES: So two other things I didn't mention in the presentation. One is that in our -- it's some of the other work we've been thinking about. In the discussion about the conversion of waiver authority to state plan authority, one of our thoughts at the staff level has been that part of the reason that managed care was originally authorized through waivers and states said they repeatedly get waivers and still have to get them for certain populations is because there was not a robust enough regulatory scheme to provide sufficient beneficiary protection, and that you could say that now that there is a stronger -- I mean, the Commission could in theory, if we did the work to support this position, say that there is now a strong enough regulatory scheme to allow the waiver protection to be replaced with a permanent state plan authority.

So one thing to think about is if we want to focus more narrowly on the question of the aspects of the

rule that could replace what is now required in a waiver for certain populations to be mandatorily enrolled in managed care. I mean, we could focus just more narrowly on something like that.

Another way we could -- I'm not arguing that we have to do any more work on this. I'm just saying that is something we could do.

The other thing we could more narrowly focus on is -- and this is really parochial -- is you all report to Congress, and what in the rule is -- you know, you're all saying you're not experts on how does CMS oversee states or how do states oversee health plans. That's fine. How does Congress oversee CMS is something you could be -- you know, that is something you could weigh in on? And what are the things that come out of all of this reporting and all of this transparency in the rule that you would want to make sure your client, Congress, would want to see preserved? And, are some of those kinds of things maybe something you would want to weigh in on? We could look at those kinds of things. That might be a very narrow place that MACPAC would weigh in on that no other stakeholder would necessarily have a view on. So that would be another thing

we could look at.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: One other point that made me think you hit it in the presentation was the differentiation between managed care and fee-for-service. I think there are some things that you look at with the expectation is in managed care, I think it's probably worth considering whether or not that should also be looked at on the fee-for-service side. And I say that in the context of -- we talk about data, and, you know, how we can see how things are really going on, and having this kind of dual system, where one's reporting certain things and the other's not, and one has standards, the other one doesn't, and yet sometimes we're talking about the same populations, it begs the question of whether or not there are some things that are being expected in a managed care environment that might need to be carried over to fee-for-service for just understanding what's going on broadly in the program and informing policy. But it's something I think we should look at at some point. Again, timing, you know, we can talk about later, but --

CHAIR THOMPSON: We did have a little bit of an

inversion of that conversation. We talked about the access rule and whether or not the activities were worthwhile given a shrinking fee-for-service population, and some of those mechanisms ought to really be part of what a plan or a state does in the context of managed care with network adequacy. So I think we always have to sort of keep in mind where the big parts of the program are and where the vulnerable parts of the program are.

Your comment, Moira, also made me think about the fact that in the draft rule there was a provision -- and this might be something that we want to think about in terms of that question that you asked about does Congress feel that CMS has the authority that it needs or is it exercising the authority appropriately. There's very little enforcement power at the federal level with respect to any of these provisions. There was a desire and a Notice of Proposed Rulemaking to create some intermediate mechanisms where, if a state was out of compliance with some of the provisions, there could be a way for the federal government to withhold partial funds. You can correct me if my memory is wrong on this. I think that they determined, as they finalized the rule, that they

didn't have the authority for that.

And so there is a certain kind of disconnect between the fact that we're talking about, you know, a rule with a lot of complexity and requirements and a lot at stake, but very little, if any, real federal enforcement authority available to address any issues of compliance. And so maybe that is an area where we could make a recommendation to Congress about that. If we felt that, as we've been discussing, a regulatory framework is necessary, you can debate details within that regulatory framework. But it does presume if there is such a thing, that there is some way to address issues of compliance. And maybe that would be something where we could make some particular recommendations.

I think I do hear a consensus among the Commissioners that in terms of focusing a lot of attention on either preparing for what changes might come from the new administration or in terms of spending a lot of time on some of these policy questions, that we would rather resources of the staff be spent elsewhere in thinking about some of the other issues that we've been discussing today and tomorrow.

Thank you, Moira.

Okay. We will move on to 1115 research and demonstration waivers.

[Pause.]

MONITORING AND EVALUATING SECTION 1115 RESEARCH AND DEMONSTRATION WAIVERS

* MR. NELB: All right. Thanks so much.

So I'm going to continue our discussion today of state flexibility by presenting some preliminary work that we've done on monitoring and evaluating Section 1115 demonstrations. I'll be the one presenting this work, but before I begin, I just wanted to acknowledge the many contributions of our newest research assistant, Daniel Marthey, who helped compile a lot of the data that I'm going to be presenting today.

So I'll begin with some background on currently approved demos and then discuss the common monitoring and evaluation standards that apply to them. Then I'll discuss some of the specific metrics and methods that have been used to evaluate particular types of demonstrations based on our review of publicly available demonstration evaluation plans. Finally, I'll conclude by discussing

recent policy approaches to reduce reporting burden and highlight some policy questions that can help guide some more focused work in this area in the future.

So first some background. As you know, Section 1115 is the broadest waiver authority available in the Medicaid program, and it provides the Secretary of HHS with the ability to approve waivers that test and evaluate new policy changes.

As of August 2017, a total of 43 comprehensive demonstrations were operating in 34 states. Some states use demonstrations to operate most of their Medicaid program, such as Arizona, while others use demonstrations to implement more targeted changes, such as coverage for childless adults.

Some of the most common demonstrations include: premium assistance and other state-specific approaches to the Medicaid expansion; DSRIP programs, which we talked about earlier today; and managed care, including managed long-term services and supports.

There are also currently 11 family planning Section 1115 waivers which we've excluded from this analysis because they're more limited in scope.

So in 2012, CMS finalized some regulations regarding the monitoring and evaluation of waivers. According to these regulations, states are required to submit annual progress reports on their demos, describing early findings about the impact of their demonstration and various operational updates. Most states also submit quarterly reports which provide more timely information about enrollment and grievances during the last quarter.

Data on Section 1115s is also included in other reports that states routinely submit to CMS, such as CMS 64 expenditure reports and MSIS claims and encounter data.

In addition, because these are research and demonstration waivers, all states are required to formally evaluate their programs. After a waiver is approved, CMS approves an evaluation plan that describes the hypotheses of the demonstration and the specific measures that the state will use to test those hypotheses. Then states are required to submit interim evaluation reports, typically a year before the demonstration expires, which helps inform demonstration renewal discussions. Finally, states are required to submit final evaluations, typically a year after the demonstration ends, which allows additional time

to gather data from the final year of the demonstration.

To help promote transparency, states are required to post monitoring and evaluation reports to their state websites, and CMS posts many of these reports on its website as well, medicaid.gov. We reviewed monitoring and evaluation reports available on medicaid.gov and state websites as of August this year and found that most states had posted quarterly or annual reports, but that only about half of states had posted evaluation design plans. We're not exactly sure the reason for some of these delays. It may be because of delays in states' submission of their evaluation plans or delays in CMS approval, or the plan could have been approved but just isn't available on the website.

In terms of evaluation results, we don't expect to find them for all demonstrations since some are new and still underway. However, looking at the subset of 26 demos that have been renewed in the past, we are only able to find evaluation results for about half of these demos.

All right. So taking a closer look at what we were able to find from the evaluation plans that were publicly available, we found that pretty much all

demonstrations included some sort of hypotheses and measures related to access and quality. Many evaluation plans used nationally endorsed measures where possible to measure performance on access and quality, such as HEDIS and other established measures.

We found that 23 of the 26 evaluation plans included at least one of CMS' child and adult core quality measures. There's currently about 57 core measures that provide common measures of access to primary care, behavioral health, maternal health, other sort of general access and quality concerns for the Medicaid population.

The three states that didn't have any of the core measures in their evaluation plans were demonstrations that focused on the disabled or elderly population, and it's important to note that there currently aren't many core measures that really focus on those populations.

We compared the number of core measures that states reported in their evaluation plans to the number of core measures that states are currently voluntarily reporting to CMS as part of the core measure initiative and found that, on average, states reported about three times as many core measures to CMS than they had included in

their evaluation plans.

On the one hand, this finding suggests that states may be able to report some more of the core measures for their evaluations, for their 1115 population. However, it's important to note that all core measures may not be applicable to all demonstrations. For example, core measures of maternity care may not be very applicable to demonstrations that are really focused on childless adults. In your materials there is some more complete information about core measures and which states are reporting.

Looking at spending measures, we found that although all demonstrations are required to track their spending in their demo in order to meet budget neutrality requirements, only about half of demonstration evaluation plans included specific hypotheses related to spending.

For example, in Massachusetts and New York, these states are planning to evaluate whether their delivery system reform efforts are reducing the total cost of care. And in Arkansas and New Hampshire, they're planning to evaluate the cost-effectiveness of their premium assistance programs relative to traditional Medicaid.

The evaluation plans that we reviewed used state-

developed measures to examine these factors, and a lot of the definitions of total costs of care or cost-effectiveness didn't really align between states.

Finally, in addition to evaluating the effects of demonstrations on some of these general goals of cost, quality, and access, the evaluation plans that we reviewed included a number of measures to evaluate the effects of some of the specific policy changes that were proposed by the demonstration. And it's important to note that because these demonstrations are pursuing very different policy changes, states use different measures to evaluate these policies. And so this is an example of why some measures may not be applicable to all demonstrations.

However, we did notice some common themes. For example, demonstrations that waived Medicaid beneficiary protections generally aimed to monitor the potential adverse effects of these actions, such as measuring the number of individuals locked out from coverage for failure to pay premiums or monitoring how the elimination of transportation benefits affected enrollees' ability to keep appointments.

In contrast, some of the demonstrations that

added new program components that weren't otherwise permissible under traditional Medicaid typically evaluated whether these programs were being implemented as intended, for example, tracking whether enrollees are using new health savings accounts and tracking how DSRIP programs are being implemented.

Lastly, we looked at the benchmarks and targets that states are using to evaluate their performance on the measures that were included in their evaluation plans. Overall, we found few examples of states that had established benchmarks or targets at the start of their demonstration, although many states described methods that they were planning to use to establish benchmarks in the future.

In general, we noted that different types of demonstrations proposed different methods for evaluating their performance. So as I mentioned before, some of these states that put pretty much their entire Medicaid program into their demonstration for comprehensive managed care generally planned to compare the performance under managed care to the state's historical performance since there wasn't another comparison group that they could use in

their state.

In contrast, states that were implementing state-specific approaches to the Medicaid expansion for a subset of their Medicaid enrollees generally planned to compare the quality and access for demonstration enrollees to other Medicaid enrollees in the state, even though it's important to note that some of these groups may not be fully comparable.

We weren't able to find examples of states using national benchmarks to evaluate their performance, such as national performance on the CMS core measures.

Just last month, Florida received approval to renew its Section 1115 demonstration under what CMS described at the time as its "new approach to state reporting activities." It's important to note that CMS has not issued formal guidance describing this approach, but I'm presenting it here because this demonstration may be indicative of the approach that the current administration will apply to other 1115s in the future.

So, first, a little bit of background. Florida's managed medical assistance demonstration was first approved in 2005, and it provides authority for the state to

implement managed care statewide and use savings from the elimination of an upper payment limit supplemental payment program to create an uncompensated care pool.

Under Florida's renewal, CMS relaxed the reporting requirements particularly for the managed care portions of the demonstration by not requiring the state to submit a quarterly report. However, CMS added more specificity to the evaluation requirements of the demonstration and encouraged the state to focus on the components of the demonstration that couldn't be approved without 1115 authority, such as the uncompensated care pool. Let me go into each of these changes in more detail.

So in Florida's approval document, CMS noted that reduced reporting burden may be merited for waivers that meet at least one other criteria listed here: longstanding, non-complex, or unchanged; rigorously evaluated and found to be successful; demonstrations that are implementing provisions that are now considered to be standard Medicaid policy; and demonstrations that are operating smoothly without administrative changes and minimal grievances.

However, again, I want to emphasize that these

criteria have not been issued as formal CMS guidance, and so it's difficult to evaluate which demonstrations might meet this criteria.

I do want to point out that in 2015 CMS did issue guidance proposing similar criteria for identifying states that would be eligible for what they called a fast-track review of their demonstration renewal requests. However, in practice, few states have met all of these criteria.

In Florida's demonstration approval, CMS also added new instructions for developing evaluation design plans and preparing evaluation reports. These instructions were added as an attachment to the demonstrations that CMS appears to intend to apply to other states as well. In this guidance, CMS encourages but does not require states to use nationally endorsed measures such as the CMS core set. And CMS also added required core components to the interim and final evaluation reports listed here. In general, these requirements try to make sure that the conclusions from the evaluation are explicitly stated and try to tease out what findings from the demonstration might be applicable to other states and could help inform CMS policy more generally.

So as the Commission continues its work to identify efficient and effective ways to monitor and evaluate demonstrations and the Medicaid program more generally, here are some policy questions to help start your discussion today about future work you might want to pursue.

As you can see, we've included a number of questions that aim to get into the weeds of these issues a little bit more than we have in the past, and the idea was to try to think about how to advance our work to the next level and to think about how specifically monitoring and evaluation can be improved. But I look forward to your guidance and feedback, and I'm happy to answer any questions you may have. Thanks.

CHAIR THOMPSON: Great. Thank you.

Rob, can you distinguish -- and I wasn't sure I was tracking exactly with your presentation -- between this issue of what the federal government is doing to evaluate waivers and what states are doing to evaluate waivers? Just to understand a little bit better about the connection between those two things.

MR. NELB: Sure. Good point. So all states are

required by regulation to evaluate their own waivers sort of individually. In addition, CMS has the ability to do its own federal evaluation of waivers, and currently CMS is in the process of conducting a federal evaluation of a couple different types of waivers -- DSRIP, some of these premium assistance waivers, MLTSS, and some of these new approaches to premiums. So that's not a required activity, and it's underway, and we're not sure when results from that will be available.

CHAIR THOMPSON: I think that's something we should keep a close watch on. You know, as I've thought about this, we talked before about the CMMI approach to a demonstration, and the advantage that CMMI has is that they have been constructing the model. And when you construct the model and you construct the way in which the model will be evaluated, and then you invite participation into that model, it's a little bit easier to track from the test to the result -- you know, a little bit easier, not totally easy at all. But there's a way in which you at least have a pathway to a decision point that you're making.

When you're dealing with states coming in with requests of different kinds, they're constructing different

models even though they may be adopting and adapting from other states, and they're putting them together in different ways, and they're thinking about them as accomplishing slightly different objectives perhaps. So it's a little bit more idiosyncratic, if you will, and I think that's challenged the federal government in terms of comprehensively assessing how different states have implemented different models and whether or not they're consistently achieving the same kinds of results, which is why I think we're seeing a little bit of a delay in some of the federal work on that level. It was also underinvested in for a number of years, and so it was not an activity that was necessarily prioritized.

But I think of this when I think of the conversation that's occurring even now about the Indiana 1115 waiver, which had some different perspectives from the federal and state side in terms of how do we evaluate the success of this model or don't evaluate the success of this model. And so do you have any comments for us or any insights based upon some of what's been going on across states, not just individually inside of states but how you can kind of add up or trend some of those evaluation

results? Do we feel like inside of these evaluations, again, apropos of our earlier conversation, there's some consistent directions about the success of certain initiatives or not?

MR. NELB: Sure. I can take a stab at that. As you note, these evaluations -- these demonstrations sort of emerge from the state level and then are approved by CMS. So each demonstration is a little bit different. The DSRIP demonstrations that we talked about earlier are an example where there's a lot of demonstrations that we've grouped together as DSRIPs for analyses, but they're doing it a little bit differently and different measures in different states. And so there is a federal evaluation looking at DSRIP, but because states are collecting different data, it's a little hard to compare results, in addition to the usual health services research challenges of how you figure out the effects of the demo.

On the premium assistance and some of the new adult demos like Indiana, there seems to have been more effort up front with the evaluation plans. There's sort of more alignment between some of these different states, at least looking at similar measures, so like whether someone

was locked out or paying their premiums and stuff. And so hopefully, at least the alignment of measures -- even if the approaches the states are taking is different, the alignment of measures will maybe help us better see how these different efforts are working across states.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: I want to ask the impolitic question about the role of politics in these evaluations, and I have only anecdotes in my head that don't help me a lot.

Certainly my understanding when the federal government commissions work of almost any sort is that there's some sort of a clearance process. You mentioned delays in release having to do with timing. What do we know about the degree to which -- I'm just going to ask this as -- you can answer it as carefully as you want. I'm going to ask it not very carefully. What do we know about the degree to which ideological agendas could potentially make their way into either the design or the selection of contractors or the review of evaluations in this process? I really don't know the answer.

MR. NELB: Sure. So it's a two-stage review

process for evaluation designs between the state and CMS. So that can -- sort of both parties get a say in that. In terms of evaluation results, you know, there's less sort of federal review of it.

As you note, like with the federal evaluation that's currently underway, there's sort of a clearance process with that, so the evaluation design -- Mathematica is the one doing the evaluation. Their evaluation design had indicated that they were going to submit a lot of these sort of rapid-cycle reports to CMS, you know, over the course of the demonstration -- over the course of their evaluation, even though their final findings aren't expected for a couple years. However, we haven't seen any of those sort of rapid-cycle results, and from our side it's hard to know why, but the clearance process could be one reason.

CHAIR THOMPSON: Marsha, and then Sheldon.

VICE CHAIR GOLD: Yeah, the clearance process has been an issue across multiple administrations and it results in a lot of delays. I don't know what we can do. You know, I was struck, even with the state-funded evaluations, the fact that you can't find the reports. I

mean, it seems that that's noteworthy and we might make a note to someone that this isn't good, and not getting timely access to information from evaluation results is not good. You know, we've certainly been waiting long enough on the long-term care one.

So I think it's too early to know whether the problems will be any better or worse in this administration, but they've been problematic for a while under multiple administrations, and I don't think it's to the good of the public interest or the government's dollars.

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: Yeah. I don't want to pile for -- I don't think I could be more impolitic than Alan, but ––

[Laughter.]

COMMISSIONER RETCHIN: -- but I'll try. I think -- yeah, and I know what triggered it with Alan, I think, why that popped into his head. But I am -- I suddenly started thinking, and it's a little disquieting, that we are really, I guess, not promoting but just sort of in a complacent way, evaluating demonstrations on the basis of

selfies. So as I started to think about that, I'm not sure where you go from there. You know, you can understand why a particular ideology might be promoted. I mean, it's really kind of a legacy stamp by an administration. So I don't know how you grapple with that.

CHAIR THOMPSON: Toby is shaking his head. You want to jump in on this? Like, no. Brian.

COMMISSIONER BURWELL: I'm less concerned about any kind of ideological bias at the federal level than at the state levels because it's in the interest of these states to perpetuate their 1115s. So I'm more concerned about -- I mean, information is around how much states actually invest in evaluation, because they have to pay for it, and, you know, how -- I've read a couple myself and am pretty unimpressed.

CHAIR THOMPSON: Pretty unimpressed or just --

COMMISSIONER BURWELL: Pretty unimpressed. I would just -- I think this is a very fruitful line of investigation of us, for research. I think we should read the evaluations that have emerged. I think we should comment on them. I think we should look for, to the best that we can, what do these evaluations say about the

results of the hypotheses that were posted in the initial evaluation plan. I mean, that's following up on yours. I mean, this is the whole point of the 1115s is we're supposed to be able to learn something.

And to the extent that certain evaluations are not being conducted, I don't know, did we follow up and try to -- did we call these states and ask them, you know, what's the status of the evaluation? Did they just like hem and haw?

MR. NELB: So our review is based on what was publicly available on CMS' website and on state websites, but we can certainly follow up. And if there's particular types of demonstrations you'd want to gather the evaluation findings for we can do a deeper dive and try to see, again, what's out there.

COMMISSIONER BURWELL: Yeah. We should certainly see if they exist somewhere.

And, you know, I think this is a very -- something that we should push and see what we can get out of it. In full disclosure, we are sub to MPR in the CMS evaluation and are, therefore, trying to extract information from the quarterly reports that 1115 states are

submitting. I mean, a very clear problem is there's no standardization of how states are supposed to report information, so we're trying to put together a database of what states are reporting, but it's extremely problematic because there is no standardization whatsoever.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: Just an observation and a comment that he said you wouldn't see it happening at the federal level but you see it at the state level, that the state would want to perpetuate it. That's not always true in either of those cases, I believe. I mean, there's always going to be a perspective of whether or not they believe that's the right policy choice and how they approach the evaluation, maybe to further their point. I'm not saying that it is or it isn't. It's possible.

I worked under three governors. The program was -- the waiver was submitted by the fourth governor, you know, before the one I came in on. It went D-R-D-R, two-term, two-term. And so, yeah, there could have been the motivation to say, yeah, the prior thing, that was crazy, but they didn't. They were, you know, thinking that this was a better alternative.

CHAIR THOMPSON: Darin, what is D-R?

COMMISSIONER GORDON: Democrat and Republican.

CHAIR THOMPSON: Oh.

COMMISSIONER GORDON: What I'm saying is that there are situations -- yeah, red, blue. However you -- but what I'm saying is there's -- in that case, you know, there could have been -- there wasn't but there could have been the political motivation to be able to point out what the prior, you know, person did was bad and it was wrong, and I'm going to spend all my energy to point that out.

COMMISSIONER BURWELL: I withdraw my comment about it's supposed to look good. Sometimes they want it to look bad.

COMMISSIONER GORDON: Exactly.

COMMISSIONER BURWELL: Okay. I'm just saying that there are also biases at the state level, not just at the federal level.

COMMISSIONER GORDON: Yeah, both. Yes.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: Well, I want to say I didn't mean to poke a hornet's nest but I actually did mean to poke a hornet's nest.

You know, I'm not naïve. None of us around this table are. What I am trying to figure out is why we're missing the information that's missing and the degree to which anyone, including us, can do, really, Penny, what you asked earlier, which is, from my perspective, the goal is not simply to know whether an individual intervention is achieving its certain goals, although that's obviously important, but going back to the framework of this entire afternoon, are there lessons we can abstract from multiple evaluations.

And the reason I want to pull back a little bit from the comment I made is I don't want us to lose sight of the other things you found about the lack of alignment, and, you know, Brian, your comment about the quarterly reports not lining up. I mean, there are some things that aren't about this that seem to me very ripe for attention for the goal of, if we want to streamline, simplify, reduce burden, then we have to actually have a knowledge base about the effects of things, and if we don't have that then it's going to be very hard to move to a higher level of trust.

So I think there is a story here that is very

positive, but I do think somewhere along the way we have to have some understanding of how much confidence we can have in these results.

CHAIR THOMPSON: I agree with that, and I don't know, in terms of these specific policy questions, whether it makes a lot of sense for us to be diving into kind of design, the evaluation approach for different kinds of 1115s, which some of this starts to feel like to me, as opposed to making this point that the rigor of those evaluations, the independence associated with those evaluations, the availability of those results matters to this larger agenda, even if only what you're trying to do is arm other states with the information they need to make decisions about whether they would like to try or implement some of these same policies, irrespective of if you're even trying to get to streamlining or some other permanency approach with some of these issues.

So I think trying to understand and dig into what are the impediments and the barriers that have -- you know, as we mentioned before, I mean, certainly at the federal level there was simply a lack of investment. I think probably at the state level, at various points in time, it

got attention, it didn't get attention. And, you know, and maybe there's some way to be thinking about the kinds of waiver authorities that deserve higher priority attention or special attention or something in which we can suggest ways in which to improve this so that we do have that knowledge base that we need in order to make decisions about policy approaches and successes.

Darin.

COMMISSIONER GORDON: I will say on that, from the perspective of uniformity and trying to get standardization in those evaluations, I think that gets really complicated really quick, seeing that the populations, the services, there's so much variation. There's probably maybe some basis of that but I just wouldn't want us to think that every 1115, we look at these things, it's the thing you run into when you look at, like, HEDIS measures. It's like, well, yeah, well this plan, you know, doesn't cover the same population as this plan, or it only handles folks in this region so it's not really an apples-to-apples comparison.

But I do believe with having some kind of baseline there, and particularly maybe that's the thing

that encourages folks to get to the point where they say, "Okay, if you do this and we are able to demonstrate what you thought you demonstrated, then we can do a longer renewal period, or a path to permanence.

CHAIR THOMPSON: That's right. Right.

COMMISSIONER GORDON: I mean, those are the types of things to say, "Okay. Happy to," if that will lead to a better place.

CHAIR THOMPSON: I think that's right. There's some way to maybe think about tiering and prioritizing to get to an intermediate level of confidence, if not a final level of confidence about what's happening here and what it means. So maybe there's some kind of framework that we can think about there and some specific recommendations about how to resource some of this and how to manage some of this, so that it happens faster and gives people some of the information they need.

Chuck.

COMMISSIONER MILLIGAN: Just along those lines, you hear a couple of criticisms of 1115s from some quarters. One is if one state is doing it and another state wants to copy it, it's not a demo and so why are we

authorizing a demo if it's not a demo.

I think this framework that we're talking about here, of, you know, is there rigor to the evaluation, is there a methodology that is independent enough, I think actually plays to where the NGA has gone many times, which we want to be able to have a simple approach to adopt in my state what another state is doing. Well, that argument is easier to make and defend if you can translate that research to your state.

So taking into account what Darin said about variations from place to place, I do think that there's a way to align the expectation of rigor with state evaluations with the governors' own requests to be able to adopt, across state lines, proven demos.

CHAIR THOMPSON: Any other comments from the Commissioners on this?

[No response.]

CHAIR THOMPSON: Thank you, Rob.

[Pause.]

MS. BUDERI: I don't know which chair to sit in.

CHAIR THOMPSON: Take your pick.

All right. We're going to hear from Kacey on

1115 requests affecting Medicaid eligibility.

Thank you, Kacey.

STATE REQUESTS AFFECTING MEDICAID ELIGIBILITY UNDER SECTION 1115 RESEARCH AND DEMONSTRATION WAIVERS

* MS. BUDERI: Thanks.

So continuing the theme of flexibility versus program accountability, this session focuses specifically on key issues related to coverage for nondisabled adults and state requests to add additional conditions on Medicaid eligibility for this population.

At prior meetings, we have examined the characteristics of the new adult group and the preliminary evaluation findings from the seven states that have used Section 1115 authority to expand Medicaid to the new adult group in ways that would mirror commercial benefit and enrollment design.

However, several states have now asked or are planning to ask CMS for further authorities, including work requirements, time limits on enrollment, and drug testing as a condition of eligibility.

So, in this presentation, I'll be focusing on

waiver requests to implement work requirements, time limits, and drug testing in seven states: Arkansas, Arizona, Indiana, Kentucky, Maine, Utah, and Wisconsin.

I will provide an overview of the waiver provisions being requested and the hypotheses these states are proposing to test.

For each of the three issues, I will describe specific elements of each state's proposal, review research findings on the effects of these provisions when they have been implemented in other programs, including TANF, and discuss the possible implications for Medicaid.

I will conclude by posing policy questions for the Commission and discuss some possible next steps.

So since we heard background information on Section 1115 waiver authority earlier, I will skip over this slide.

These states requesting -- the seven states requesting these changes include both expansion and non-expansion states. The expansion states -- Arizona, Arkansas, Indiana, and Kentucky -- would apply these changes to expansion adults, while the non-expansion states -- Maine, Utah, and Wisconsin -- would apply these changes

to other adults.

So here on this table, you can see that all seven are proposing work requirements. Four, Indiana, Maine, Utah, and Wisconsin, are proposing time limits, and one, Wisconsin, is proposing drug testing.

And I'll just note that while each of these waiver proposals also include elements seen in other waiver states, such as health savings-like accounts, and some of them are proposing additional requirements on eligibility, such as asset tests, these issues are beyond the scope of this session.

So, in addition to these state waiver requests, two federal legislative proposals, the American Health Care Act and the Better Care Reconciliation Act, would provide a state option to implement work requirements for this population, meaning states pursuing this provision would no longer be required to request Section 1115 waiver authority in order to do so.

So each waiver application proposes evaluation requirements, although the specific research questions and design are settled through a subsequent approval process. States are generally proposing to test the hypotheses that

work requirements will increase rates of beneficiary employment and participation in job search and employment-related training and earned income among those who leave the program.

Work requirement and, where applicable, time limits support beneficiaries' transition to commercial coverage and self-sufficiency and decrease reliance on public programs, and drug screening and testing will lead to improved health and employment outcomes.

So, in this discussion, the Commission may wish to consider the merits of these state proposals, including the extent to which they would support achievement of the stated goals, how they would meet the purposes of the Medicaid program, issues related to implementation, and whether Section 1115 research and demonstration authority is the appropriate vehicle for implementing these provisions in Medicaid.

So I'll discuss some of the features of the work requirement proposals. They differ from one another as well as from the federal proposals in terms of exemptions, qualifying activities, and penalties for noncompliance. State proposals provide a range of different exemptions

from the work requirement. Examples include individuals determined to be mentally or physically unable to work or with exemptions from other programs, full- or part-time students, individuals with caretaker responsibilities and more, which are listed in your materials.

In some states, the list of exemptions covers a majority of the waiver population. For example, Indiana estimates that about 70 percent of HIP 2.0 members would be exempt, though I will note that Indiana is one of a few states that counts employment itself as an exemption rather than as a qualifying activity.

The states also include a range of different qualifying activities, so examples include employment in the states that don't include it as an exemption, job training activities, volunteer work, and more. In five states, individuals meeting TANF or SNAP work requirements would automatically meet the Medicaid ones.

States are generally proposing to require beneficiaries to participate in qualifying activities for a specified number of hours, typically 20 per week. One state, Indiana, is proposing to gradually increase the number of required participation hours for beneficiaries as

they are enrolled in the program for longer.

The penalties for noncompliance include disenrollment, with or without a lockout period, as well as time limits on enrollment, which I'll discuss a little bit later.

So proponents of work requirements in Medicaid suggest they would incentivize work and help transition enrollees off the program, ideally to employer-sponsored insurance, and opponents contend they would create a high administrative burden on states and lead to substantial coverage losses while doing little to increase employment.

Both sides cite areas of the TANF experience implementing work requirements.

Following the enactment of TANF work requirements, the TANF caseload declined significantly, 50 percent between 1997 and 2010, as the take-up rate among eligible families and the length of average enrollment in the program declined.

Employment grew among low-income single mothers, the population most predominantly served by TANF, but these gains were not sustained over time, and families leaving the program experienced little income growth.

Consistently since enactment, about 30 percent of TANF beneficiaries subject to the work requirement have met it, and of those, most meet it through employment. Research indicates that individuals not meeting the work requirement face barriers to finding sustained employment, such as physical or behavioral health issues or difficulty arranging child care, and that they may need additional resources or job training beyond what is typically provided.

Finally, the Government Accountability Office has reported that states experience administrative capacity challenges associated with tracking beneficiary work and community engagement participation hours.

So in assessing the impact of Medicaid work requirements, as seen in TANF, coverage losses are likely. Almost all these states are anticipating coverage losses, except for Utah, which is proposing work requirements as part of a limited expansion.

While many Medicaid beneficiaries are likely to meet new requirements through work or other exemptions or activities, new requirements related to verifying employment or exemptions could lead to individuals not

applying for coverage or renewals, further contributing to coverage losses.

In terms of the ability of Medicaid work requirements to incentivize employment and transition beneficiaries off of Medicaid, jobs and volunteer opportunities have to be available, which may not always be the case.

Additionally, gaining employment does not supplant Medicaid benefits in the same way that it supplants cash assistance; firstly, because people get sick or injured, regardless of employment status; and secondly, because research has indicated that a large portion of Medicaid beneficiaries are employed in industries with low employer-sponsored insurance offer rates.

So turning to time limit proposals, in addition to work requirements, four states are proposing time limits on enrollment: Arizona, Maine, Utah, and Wisconsin. The length of the time limit and process for reenrollment varies by state. Two states, Arizona and Utah, are proposing a lifetime limit of five years, which is equivalent to TANF time limits, although states can set them lower. Wisconsin is proposing a four-year limit, but

beneficiaries can reenroll following a six-month lock-out. And Maine is proposing a limit of 3 months of coverage per 36-month period.

In each state, the time limits are tied in closely with the proposed work requirements. In Arizona, Maine, Wisconsin, and for some beneficiaries in Utah, time in which members meet the work requirement or an exemption does not count toward the time limit.

Additionally, in all four states, time in which members were enrolled prior to the waiver or qualified through a separate pathway does not count toward the limit.

So just like for work requirements, proponents argue that time limits would serve as an additional incentive to gain employer-sponsored insurance and help conserve resources, while others argue that such penalties would limit access, lead to coverage losses, and be administratively complex.

It's difficult to estimate the impact of a Medicaid time limit due to lack of data about how many beneficiaries would remain eligible through this pathway for the length of the time limit, while simultaneously failing to meet the work and community engagement

requirements or not qualifying for an exemption, such as pregnancy.

Available data and research about the effect of time limits in TANF indicate a relatively low rate of disenrollment due to the time limit.

For example, in FY2013, 1.8 percent of closed TANF cases were due to families reaching the time limit, and this has remained fairly consistent. This is due in part to families not remaining enrolled for long enough. For example, in FY2013, only 13 percent of TANF families had received benefits for over four years. This is also due in part to states' ability to extend eligibility, past the time limit in some circumstances, which on average they do for about 2 percent of families in any given month.

In terms of the implications of time limits for Medicaid, though, it's important to note that unlike most of the time limits being proposed in states requesting waivers, TANF families meeting the work requirement are still subject to the time limits, which along with the difficulties of comparing medical assistance to cash assistance I discussed earlier complicate the ability to draw on the TANF experience in assessing what may happen in

Medicaid.

So going on to discuss drug testing, under Wisconsin's proposal, Medicaid applicants would be required to undergo a drug screening assessment and, based on the results, a drug test. Individuals testing positive would be referred and required to agree to treatment in order to remain eligible for Medicaid. Applicants who refuse at any stage of the process would be ineligible but could reapply at any time.

Proponents of drug testing in Medicaid and other programs suggest that beneficiaries of public assistance programs use drugs at a higher rate than the general population, and that drug screening and testing in the application process is a way of achieving cost savings and referring individuals to treatment programs. However, others note that it's not cost effective, has been ruled unconstitutional in some cases, and would create a barrier to access for individuals most in need of substance use services.

Estimated rates of substance use among beneficiaries of public programs as compared with the general population vary widely, though MACPAC work has

found that Medicaid adults have a higher rate of opioid use disorder than adults with private insurance.

While no Medicaid programs currently make drug testing a condition of eligibility, as of 2015, 15 states had enacted drug screening or testing requirements for TANF applicants. Data from enacted drug testing programs generally show small portions of overall applicants testing positive. For example, in North Carolina, about 2 percent of individuals met the criteria on their application questionnaires to require a drug test, and of those, 14 percent were positive, or .3 percent of all applicants, and 47 percent dropped out of the application process, or .9 percent of all applicants.

The small number of positive tests suggest that such drug testing programs may not be cost effective. For example, in one state, the cost of drug testing exceeded the cost of providing benefits to the individuals who tested positive.

There's little research or data on the extent to which people were referred to or underwent treatment.

The low rates of positive drug tests in TANF as well as the fact that Wisconsin is not proposing to

disenroll individuals who test positive, unless they refuse treatment, suggest that coverage losses as a result of this particular provision could be small. However, Wisconsin's ability to effectively enroll individuals into treatment programs will depend on treatment availability, which MACPAC has found in past work to be a barrier to addressing substance use disorder.

So as states and the Secretary consider these new conditions on eligibility, the Commission may wish to consider the request for work requirements, time limits, and drug screening requirements with respect to the following policy questions.

What are potential effects of requiring beneficiaries to work, imposing time limits on eligibility, or implementing drug screening and tests as conditions of eligibility?

What have we learned about the use of design elements from other programs that is instructive for how to introduce them to the new adult group in a way that helps achieve policy goals without harm? For example, how can work requirements be implemented in a way that allows for the transition to employer-sponsored insurance and avoids

dropping otherwise eligible people off the program?

Are some of these features more appropriate for some population than others, given the different health needs and barriers, and how should states identify these populations? For example, how should states craft exemptions?

In developing and preparing to implement these provisions, what factors and strategies should states consider with regard to administrative capacity? For example, should satisfying one program's work requirement automatically satisfy in others?

And, finally, as additional flexibilities are granted to states by the Secretary in their waiver applications, what changes, if any, to the evaluation requirements and expectations are appropriate?

So as the Commission discusses these issues and considers how to move forward, next steps could include publishing descriptive work on each of these issues separately or together, for example, in MACPAC issue briefs; further developing the Commission's views on these provisions to note issues or concerns that states and the Secretary should consider in granting and implementing

these types of requests or further analysis based on areas of Commissioner interest.

Looking forward, we will continue to monitor state requests and CMS decisions regarding the use of Section 1115 demonstration programs to expand coverage to the new adult group as well as to institute new eligibility requirements in Medicaid.

We will also continue to monitor implementation of current Medicaid expansion waivers and provide further evaluation data and information as it becomes available.

And with that, I'll conclude.

CHAIR THOMPSON: Thank you, Kacey.

I'll open it up for Commissioners to ask questions or to provide any comments.

Peter.

COMMISSIONER SZILAGYI: Yeah. Thank you very much. Very nice presentation.

I may have missed this either in the slides or the accompanying materials. Not for TANF, but within the states or other states, what percentage of eligible adults are working, are looking for work, are caretakers? So what percentage of eligible adults would these apply to? The

work requirements, I'm talking about.

MS. BUDERI: Sure. So we have that. It's about 60 percent who are currently working. I can get the breakdown. It's somewhere in here for you. I believe the remainder, about 14 percent, are looking for work, and then of that -- let me just grab it, instead of trying to remember.

COMMISSIONER SZILAGYI: Page 7.

MS. BUDERI: Page 7. Okay.

COMMISSIONER SZILAGYI: What is the delta? What percentage would this apply to if you subtract out the adults working, looking for work, caretaking, disabled?

MS. BUDERI: It depends.

COMMISSIONER SZILAGYI: What's left?

MS. BUDERI: It would depend by state based on the specifications, but the numbers in that refer to the overall Medicaid population rather than by state that this would apply to. So we don't really know.

I think for Indiana, we have the numbers. In their waiver application, they estimate that about 70 percent would be exempt from the work requirement, but that includes people who are already working or caretakers, so

it would be about 30 percent of the HIP 2.0 population who would be subject.

CHAIR THOMPSON: Peter, did you have more that you wanted to --

COMMISSIONER SZILAGYI: No.

CHAIR THOMPSON: Okay.

Sheldon and then Toby.

COMMISSIONER RETCHIN: Yeah. It's actually not an insubstantial number. I actually thought it was a little lower, 15 percent of beneficiaries would be affected, about 11 million, I think, nationally, if you were to impose work requirements.

I don't know. Has the Commission looked at this before? This is an interesting -- I don't want to even be further in politic, but it's not something, though, that I think the Commission can -- I don't want to use the word "duck," but I do think it's worthwhile to look at in some proportion.

Here's where I have an issue. Well, first of all, there's a lot of modeling that's gone on out there as to whether this works in the intended way, and I think most would conclude that it doesn't really have sustainable

value, and really, there's --

CHAIR THOMPSON: In terms of promoting work?

COMMISSIONER RETCHIN: Yes.

CHAIR THOMPSON: Okay.

COMMISSIONER RETCHIN: I'm sorry. Yeah. I mean, you'll reduce costs because you'll knock people off of the rolls.

Where I have a problem is that if it was paired with a job training effort, either at the state or the national level, we're going to really look at jobs, and this assumes that there are jobs out there and that it's just the population is complacent or idle. I think even very conservative organizations have concluded that it's not true. So that's where I have a problem.

But I do think whether we have an issue brief on the subject or not, this is something that ideologically is just sitting out there.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: So, first, a question, and it gets around the 1115 authority, and I don't know if it's MACPAC's role. Just understanding it, where the authority of CMS to actually approve these, this is -- especially the

drug testing. Other ones are just uncharted territory and wondered if that -- I mean, we do legal analysis, or that's more outside our purview? Just understanding that is one question.

The other -- and, Kacey -- since we were at a meeting together -- and I'll channel someone else on my panel -- the thing that I think we also need to assess is just kind of the chilling effect. Looking at the impact of those on the rolls, but how did it impact those who never participated, just based on the requirements? So is it a deterrent to enrollment in the first place is something you need to look at.

I think Sheldon's point, just as I see what's going on in Indiana and taking the other side, there are -- so, for example, Indiana is looking at this as a partnership with the plans, and so part of developing it is what are the plans going to do to develop and invest in workforce development and ways to get them.

Now, it gets back to some of these questions we talked about, is where does Medicaid end. What's the role now, or where does the role of a plan end from social determinants to now doing -- getting people into jobs? But

a plan is invested in retaining both from the outcome standpoint as well as from the standpoint of keeping them on the program and their membership, but this is a tough one to grapple with. But it's definitely -- we can't duck it because it's the wave of the future, and as we see states thinking about their coming into the Medicaid expansion, who haven't, this will be -- continue to be a focus, an integral part of it.

CHAIR THOMPSON: I think that point that you raise about -- sort of surprising to me, a few months ago, as I started to realize people were talking about putting these responsibilities on plans. And what you've said is -- makes it make more sense to me about the idea that you're trying to sort of support the whole person. But, you know, I do think that, as we've been discussing today, it's sort of like, who is in a position to help with this? How big does the job become about how to support people in terms of their daily lives, and, you know, are we asking too much of people, of plans or providers to try to solve for this?

Brian, Marsha, Alan, Fred -- Sheldon, do you want back in? -- Darin.

COMMISSIONER RETCHIN: I was just going to say

that one of the exemptions is not being in school, you're not exempt, for at least some of those that have been proposed. So there's --

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: I just have a question. So looking at Table 1, the states that have 1115 waiver applications in the CMS, it seems to me -- it looks like a lot of them are on the same timetable, as if they all kind of -- somebody had the idea and they all replicated it very quickly.

Do we have any sense of likelihood of approval and when -- when would these waivers actually begin?

MS. BUDERI: Yeah, I think some of them are not quite done with the federal comment period, but probably Kentucky and then maybe Wisconsin would be the next ones to look out for.

COMMISSIONER BURWELL: This fall it would be approved?

MS. BUDERI: I don't know.

EXECUTIVE DIRECTOR SCHWARTZ: We were concerned whether some of these would be approved and make Kacey's paper obsolete before we came.

COMMISSIONER BURWELL: So imminent. I mean --

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

COMMISSIONER BURWELL: -- they're pretty close.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

COMMISSIONER BURWELL: Second question on the Wisconsin drug testing. So they're proposing a drug screening assessment -- is that correct? -- not actual drug testing.

MS. BUDERI: Drug screening assessment for -- yes, and then, if indicated, a drug test.

COMMISSIONER BURWELL: So that's a questionnaire. Okay.

MS. BUDERI: Yes.

COMMISSIONER BURWELL: Do we have any sense of the degree, again, of accuracy of such assessments in terms of identifying substance use disorders?

MS. BUDERI: I haven't seen the assessment questions, so I'm not sure.

EXECUTIVE DIRECTOR SCHWARTZ: It's a screener and then a test, so it's both.

COMMISSIONER BURWELL: No, but if you score a certain amount on the screener and you are identified as a

likely, or have a high probability of a substance use disorder, then you're referred to a test. But it is, initially -- you could game the assessment.

EXECUTIVE DIRECTOR SCHWARTZ: You can reapply again and then you know the answer to the screener.

COMMISSIONER BURWELL: Or -- you know, okay. I just want to be clear about how it is supposed to work.

CHAIR THOMPSON: I have Marsha, Alan, Fred, Darin, Chuck.

VICE CHAIR GOLD: I guess one of the questions with these demonstrations is how seriously they are about achieving their hypotheses versus just keeping people out of the program. And one of the questions I have from the demonstration, it looked like the states varied in the criteria that they used and they decided who needed to get a job. And so one of the questions is, you know, how good is that screening? Are they targeting it to people who potentially really could potentially work or have other problems that can't, and are they going to be sensitive to that? I think, in a lot of places, you know, we've learned a lot about the people with a lot of conditions that may or may not show up as disabled but, in fact, are disabled,

because they can't hold a job, and how those people would be affected.

The other question is how serious are they about helping people get employed. And are there efforts with these state initiatives? Do they build in components to search for jobs, to line up jobs, to educate people with jobs, to fund job training, to pay for day care, you know, after school or something if there needs be? Can we tell anything from the applications about all those things?

I mean, my sense, I was in Maine in the summer and Maine has one of these proposals pending, and I had occasion to talk to one of the big -- the groups -- the local group there. Very little recognition that this was even pending. They had had the public hearings but, you know, there wasn't a lot of people who knew about that this was pending. And Maine's proposal, in addition to these requirements, had a lot of reductions in presumptive eligibility, and providers allowing people to get retroactively eligible, and those sorts of things. And you put that together, and I guess the question is, do we have a sense of, from what we can tell, about what these -- how effectively these things are designed to achieve their

goals?

MS. BUDERI: Well, Indiana has a program called Gateway to Work, which is authorized through their current HIP 2.0 waiver. It's currently optional. And that is supposed to connect beneficiaries with job training resources. The take-up has been pretty low with it in its current form, which is optional, and so they are proposing to make it required, which is their work requirement. But I don't know if we know the -- I don't believe there are any evaluations on whether that program specifically led to people becoming employed.

Wisconsin and Utah, some of the job trainings that would qualify as job training that would satisfy the work requirement, are through current state job training initiatives, but I haven't reviewed the results from that, and we can see if there are.

VICE CHAIR GOLD: I mean, I guess the question is, is it up to the individual to find these things, or do the initiatives build these in up front to help people find these things so that they can get employed if they are, in fact, employable? And, you know, how much of a factor -- will that be something that's only looked at after the

fact, or is it a factor behind whether they get approved? Are they required to have any effort to really have the components of a demonstration that you would need to have in place if you really wanted to get people working?

I know, in the -- I think -- when the TANF got debated there was a large debate on what else was in place and whether they would help them or anything like that.

CHAIR THOMPSON: Alan, Fred, Darin, Chuck.

COMMISSIONER WEIL: I did spend eight years running the largest welfare reform study in the country so I have a little experience on the topic. And -- sorry, I don't mean to boast. I just want to give you my perspective on this.

What I'm struck by from that experience is two things that I hope can be helpful in this context. The first is welfare reform was very heavily studied, very well studied. I can spend a lot more time talking about what I think the strengths and weaknesses of that were. Yet, the conclusions people draw about whether it was successful or not are very much dependent upon what their prior is, in terms of what it was designed to accomplish. And when we released our very first -- it was the first data out on,

you know, how people who had left welfare were doing, there were a bunch of op-eds in newspapers around the country and half of them said that welfare reform was a success and half said it was a failure, and they were all using the same data.

So I think we have to be realistic given what is going on and what the thinking is behind this, that this is not sort of a situation where, you know, there's evidence and it tells you what to do, because the evidence tell you something but the reasons this happened, these ideas are being put out are more -- have to do with view of what you're trying to accomplish that not everyone shares. And so I just want to put that out there.

That said, I think there is a critical role for us here, partly given the speed and partly given what's at stake, to weigh in, in two ways. I feel strongly about these and I'm hopeful we can.

One is that there is an evidence base having to do with some of these items that I think is worth bringing in. It's imperfect. It draws from other places. But there's a lot at stake for this program and if there is a rapid spreading around the country of new models of

particularly what eligibility means, that will have a huge effect on people in the program, and that's something that I think we have to speak up on. Even if the questions that are being posed by the states are correct, there are still going to be significant impacts for people in the program, and I think we have a responsibility to speak up about that.

And that leads me to the second issue, which has to do with the whole research agenda here, which is -- and I'll do the very short version -- but, you know, welfare -- TANF was enacted in the wake of experimental research, randomized control trials of putting some people in one kind of welfare system and other people in other kind of welfare system, comparing results over time with respect to multiple outcomes. It was done with very small subsets of the population around the country, and then there were sort of conclusions drawn from that.

That could not be further from what we are talking about, and, really, what we've almost ever done in 1115s, which are used more to sort of take an entire state and then use certain econometric techniques to try to do comparison groups. And I think, to the extent that there

is a real interest among some in making changes of this magnitude, we need to speak up for the importance -- and it gets back to what the authority is -- if this is research and demonstration, we need to treat it as research and demonstration. If these hypotheses are to be tested, they should be tested in ways that actually can give us some answers.

And I'm thinking, Toby, of, you know, the duals and the notion that -- what was the number that were going to be in that demonstration? I mean, at some point you have to say this isn't demonstration -- if we are trying to learn we need to treat it as demonstration, and the approach ought to be that way. That doesn't answer or prejudge the question of what the results will be, but it does say if you're going to do this under 1115 authority it ought to be done in a way that we actually learn.

CHAIR THOMPSON: You know, the other thing that that raises, Alan, is the fact that in some of these changes that people have wanted to pursue under 1115s there's been a question about whether or not, in the context of an R&D effort, the federal government should limit the number of states that do that, before there is

some kind of a result that demonstrates that it could be replicable or successful in other venues.

So I think that is another kind of question here, in addition to yours, which is, if we're doing something of this significance, we want to actually construct a model that has a testing proposition and an ability produce results pretty quickly, which I think you could do in this case. But it also means that, you know, in addition to doing that maybe you don't have everybody in the country do it all at once. Maybe you take it in some stages and sort of approach it in that way.

Fred, Darin, and Chuck.

COMMISSIONER CERISE: Well, I was going to make the same point that Alan made without the eight years of welfare reform experience.

CHAIR THOMPSON: That was all wasted on --

COMMISSIONER CERISE: Right, right.

[Laughter.]

COMMISSIONER CERISE: That's right. You know, I do think our expectations that this is a demo that's going to give us an answer is not really -- it's a bit of a reach, right? We are arguing -- you've talked about

welfare reform, you've quoted TANF results, and we are still arguing about whether that's -- what's the right answer there. We have RCTs talking about do we -- effective screening for breast cancer and prostate cancer, that we still argue over. And so the idea that we are going to randomized here and some people are going to have a work requirement and some people won't, and we're going to fix the unemployment rate for over a period of time, so that, you know, everything is stable -- we're not going to get it.

And so I guess the question is, on these things, these important issues like substance abuse and poverty and things that are important social issues, and you're looking for leverage of where to impact them, it's probably not the role of the Commission, but do you really tie those to health care, right? I mean, they're important things that we've got to grapple with, but it just seems like a bad idea to attach that to a health care program in that evaluation. I know that sort of -- the horse is out of the barn on that, but I'm just a pessimistic that an evaluation, a demo is going to give us an answer there.

CHAIR THOMPSON: Well, and that somewhat raises

the question that Toby raised before, which is there is an element here that could be challenged legally about whether or not this serves the purposes of the program support. You know, it may well be that if the administration does grant these waivers there will be court action and that could be tested there. It's possible.

Darin, Chuck, and then Peter.

COMMISSIONER GORDON: So we talked quite a bit, and I think rightfully so, about social determinants of health. I think the issue we're having the discussion about today isn't so much the value of what could be added as we look more holistically at the people Medicaid serves and how we can help them, connect them to different services and job training and jobs, or housing, or food supports and the like. I think the issue, as I'm hearing, I think, is really more about it being the requirement in order to receive services.

And the reason I say that is because, you know, we started a program -- and we talk about, oh, certain populations can and can't -- we started an incredibly popular program called Employment and Community First CHOICES for our intellectual and developmentally disabled

populations, and it was based on tons of feedback and town halls with advocates and caregivers who really wanted us to develop a more robust way to help connect their loved ones with employment opportunities, because, quite frankly, we had done a haphazard job at that in the past. We talked about it, we knew it was important, but pretty much left it up to them to figure it out. And that program has been widely well received by the community.

And we did look, as part of our alternative expansion proposal at what we were going to think about from a work perspective, and our approach was not so much as it being a threshold to get eligibility but we did think of a variety of things, you may recall, that we would incentivize and try to reward, but at the same time not just reward and say, "Good luck, go find it," but ways that we could connect them to programming we're doing, for these same people, in many respects, over in labor and workforce development. But we're not connecting the dots.

So I guess what I'm just saying is I don't I think we need to make a distinction of what we're discussing here, not that things that can be done from a social determinants of health perspective, things that can

be done because we are at a critical -- we have a critical relationship with our members and we want to think more holistically about how we can assist them in ways that we are capable. I think the distinction we are making is, is that the right thing to have as a threshold that you must cross in order to receive services, and I hope that's right.

CHAIR THOMPSON: I think that is right. Chuck and then Peter.

COMMISSIONER MILLIGAN: Just a couple of things. One is this -- you thought you were talking about politics and 1115 stuff earlier and here we are. I mean, I think a lot of the reforms, to me, a bucket and two buckets. One is the welfare reform bucket and one is the commercial insurance bucket. And I think there are elements of both of those. And I think that, you know, once the Affordable Care Act -- the Supreme Court ruled on the Affordable Care Act, it did become a little bit of kind of like Let's Make a Deal for the states that were reluctant in expanding. And, you know, I think that there were some tradeoffs made by CMS to try to engage those states and bring them into the Medicaid expansion, and it became a little bit of Let's

Make a Deal.

There's a couple of things I want to just mention, and, actually, one of them is actually a question that maybe, Stacey, you're the person I should direct the question to. I think, when I read through the materials I think that one of the elements of some of the waivers that I would suggest that we also look at is the coverage of retroactive spans, and I think that this has implications to DSH and hospital uncompensated care. So I do think -- I want to make that connection explicit. If states are not going to cover the period of time before some prospective commercial insurance model of, like, I'm applying today, my coverage is effective October 1st of 2017, it's not going to pick up this money or previous months, even if I was financially eligible. The triggering for people to see coverage a lot of times is a traumatic experience that is very expensive, you know, car accidents and whatnot.

So I do think that there are some implications about this work in DSH and I just want to make that part explicit, as well as making explicit the commercial insurance and welfare part of it.

The question that I actually -- and, Stacey,

depending on how adventurous you feel at the moment -- you know, this is a live conversation in New Mexico where I work now, and premiums as a component of an 1115 waiver, and there's implications about, as you noted in the materials, when would that result in dis-enrollment, you know, all of those implications of nonpayment of premiums, and churn and all of those pieces we talked about this morning. The way it is stated in New Mexico, in envisioning it, is it would be a plan responsibility. The state would cut our capitation rates with an expectation we would bill and collect from the member. I don't know to what extent the actuary is going to build into rate a, you know, an assumed bad debt or not, so I want to flag that, Stacey, and however you want to think about that. But I don't know how, from the plan perspective or the state perspective, the non-collectability or bad debt aspects implicate actuarial soundness, implicate certification of rates, all of that stuff.

And I just want to flag a separate part with the premiums, which is due process and termination of eligibility, how that would play through fair hearings, how that would play through the state's responsibility to

ultimately determine who is eligible for Medicaid and not when dis-enrollment is appropriate or not, but it's the plan that has a lot of the underlying data about non-collection of premiums.

So there are some, I think, elements that I want to have introduced into this framework as we're thinking about the research agenda here, and that's really what I wanted to kind of contribute.

CHAIR THOMPSON: Thank you, Chuck. Actually, that makes me think about, you know, earlier I said I didn't think that we wanted to sit here and design an 1115 evaluation, but maybe, in some ways, we do. With respect to some of these kinds of major new thrusts where we, at least, want to be sure that there is a consideration or a look at some of these other effects and these other issues, and that they are taken into consideration in addition to the question of whether or not we want to propose that in some of these cases there should be a very strict experimental design and approach to those models, et cetera.

Peter and then Toby.

COMMISSIONER SZILAGYI: Yeah, I actually like the

idea of trying to design something very rigorously.

I like this paper, this descriptive paper, and I think we should get it out as soon as possible. One of the things that I'm wondering is, might we follow this up with a modeling analysis? And I don't know this literature but really looking at the potential benefits -- and I'm talking mostly about the work requirements, because I think the time limits and the drug testing, there's not going to be much evidence base for that.

But for the work requirements, can we translate from the studies that have been done, translate from the TANF population, and try to model what are some of the benefits of work requirements-- you know, potential increase in jobs -- what are some of the costs -- the increased number of uninsured, the administrative costs of screening carrying through. What are some of the costs if the work requirements are coupled with job training? You know, there are costs to that, and could we actually attempt a modeling exercise? Because I don't know whether there is going to be randomized clinical trials of work requirements, and if we, you know, suggest how to design a waiver, I'm not so sure people will listen to us. But

might we attempt a modeling exercise, and could that be a paper?

CHAIR THOMPSON: And, Peter, are you thinking a modeling exercise with actual evidence inside of it --

COMMISSIONER SZILAGYI: Well, based on prior studies, based on --

CHAIR THOMPSON: -- or a question about the need to populate that model with some evidence?

COMMISSIONER SZILAGYI: No, actually, to try to predict how many more uninsured there will be, how many more jobs, or how many less, you know, to try to -- and again, I don't know the evidence base in this case, but there have been some studies. There's been the experience with TANF and other similar programs.

CHAIR THOMPSON: We've got Sheldon and then Bill. Oh, I'm sorry. Toby, you were next. Sheldon, Toby, Bill.

COMMISSIONER RETCHIN: Yeah, by the way, just a correction of what I said earlier, that actually some of the 1115 applications actually do exempt students, so I stand corrected, in case you were probably going to tell me that.

So just to respond to Peter that it may be a good

idea to do some sort of simulation. But first I think it would be useful to describe the population, which we would know. That's pretty easy to predict who these are. So at least we would know, for example, there are some assumptions from policymakers that these individuals are mostly men, and two-thirds are women. And if you look at the degree of chronic illnesses, it's disproportionate -- 50 percent. I just think describing some of those things would be helpful, so that you can really look at the population, not just the 11 million that might be knocked off the rolls but what would we be left with in the emergency rooms and the like. No need to -- I mean, maybe that's sort of a poor man's simulation, but --

CHAIR THOMPSON: Okay. I want to go to -- we are coming up against time here but I want to go to Toby -- Toby passes -- Bill, Brian, and then we're going to need to wrap up so we have some time for the public comment.

COMMISSIONER SCANLON: I just wanted to make a quick observation on how well-structured the afternoon was. We started off talking about flexibility and the idea that maybe waivers could be either easily replicated or made permanent, and then we started to talk about sort of the

last session here, which is sort of a design of waivers, and I think we clearly laid out the idea that they should have a very reasonable basis to begin with, should be incorporating evidence from both prior experience that directly tests that as well as indirectly sort of tests that, before one would think about approving a waiver. And then they should be evaluated in a very rigorous fashion, and the evaluation should not be just designed that way but actually should be carried out.

So, I mean, the whole afternoon kind of comes together, in my mind, as a very good lesson in terms of this area. Thanks.

CHAIR THOMPSON: That's the genius of the MACPAC staff. Brian.

COMMISSIONER BURWELL: I'm just wondering to what extent these work requirement waivers might be part of state strategies to combat the opioid epidemic.

VICE CHAIR GOLD: The what?

COMMISSIONER BURWELL: The opioid epidemic, I mean, because there's two lines of thinking around this. There's the sticks approach and there's the carrots approach, and, you know, the sticks, of course, is we need

more punishment, well, you know, for bad behavior. And I just wondered --

COMMISSIONER RETCHIN: You mean drive people to opioids, or --

[Laughter.]

COMMISSIONER BURWELL: I just wonder what percent of this population that would not -- that would be kicked off would be people with substance use disorders.

CHAIR THOMPSON: All right. Martha.

COMMISSIONER DOUGLAS: Just in Indiana, that's an exemption. Because they don't

COMMISSIONER BURWELL: [Off microphone.]

COMMISSIONER DOUGLAS: -- substance use or mental illness.

CHAIR THOMPSON: All right, so Martha and then we're going to have to wrap up.

COMMISSIONER CARTER: There are validated tools, by the way, for a questionnaire for opioid or drug use, but I don't know if those studies were conducted in a non-punitive environment and whether you'd get the same responses if your benefits were on the line with the question, with your answers.

I was curious. I'm really concerned about the drug testing waiver, and I wondered what Wisconsin was proposing in terms of remaining in treatment. You know, addictions -- treatment is fraught with multiple relapses, and so what happens to people who agree to treatment and then fall of? Do they also lose their benefits? And we should be looking at those kind of requirements, I think.

MS. BUDERI: To answer that question, I don't believe we know what would happen. I don't think they specify in the waiver application what would happen if a person agreed to treatment and then left.

CHAIR THOMPSON: And, you know, I will say, Marsha just made the point that, you know, there's a lot of questions in terms of the details of some of these proposals. That is not atypical in a waiver submission. That is a lot of what is happening in this conversation that we talked about, about why do things take so long, about, well, how is this going to work, how are you going to handle this situation, that sometimes becomes part of the special terms and conditions that are attached to the waivers and so forth.

So I just want to wrap this up by saying,

obviously, Kacey, great job in bringing this to us. Lots of interest here. I think it sounds like the Commission has a desire to weigh in. And I think that what would be helpful is maybe to plan to come back in October, maybe proposing some ideas about what we think would be guardrails around some of these kinds of waiver proposals. I mean, you know, there's always the chance of OBE here. We may be overtaken by events. But I think there's also potentially an opportunity for us to help shape some of what happens after any waiver approvals, in terms of how something is evaluated and so forth.

So I think we would want to think about making sure that we've collected and understood all of the evidence, to sort of Peter's point, Alan's point, others. Do we understand the totality of the evidence that's available to us in looking at these matters? What do we think are the considerations and the issues, the things that ought to be part of an evaluation, ought to be part of what's considered, in terms of whether this is a success or not a success? Is there -- are these the kinds of steps or policies that ought to be addressed in a different way, if we can conceive of looking at 1115s through a real

demonstration model where we want to really test rigorously and quickly understand implications and impacts?

Have I missed anything, any other comments on that direction?

COMMISSIONER DOUGLAS: Could there be any value to have any of the states come and --

CHAIR THOMPSON: I think that could be very useful to hear from states who are thinking about these things. Whether or not we can do that for the October meeting, I think that's a question. And that may be a place where, when we start to think about administration of these requirements that we would particularly want to hear from states around some of those issues.

Okay. Let's open it up for public comment. A lot of murmuring as Andy approaches the microphone.

PUBLIC COMMENT

* MR. SCHNEIDER: Good afternoon. I'm Andy Schneider. I'm a research professor of the practice at the Center for Children and Families at Georgetown University. I appreciate the opportunity to address you all. I just want to say, as a preliminary comment, this is a very impressive collection of Medicaid expertise, both at the

member level and at the staff level. It's really great to see.

So work requirements. You can't duck it. You shouldn't duck it. It's foundational. In 1984, we started to break the link between welfare and Medicaid, and by 2010, some of us were under the impression that most people agreed Medicaid was a health insurance program, not a welfare program. This is watershed -- this is watershed. You need to weigh in on this. Do you think we need to go back to welfare? I wouldn't agree with that, but I'll say it. If not, let's talk about how to run a health insurance program.

On the authority, so I've spent some time on the Medicaid statute. The Secretary doesn't have it. I think the Secretary is going to try to exercise it. I think there's going to be litigation. We'll see what the courts have to say. But wherever you come down on the merits of welfare versus health insurance, you cannot be conceding the authority. That is an open question. If you want to do your own analysis, fine, but the presentations so far have sort of assumed the Secretary has got that authority. I will concede -- I'm a Legislative branch guy, although I

did spend some time in the Executive branch, but I wasn't fully persuaded. Still, I would treat this as, this is a very open issue, from a legal standpoint.

And finally, since I'm now with the Center for Children and Families, wherever you come out on these previous issues, we need to think about, if these things go forward, what the effect is going to be on the enrollment of children. I don't think we're quite at the stage yet where we are talking child labor, but there is clearly a relationship, as you know from the literature, some of which is in *Health Affairs*, between coverage of the parent and coverage of the child, and if the parents start getting chilled from enrolling, or upon enrollment get knocked off for not meeting a work requirement, what's the effect of that going to be on children and how does that advance the purposes of the Medicaid program? Thank you.

CHAIR THOMPSON: Thank you, Andy. Any other comments from the public?

[No response.]

CHAIR THOMPSON: Okay. We are adjourned. Thank you.

* [Whereupon, at 4:23 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, September 15, 2017.]

PUBLIC MEETING

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

Friday, September 15, 2017
9:05 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
MARSHA GOLD, ScD, Vice Chair
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FREDERICK CERISE, MD, MPH
GUSTAVO CRUZ, DMD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
STACEY LAMPKIN, FSA, MAAA, MPA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:05 a.m.]

CHAIR THOMPSON: Okay. Welcome to Day 2 of our September MACPAC meeting, and we're kicking off today with a presentation on policy options for controlling Medicaid spending on prescription drugs and have a staff presentation to kick off our conversation from Chris Park and Rick Van Buren.

POLICY OPTIONS FOR CONTROLLING MEDICAID SPENDING ON PRESCRIPTION DRUGS

* MR. PARK: Thank you, Penny.

In today's presentation, I'll provide a quick background on Medicaid payment and rebate for prescription drugs, and then we'll discuss some of the factors that increase drug prices for all payers. Then I'll turn it over to Rick to discuss factors that are specific to Medicaid and some of the potential policy responses to those issues.

So for some background, growth in Medicaid spending on prescription drugs has been a particular concern for states in recent years. Medicaid experienced about 25 percent growth in 2014 and 14 percent growth in

2015. In fiscal year 2015, Medicaid spent approximately $29 billion on prescription drugs. This accounted for both $53 billion in payments to the pharmacy as well as $24 billion in manufacturer rebates. So, on average, Medicaid receives close to 50 percent back in rebates at the end of the day.

Medicaid faces the same pressure on drugs prices that all payers face in terms of where the manufacturer sets their prices. However, there are some unique factors that affect Medicaid's ability to control prescription drug spending compared to other payers.

On the next few slides I'll provide a quick refresher on prescription drug policy in Medicaid. Prescription drugs are an optional benefit that all states have chosen to cover. Section 1927 of the Social Security Act establishes the Medicaid drug rebate program. As part of this program, drug manufacturers must enter into a rebate agreement with Medicaid in order to have their products recognized for federal Medicaid match. In exchange for these rebates, states must generally cover all of a participating manufacturer's drugs.

In terms of Medicaid drug spending, the dollar

amount reflects both the number of prescriptions filled as well as the amount paid per prescription. The net amount paid for a particular drug reflects the state's payment to pharmacies as well as the rebates it receives from manufacturers. These are separate transactions.

The payment to a pharmacy covers the pharmacy's cost to acquire the drug as well as a fee to cover the professional services required to dispense the medication to the beneficiary. Medicaid receives statutorily defined rebates that are based on average manufacturer price, which is a price between the manufacturers and the wholesalers.

The rebate for brand drugs may also be based on best price to any other payer. There is also an inflationary component that is added should a drug's price increase faster than inflation as measured by the Consumer Price Index.

Because these federal rebates are defined in statute, every state receives the same rebate amount for a particular drug, regardless of what they paid the pharmacy. In addition, states may negotiate their own supplemental rebates with manufacturers.

The forces that go into establishing the market

price set by the manufacturer affect all payers, and the policy responses can be broad and go beyond the Medicaid program. However, it is useful to review some of the commonly cited causes for increasing drug prices to get a sense of the larger market dynamics at play.

Federal patent law provides incentives for the development of drugs by granting periods of market exclusivity that allow manufacturers to engage in monopoly pricing. Once the patent expires and generic manufacturers can enter the market, the price can come down dramatically.

Price competition for generic versions is one of the primary mechanisms for reducing drug spending. In an effort to preserve market share, drug manufacturers can employ a variety of strategies to delay the introduction of generic alternatives. These can include: paying a generic manufacturer to delay market entry; making it difficult for the generic manufacturer to obtain samples that they need to obtain approval from the FDA; as well as selling or licensing an authorized generic that can undercut the market available for the first generic entrant.

There are also orphan drugs, which are those that have been designed to treat a small patient population,

which is defined as under 200,000 people in the United States; and these orphan drugs receive incentives, including a longer period of market exclusivity. Manufacturers in recent years have been seeking to get orphan drug designation for as many of their products as possible, and critics point out that many of these products also include mass market indications, and so they believe there's some abuse of this statute.

Additionally, sometimes the market itself -- the size of the market itself leads to a de facto monopoly. A brand drug may lose its patent exclusivity, but the potential market is small enough that a generic manufacturer does not have the incentive to enter the market. So, therefore, the brand manufacturer still controls kind of a monopoly share and can set the price as they see fit.

Another factor in establishing a market for a particular drug is the FDA approval process. There have been complaints that the FDA is taking too long to review and approve generic drugs, which delays market competition. There have also been many proposals to increase competition such as reducing the period of patent exclusivity,

eliminating the ability for manufacturers to delay generic entry, and speeding up the generic approval process.

Another complaint is that there is a lack of price transparency throughout the drug supply chain. First, it is difficult to understand how the price of a drug relates to the manufacturer's cost of research and development, and the numerous and confidential prices and rebates that exist in the supply chain, such as those the pharmacy benefit managers can distort the amount that payers such as health plans and beneficiaries ultimately pay.

There are many proposals at the federal and state level that would require manufacturers to justify their prices and PBMs to disclose their rebates. These approaches generally make information available but do not explicitly prohibit high prices.

Some observers suggest that the lack of national price controls, similar to those used in other countries, also contribute to high prices in the U.S. Some policymakers have suggested that authorizing the importation of less expensive drugs from other countries would help lower the price in the U.S. for the consumers as

well as some have suggested that the U.S. implement national price controls, such as reference pricing.

And now I'll pass it over to Rick to discuss some of the key drivers of Medicaid drug spending.

* MR. VAN BUREN: Thank you, Chris.

So now we're going to drill down and talk about some of the issues that may be driving drug expenditures in the Medicaid program. As Chris mentioned, Medicaid's rules relating to mandatory coverage and statutory rebates can create opportunities for manufacturers to maximize their revenue through strategies that minimize their rebates while protecting their market share. This section is going to describe some of those strategies and possible policy responses as well as briefly identify pros and cons of those policy options.

We have generally tried to fit these strategies into one of several buckets based on how they operate and possible policy responses. It's also worth noting at the outset of this section that cost containment approaches favored by private insurance companies such as cost sharing, tiered formularies, and excluding coverage of certain drugs are either prohibited by the Medicaid statute

or are extremely curtailed by the rules on coverage and cost sharing.

So the first bucket we'll look at are strategies manufacturers use to reduce their rebate obligations. As Chris described, manufacturer rebates are tied to a drug's average manufacturer price, or AMP, and how much the price of the drug has increased relative to inflation since it first entered the market. If a manufacturer can lower its AMP or rebase its inflationary component, it can reduce its rebate obligations.

In past years, Presidents' budgets have specifically cited some of the strategies used by manufacturers to limit their rebates and have proposed statutory changes to mitigate their use. These include blended AMP. So this is a strategy for manufacturers to reduce their rebates if they sell a brand drug as well as an authorized generic. And as Chris mentioned, an authorized generic version of the drug is essentially a drug produced by the brand manufacturer that is intended to undercut the market for generic entrants. It's typically introduced near the end of the patent life or the market exclusivity period of the brand product.

So under the law, the price of the authorized generic is blended with the price of the brand drug. Sometimes the brand manufacturer will sell an authorized generic to a secondary manufacturer for distribution, and the primary manufacturer may have a corporate relationship with the secondary manufacturer. So the price of the sale is not a true arm's length transaction and may be artificially low. So that has the effect of lowering the AMP of the brand product and lowering the rebate obligation on the brand drug. The FY17 President's budget proposed excluding sales of authorized generics from the brand product's AMP and predicted savings of $200 million over 10 years.

The next issue in this bucket are line extension drugs. So introducing a line extension drug is a strategy manufacturers may use to mitigate the inflationary component of the rebate. The inflationary component can sometimes represent a sizable amount of the drug's total rebate obligation. So a line extension is essentially a version of the drug that makes sometimes only minor changes to the original drug, for example, an extended release formulation.

Because the line extension is a new product, it essentially resets the inflationary component of the rebate. The Affordable Care Act attempted to address this issue by authorizing an alternative rebate for line extension drugs, but a drafting error in this provision has limited its effectiveness. Again, past Presidents' budgets have proposed correcting this drafting error to ensure the proper rebate on line extensions is collected, and the estimated savings for this are $4.2 billion over 10 years.

The final category in this bucket are improperly categorized products. Under the statute, manufacturers are responsible for correctly classifying their drugs as brand or generic. They're also responsible for listing that the drug is eligible to participate in the rebate program.

Sometimes manufacturers can classify brand drugs as generics to decrease the rebate obligation, or they may list drugs that are not eligible to participate as eligible in order to benefit from Medicaid payments.

Both of these practices are inconsistent with federal law, but reports from the Office of the Inspector General have found some evidence of both practices taking place. Possible responses to these practices include more

regular audits of manufacturers and the drug rebate program, increased penalties for noncompliance, explicitly authorizing CMS to reclassify drugs that it believes are improperly classified, and authorizing CMS to terminate the participation of individual drugs in the rebate program. Currently CMS only has the authority to terminate the participation of a manufacturer, which would eliminate all of its drugs from the rebate program.

The next subject we'll discuss are possible incentives in the rebate program that may inadvertently lead to higher launch prices or disincentivize value-based reimbursement for other payers. Some commenters have suggested that manufacturers may set higher launch prices as a way to negate the need to increase the price of the drug for a while. So, for example, a manufacturer would typically introduce a drug at a certain price and every year increase the price of the drug by a set amount. But that would trigger the inflationary component of the rebate. Alternatively, the manufacturer could just set a higher initial launch price and not increase the price annually and limit their rebate obligations.

Other commenters have suggested that Medicaid's

best price provision, which, as Chris said, basically gives Medicaid the best rebate available to another payer on the market, that this may create a disincentive for manufacturers to enter into value-based purchasing or certain value-based purchasing arrangements.

Policy responses in this space may help lower prices for Medicaid and other payers, depending on how they're operationalized. One of the approaches could be to uncap the rebate amount. Currently, the rebate is capped at 100 percent of AMP. Removing this cap would expose manufacturers to more punitive rebates for excessive inflationary increases. It may also be necessary to uncap the rebate for the full effect of some of the other policy options in this space to be realized.

Another idea would be an escalating inflationary rebate. This would be applied to drugs that have especially sharp price increases and could be on top of the existing inflationary rebate.

Another idea would be to tie the rebate amount to launch prices. This could be done either by having a lower rebate amount for lower launch prices or a higher rebate amount for higher launch prices. Again, there are a lot of

ways this could be designed from a policy perspective.

And the final idea in this space would be to eliminate the best price provision, which could open the doors for more value-based pricing -- purchasing outside of the Medicaid program. This could be in a budget-neutral manner by raising the basic rebate amount.

The next bucket we generally call Medicaid purchasing and contracting. So in addition to the statutory rebate as Chris described, states can negotiate supplemental rebates from manufacturers. They can do this either on their own or banding together with other states in a purchasing pool. Typically, supplemental rebates will be tied to either favorable placement of a drug on a state's preferred drug list, which is similar to a formulary, or tied to a value-based model of reimbursement. However, lack of coordination among states and statutory ambiguity may prevent states from leveraging the full purchasing power of the Medicaid program.

So some of the ideas in this space include allowing states to partner with CMS to form a national purchasing pool that would negotiate supplemental rebates. This could be done either by CMS directly negotiating with

purchasers -- with manufacturers on behalf of states or CMS contracting with a PBM to negotiate supplemental rebates. Obviously, this could limit state flexibility if participation is mandatory for states. The President's budget for FY17 estimated savings of $5.8 billion over 10 years for this proposal.

Additionally, CMS could encourage states to use value-based purchasing. It could clarify what types of arrangements will trigger -- or it could clarify what types of arrangements will trigger best price in this space. That would primarily benefit payers outside of the Medicaid program. One of the drawbacks to this is it may be difficult for CMS to identify all possible value-based purchasing arrangements in advance.

So up to now, we've discussed strategies that are aimed to reduce prices, but obviously controlling volume is another way to reduce drug spending. As already mentioned, Medicaid has limited ability to use the tools commonly used by private payers to limit volume, but there are some utilization management tools available to state Medicaid programs, including prior authorization; step therapy, which is sometimes called "fail first," which essentially

means a beneficiary has to try a less expensive therapeutic alternative to a drug before Medicaid will pay for the more expensive therapy; and pharmacy lock-in. This is typically used in cases where there's potential substance use disorder to prevent doctor shopping or pharmacy shopping.

So one area the Commission could explore would be to promote greater adoption of utilization management among states. This would probably require researching the extent to which states have currently adopted utilization management, which practices work best for which drugs and which beneficiaries, and determining if there are promising strategies that could be promoted across states.

Another idea would be to explore clarifying safe harbors around the use of prior authorization and preferred drug lists that will be presumed to comply with federal law. A related idea in this space would be to promote greater medication adherence, which some studies suggest can reduce spending.

One consideration in this area is how these policies can be implemented in a way that ensures sufficient beneficiary access to needed medications.

Finally, the final bucket would be more

comprehensive changes to the rebate program, and as Chris alluded to, the underlying deal on the rebate program is generally mandatory rebates from drug manufacturers in exchange for mandatory coverage by states of their drugs. This overall structure could be reevaluated to determine if modifications could improve state flexibility, save Medicaid money, and protect beneficiary access.

It is worth noting that the rebate program currently results in rebates of about 45 percent on drug costs, and some of these options would fundamentally change the program. But some possible ideas in this space include allowing states to adopt exclusionary drug formularies. Right now, states, while they can adopt preferred drug lists and implement prior authorization, ultimately if a drug is a covered outpatient drug and treatment is medically necessary, the state must ultimately cover the drug.

An open question is how an exclusionary formulary would be structured. What provisions would it include to guarantee beneficiary access? A possible model in this area is Medicare Part D, which has protected classes and other coverage and access requirements.

Another idea would be that drugs have to meet a cost effectiveness or comparative effectiveness standard in order to be included in the rebate program rather than being included by virtue of meeting the definition of a covered outpatient drug.

States could also be given the option to opt out of the rebate program and negotiate rebates directly with manufacturers without the statutory floor. Obviously, there's a risk that states may fail to get better rebates than they're currently getting under statute.

The final idea in this space is slightly different but related, and that's to include safety valves for unexpected costs. This can include additional federal funding for higher drug costs or delayed coverage of blockbuster drugs to give Medicaid managed care plans and states adequate time to budget for those costs.

To conclude, just some overall observations, proposals that increase rebates or reduce the availability or coverage drugs will likely be met with concern by drug manufacturers. Proposals that restrict beneficiary access are likely to raise concerns among patient groups.

Some of these proposals are more administratively

complex than others and would be data- and time-intensive. They may require significant state and federal resources.

But now you've heard a range of policy options with the potential to mitigate Medicaid drug spending. Some are quite discreet. Others are more far-reaching in terms of how they would change rebate policy.

In terms of next steps, it would be helpful to know what the Commission is interested in doing in this space, specifically if you'd like to pursue recommendations this report cycle and, if so, on which topics, or if you're more interested in more research-intensive examination of larger-scale changes, these aren't necessarily mutually exclusive, but it would be helpful to get a sense of your priority and thoughts.

CHAIR THOMPSON: Great. Thank you, Chris. Thank you, Rick.

First of all, congratulations on being able to give us a coherent presentation on a very complex subject. So I think the way that you've laid out some of these different areas and the way that you've described them is very helpful, so I'll open it up for Commissioner comments.

While you're thinking about this, can you -- one

issue is we spent yesterday talking a little bit about state flexibilities, and you've touched on that a little bit here. Some of these areas might be areas that would be useful to have states experiment with. What are the limitations on states' authorities generally here? Can they seek waivers for some of these provisions, or are they unable to do that under current law?

MR. PARK: Well, and Rick can correct me if I'm wrong, but I don't think, you know, is governed by this, you know, rebate program. And there is a requirement from Medicaid, you know, if you're going to cover outpatient drugs, then you must participate in the rebate program, and it hasn't been really tested as to whether states and CMS have the authority to waive participation in the program. So some of these options right now, I think, might be limited by CMS's authority to actually waive a state's participation in the rebate program, but I'm not exactly certain if that's possible or not.

CHAIR THOMPSON: But, I mean, even beyond participating in the program itself, there are some individual requirements that you identified here, and if a state wanted to, for a particular class of drugs or for a

particular set of therapies, take a different direction that would be otherwise provided for in statute, do they have some avenue to seek that authority through some kinds of waivers, or is that unclear?

MR. PARK: It's a little bit unclear as to how far they can go.

I think Oregon might have the best example of maybe doing some tweaks to their program, where under their waiver, I think -- you know, I'm not completely familiar with all their waiver requirements, but they've kind of created this list, a prioritized list of the things that they will cover and the treatments that they'll offer for specific conditions. And as part of that, CMS has given them authority to kind of create like a cost-effectiveness standard, where they'll be able to cover some treatments but not all treatments if they believe that treatment is not as effective, cost effective as other options.

And part of that process, I think they could include drug costs as part of that cost-effectiveness standard. So I think they do have a little bit of authority if they determine that the treatment for a particular condition includes a high-cost drug, and

therefore, it's not as cost effective as treatment with a lower-cost drug, that they have some ability to not cover that high-cost drug. But I'm not clear as to how far they have the authority to do that.

MR. VAN BUREN: Yeah, I would agree. I don't think it's been -- the outer bounds of that have been really tested.

I would say -- and I'm not sure if this is quite related to what you're talking about, but there's not just the waiver of state authorities to keep in mind or statutory provisions, but also some of the provisions in statute related to best price and how manufacturers calculate AMP, those may not be waivable under an 1115. So it's important to keep in mind that there may be there are actors beyond states that may have repercussions in this space.

CHAIR THOMPSON: If CMS wanted to grant -- or a state wanted to seek an authority to waive best price in the context of a particular program around VBP, as we understand it now, that would not be something that would be available to them?

MR. VAN BUREN: Yeah. I think it's an open

question. I don't think CMS is specifically -- I can't think if CMS has specifically said whether they can waive best price or not.

But, typically, an 1115 waiver, I think -- and correct me if I'm wrong -- is related to like waiving obligations on the state. So these are obligations on the manufacturer to report best pricing and AMP, and that might be kind of untested bounds with the waiver.

CHAIR THOMPSON: Okay. Sheldon and then Darin.

COMMISSIONER RETCHIN: So I thought it was a terrific presentation. It's a really important subject, and I wanted to raise a couple things. One, I don't think you mentioned 340B, but whether that -- and how that ties in since it's a provider-initiated event -- benefit, but that's really not the substance of my, I guess, comment and then question.

It's really the explosion of specialty pharmaceutics, and so the good news is, with new platform technologies, the biologics -- the swell and the availability of biologics with immeasurable benefit is amazing. I see small start-up companies with eight -- I mean, now the PhD graduates in our medical centers are

going into the private sector and doing great things with monoclonal antibodies and just genomic research organizations that are using micro RNA interactions. It's just amazing. So that's the good news.

The bad news is the specialty pharmaceutic costs are exploding. Honestly, I think, again, the good news is we ain't seen nothing yet. It's going to continue, and there are projections that the entire industry, just specialty pharmaceutics, will clear way over a trillion dollars within the next 10 years.

So I'm not sure what to do about it. This has allowed the opportunity to be treating a rare disease, but as Yogi Berra might say, "Boy, rare diseases are really common."

[Laughter.]

COMMISSIONER RETCHIN: So when you put it all together, there is something like 25 million Americans who have rare diseases.

So I just wonder, when you meet with MedPAC, is this something that since there is a commonality here -- this is beyond just Medicaid. It affects Medicare, commercial payers for sure. There are a lot of discussions

in Congress. It's just a question I have.

CHAIR THOMPSON: Darin and then Chuck.

COMMISSIONER GORDON: I was going to go where Sheldon was going. I think pharmaceutical spend has been relatively under control. I had seen for probably 10 years, you know, a very moderate growth. In the last few years, with some of the biologics, it's exploded.

I mean, to put it in perspective, we were averaging about a 1 percent year-over-year growth right up until like Sovaldi and Harvoni hit the market. Then we went up to 10 percent, total pharmacy spend.

And as Sheldon was observing, there's going to be more -- there are more coming down the pike.

So the issue that I think we should be exploring here are some of the questions around what could be done there, and most of the conversation is around value-based purchasing. I am on an advisory group with Duke-Margolis, who is about to put some stuff out on this that I think might be helpful for us to look at, which involves a lot of industry folks as well as payers, a good mix of folks looking at this very issue of what might be some of those hurdles and are they real or are they perceived.

But one of the things that we saw -- and it's going to have to come up in the context of value-based purchasing -- is it's great that we're living in the age of some curative treatments. That's great. The current model in which we do insurance, even in Medicaid and Medicare, makes it difficult to recover the savings from that particular investment.

And what I mean by that -- Sovaldi and Harvoni are a great example -- a lot of the investment states were making in Medicaid, the benefit would, more times than not, accrue to Medicare, and how do you account for that? And looking at our current insurance system, you may have an individual with a plan -- even in Medicaid -- with a plan one year, we make the investment, and the member is with a different plan later. And so how do we think about those things when we think about value-based purchasing? And the best I can come up with in some cases, you're going to have to think about -- in like a Medicaid or a Medicare, we'll probably have to be thinking about whether or not those are things you need to carve out of those systems, because the benefit is there. It's just only recovered over an extended period of time.

So I think there's this real big financing element that comes into it, how that overlays with our insurance market, and again, primarily in the context of the specialty drugs, I think that's really where we should take this.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: So I have one question, and I think I have a couple of suggestions.

So I've had two stints doing it as a Medicaid director. In the late '90s, the big fear was in Viagra came out and then more recently when some of the hep C treatments came out.

Rick, I think you mentioned some limited issues with utilization management. I think, actually, there's one that ought to be incorporated in this that was used both times. There was a lot of hullabaloo about this stuff, and it was really medical necessity.

In both instances -- and there's going to be a question coming out of this and then I think a suggestion about MACPAC's role going forward. But with the issue of medical necessity, the Viagra example was limiting it to certain diagnoses and not more generally available, and

then similarly, actually with Sovaldi and Harvoni, it's medical necessity around fibrosis scores and lots of threats of litigation about whether that was too restrictive and whether we were missing opportunities to cure people with lower fibrosis scores.

But I think there's an interplay between all of this, and I think it will play out with the biologics around what's the diagnostic profile that warrants, from a medical necessity point of view, proper administration of a medication, and how much of that is a state backing into it for budget reasons, and how much of it is clinical? So I think that merits some discussion, if we're producing any public report.

Going forward, my own suggestion is I think it's important to keep current on some of these scores, the budget scores that you mentioned, because if and when some of this turns into a legislative discussion or a regulatory discussion, where we're asked to provide feedback, I think we should have some current data and current information on some of the pros and cons and potential savings. So I think we need to keep current with all this research, but I don't think we necessarily need to go looking for an

opportunity to insert it until and if there's a proposal on the board for us to respond to.

CHAIR THOMPSON: Thanks.

Let me just follow up on a couple of those points. Some of the proposals that you mentioned, especially around changing aspects of how manufacturers claim rebates, I mean, is there any analysis to be done there except what has already been done about what you could make that change and create more savings for the state and federal governments? I mean, it's just a price proposal, right?

MR. PARK: Yes. Some of them, I think are -- in terms of the analysis are not necessarily complicated to carry out, but MACPAC's ability to actually try to estimate the impact is a little bit limited because the manufacturer rebates are considered confidential.

And we've had some discussions with CMS about our ability to get those specific rebate amounts, and right now, CMS's legal counsel has said that MACPAC does not have the authority to get specific rebate amounts.

They've been willing to give us some summarized data, so I think we could come up with some estimates if we

changed certain rebate provisions such as remove the cap on the rebate from 100 percent of AMP -- you know, I think we can get some summary data that would allow us to estimate the impact of that.

But if we're trying to estimate the impact of specific drugs or changes at a very defined level, then we may not be able to do that ourselves.

CHAIR THOMPSON: But when you say estimate the impact, do you mean --

MR. PARK: In terms of spending.

CHAIR THOMPSON: -- just estimate the savings?

MR. PARK: Yeah. The rebate dollars, how they would change.

CHAIR THOMPSON: Okay.

Darin.

COMMISSIONER GORDON: So along the lines of what Chuck was saying, I think it would be worth also looking at what Medicaid -- if there are certain things that Medicare can do in the Part D program that should be considered or looked at from a Medicare perspective.

And the reason I'm bringing that up is Chuck was talking about the appropriate clinical indications for

certain things that are coming out. The way that I have been told back when I was running a program was because of the rebate agreements, the law that we have to cover the agent, as soon as the FDA approves it, which complicates things of figuring out what was the evidence that the FDA reviewed to make sure that you're designing our clinical criteria to match the evidence, because you don't really have time to review that.

And I understand in Medicare, at least on the Part D side, that they do have some period of time to be able to make sure that they're able to review that and make sure that they understand the appropriate clinical protocols for where that agent has proven to be effective.

That's on the quality side, but also, I think about that in the context of states could be put in a position to where they're providing these high-cost agents in situations where there is no evidence that it's a benefit, and there's other situations where it could actually, potentially cause harm because you didn't have the time to review the clinical criteria appropriately beforehand. But looking at that and seeing if there's some things that should be done there as well, I think would be

helpful.

CHAIR THOMPSON: And that's sort of part of this constellation of utilization management activities, right, which is how do you make sure that beneficiaries are properly educated, what are the tools that you're using, and what is there to support the clinical evidence, what are you doing with your prescribers. I do think there is a whole set of issues there that is worthy of our discussion and examination that can be useful.

Let me go back to the National Purchasing Pool, and I just want to understand. You described the fact that we have states who have engaged in fairly large multistate purchasing pools. So I'm trying to understand why we need or there's even a savings associated with the National Purchasing Pool, given the fact that you have states presumably fairly well-incented to try to band together and negotiate what they can. Can you just talk a little bit about the state experience in multistate purchasing pools and how a National Purchasing Pool would be different?

MR. PARK: So there are three large state purchasing pools and I think, roughly, probably like 8 to 15 states in each of the pools. So I would say the

majority of the states end up belonging to one of these three pools.

We don't know exactly how much each of the specific programs may obtain in rebates since that information is confidential, and each rebate pool may have different requirements on the states. If they negotiate a rebate with a manufacturer for a particular drug, what are the requirements of the state to kind of follow through and put that drug on a PDL? It may be kind of a voluntary thing where the pool has said, "We've negotiated this rebate for this particular drug. If you want to put this on your PDL, then you'll get the rebate, and if you don't, you don't have to, and you can choose to do whatever you want on that."

So I think part of the thought on the National Rebate Pool is that instead of having these three separate pools, which depending on the states in there, the purchasing power may not be as big as California by itself, and if you combine all of the states together, you would have significant purchasing power and could maybe negotiate better rebates.

I don't know what went into the calculation of

that estimated savings in the President's budget, so it's hard to say what all things they were considering under that.

Additionally, as I mentioned, there are some technical details about a National Rebate Pool as to whether states would be mandated to participate or if would just be an option for a state to join the pool. Would they have to follow the exact preferred drug list that was established by this rebate agreement, or could they have flexibility outside of that?

I don't know if Rick has anything else to add.

MR. VAN BUREN: No.

MR. PARK: Okay.

CHAIR THOMPSON: But there's nothing preventing states from getting into bigger pools?

MR. PARK: There's nothing preventing them from -- like if they wanted to combine into one big pool, I think they would be allowed to do so.

COMMISSIONER GORDON: Yes, there's no explicit --

CHAIR THOMPSON: I don't know. Did you have experience with a purchasing pool, Darin?

COMMISSIONER GORDON: Yeah, we have. We've been

in different ones. I don't believe there's a statutory restriction, but I think you hit on maybe some practical situations, like in order to be in a pool, do you have to align your entire PDL with that particular pool? Does that make the best sense for you? But I do think, as you hinted to, it's not always clear which pool's best. I think the way that we tended to look at it was number of lives. Obviously, the bigger number of lives that are covered under that pool, the assumption would be that you were getting the better deal. But I didn't ever see any kind of restriction from pool to pool other than a more operational practice and did that make sense based on your PDL construction.

CHAIR THOMPSON: Presumably, that issue would come into play with a national purchasing pool as well and maybe restrict some states from making some choices that would fit their situations better. Thank you.

Any -- Fred?

COMMISSIONER CERISE: Just on the general -- we've talked a bit about the general question of is this something worth considering. It's such a big issue that I think it does merit consideration. At the same time, it's

such a complicated issue and it impacts programs beyond Medicaid. It's so complicated I don't think we should surrender on it, though.

Everybody's struggling with this, and we're in uncharted territory. You've got -- never before did you imagine you had something that would cure a disease that we are having a policy discussion around whether we would make it available to individuals or not, you know? And so it's just -- it's just new territory for us, and providers all over are struggling with these things. You know, you've got committees with ethicists on it trying to determine -- because if you spend all of your money on one drug, then you can't run the rest of your program. And so we're going to be forced to make decisions around this, and it can't be by default, whatever comes up gets included. And so I think we're going to have to make tougher and tougher decisions around it.

You know, the value-based purchasing piece, the problem is there's value maybe for 10 percent of people that get this type of drug, but -- for someone there's going to be value, and most of the times it's not going to be offset with savings somewhere else. It's going to be a

benefit to someone, but it's not going to come at a future savings. It's going to come at a cost. And so they're very tough questions, and so everything on your list I would say pursue. You know, it's just how do you constrain the program to try to make these therapies available to people that, quite frankly, society has invested -- it's not just the manufacturers, but society has invested heavily in the build-up to that drug. And so I think it's worth keeping on our list because it's such an obvious issue for us, it's going to continue to be something that we struggle with.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: I would go back to sort of where Sheldon started and say I think that what we should be considering is whether we're focused on drugs in their entirety or a class of drugs that are the problem.

There's a GAO report from just relatively recently looking at generics where the average price I think dropped about 50 percent over a three-year period, but you had these spectacular increases over a set of drugs. And so the question is: Is there a more effective and in some respects more palatable policy that's targeted

at what the problem really is as opposed to trying to deal with drugs more broadly, which may sort of encounter a variety of kind of obstacles and then end up sort of us not being able to be as effective as we could have been if we really targeted the real problem?

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: There's one other issue this plays into, which is an interesting one as well, and that's in the whole debate on getting into block grants and per capita payments or caps. So on the other side, if you have a breakthrough technology, like the treatment for hepatitis C, and you're in per capita caps, it actually forces you into some of these ethical discussions in a very difficult way. And I think Sara Rosenbaum was recently quoted: What if you had a vaccine for Zika that cost $50,000 a dose? Would you -- I mean, there are some issues where there is an investment for something that would actually have different costs for society. How do you measure that?

So, anyway, it's just a different perspective, I think -- not that it couldn't be -- I mean, it's still just -- it just attenuates this whole issue of how do you

address this from an ethical standpoint.

CHAIR THOMPSON: Marsha.

VICE CHAIR GOLD: I wonder -- and this isn't -- I don't think this is a specific Medicaid policy issue. It's a broader one. But there's sort of the issue of these super expensive drugs that do well, but then there's the issue of pricing of those drugs. And is there or is there not a rationale for the price being as high as it is? I don't think that's something that Medicaid alone can take on, but I think it's important to distinguish the availability of the drug from the way in which that pricing occurs. And I'm not sure where the focus is for looking at that from a policy issue. Medicaid's obviously affected by it, but it's a broader question.

If we met with MedPAC on that, that might be something to talk with them about.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: First, I just want to say there's a National Academies of Sciences, Engineering, and Medicine panel on access to affordable drugs, and I'm on it. I can't say what's in the report because it's in review. But, Marsha, I'm glad you mentioned MedPAC.

There's a relationship here between the programs that needs to be discussed.

I think taking on the broader issue of drug pricing probably would bury us in ways that are not productive. I think the challenge is if we don't feel like we can take on the broader issue -- and I would endorse that view -- then what we're left with is the issue of how do states make decisions and how would we either advise states or the federal government on the decisions states have to make on restricting access. I mean, if you can't affect price and you don't have an unlimited budget, then by definition you see access restrictions, and that's what we see with the hepatitis drugs.

So I wonder if maybe we could narrow in on a piece of this which has to do with sort of levers states have and don't have. There have been legal challenges around those restrictions. I think the whole issue of the specialty drugs, that's going to lead to some -- again, if we don't tackle prices, by definition it's going to lead to decisions about access restrictions, and we are MACPAC. So I wonder if we could do some productive work just focused on that topic -- not that it's unimportant, but I'm not

sure controlling Medicaid spending is something we can do in isolation. But examining and questioning whether states have appropriate tools to manage the cost of particular high-cost drugs and what implications of those tools are for beneficiaries, I think that would be useful.

CHAIR THOMPSON: Yeah, I think I hear a consensus around that point, that the appetite for thinking about a redo of the rebate program is not high, and I'm not sure that there's a whole lot for us to do on some of the specific cost savers except to maybe acknowledge them if we come into a place where we have some recommendations that might generate some additional costs and identify those as potential offsets to those costs.

I think the idea of looking at the levers -- and that's a good way, Alan, I think, to put it -- gets us to the management issues and the formulary issues, and maybe as we think about that in the context of some of these very high value pharmaceuticals, specialty pharmaceuticals, it could also open us up to some thinking around if the existing levers are insufficient, are there some tweaks to authorities or is there some special handling with some additional new levers that ought to be considered for some

of these particularly high-value but high-cost pharmaceuticals?

Martha, you wanted to jump in.

COMMISSIONER CARTER: Sheldon mentioned the 340B program, which I know is a hot topic right now. That's a program that the FQHCs and DSH hospitals participate in to purchase drugs at a lower cost. So is there room to understand how that -- so the discounts that are inherent in that program, you can't double-dip so you can't get a rebate and a discount. So how does that impact the Medicaid programs? What's the interplay? And is there room to consider those two programs that really are operating in the same space, in the same populations? How do they work together?

MR. PARK: Certainly. We can definitely do some more work on that. As you mentioned, you know, there's prohibitions in the rebate program from counting utilization that was obtained at the 340B price and also getting an additional rebate on that. The 340B price is essentially getting the Medicaid rebate up front, and so that the 340B entity is basically getting the net price that Medicaid would pay for that particular drug. So it's

not clear as to whether one program or the other would get you lower costs necessarily, but we can certainly look into more of the interactions between the two programs.

COMMISSIONER CARTER: I want to check my facts on this, but I'm pretty sure that the 340B programs can have limited formularies.

MR. PARK: Yes, they can in terms of, you know, like a 340B provider could decide not to cover a drug, and there's also a Prime Vendor Program that is kind of like a national purchasing pool that allows -- you know, the program can negotiate prices below the 340B price, and 340B providers can, you know, participate and get that lower price.

The difference here is that, you know, the Medicaid rebate program basically says that you have to cover all covered outpatient drugs, and, you know, it's not clear as to whether you could carve out a portion of the Medicaid program and put it under 340B and still, you know, get the rebates up front but, you know, not be considered as a part of the rebate program. So right now, I think everything that receives the Medicaid dollar in terms of prescription drugs would fall into the rebate program and

be required -- like the mandatory coverage requirement would still exist.

CHAIR THOMPSON: Okay. I know that our guest speaker for the next session has arrived, but I do want to just, because of the importance of this topic and the broad range of things that we've been discussing, invite the public to come up and have an opportunity to comment on any of our discussion with respect to this issue.

[Pause.]

PUBLIC COMMENT

* MS. WILKNISS: Hi. Sandra Wilkniss from the National Governors Association, Center for Best Practices. A quick question about the focus. I heard a lot of discussion about emerging interests and evidence in value-based purchasing arrangements, and I heard also that you want to kind of focus narrowly on the utilization management strategies, and I'm wondering if there are thoughts about weighing in on the VBP kinds of arrangements that are emerging from this group.

CHAIR THOMPSON: I would think that that would be part of what we would be looking at in terms of the available levers and impediments to exercising some of

those levers to negotiate a different kind of an arrangement for those. Yeah, so I would see those as in view.

Okay. Thank you, Chris. Thank you, Rick. A really great job on a challenging subject. Thank you very much.

[Pause.]

CHAIR THOMPSON: Hi, Tim. Welcome. Thank you for joining us. We are so happy to see you this morning.

UPDATE FROM THE CMS MEDICARE-MEDICAID COORDINATION OFFICE

* MR. ENGELHARDT: Thank you for having me.

I should confess to the Commission that my attendance here required a very energetic sprint across Constitution Ave just a few moments ago --

CHAIR THOMPSON: Would you like a moment?

MR. ENGELHARDT: -- so I hope you will forgive me if I am winded.

[Laughter.]

MR. ENGELHARDT: But I'm happy to be here, nonetheless.

CHAIR THOMPSON: So we have an hour with Tim this

morning. We've been eagerly looking forward to this, as always. Great interest in the progress that's being made by the Medicare and Medicaid Coordinating Office at CMS, and on the subject of dual eligibles, in general, we spent a little time, Tim, yesterday talking about this issue. We had Gail Wilensky and Andy Slavitt starting us off yesterday, and it was a subject of their conversation as well.

So we'd like to hear from you in terms of an update on your activities and then, hopefully, have a really robust conversation with you about this.

MR. ENGELHARDT: Thank you again for having me.

I do want to acknowledge some contributions from some of the people in this room with whom I've been really fortunate to work over time. First, there's Chuck Milligan who while with UMBC in the Hilltop Institute really jump-started a lot of the analytic work in our own office, and we're grateful for that. Toby Douglas, while in his role in California, certainly instrumental in getting an integrated care program off the ground there. Darin Gordon, who helped kind of embed an integrated care focus into TennCare, and I know in absence, Kit Gorton, who has

been really kind of a pioneer with us in work serving younger adults with physical disabilities especially and serious mental illness in Massachusetts, so we're grateful for all of that.

I also want to acknowledge the really terrific work of some of the Commission staff over the past few years in some analytic work that has actually been really kind of operationally important to us in several ways, and I'll try to highlight those as I go through my remarks to start.

I also want to acknowledge that MACPAC and MedPAC have teamed together in a joint data book on dual eligible beneficiaries that we find to be an invaluable resource, so we're really appreciative for that ongoing collaboration and the ongoing investment in time.

At the risk of dumbing it down too much for this audience, I am going to start really briefly with some of the basics, just to ground ourselves.

11.4 million people dually eligible for Medicare. In Medicaid, of those, 3.2 million, what we call partial benefit duals, it means the Medicare beneficiaries, Medicaid helps with either their Medicare premiums or cost

sharing or both, but otherwise do not really have access to the full Medicaid benefit package.

I think we maybe, sadly, don't spend as much attention as we should on that group from a Medicaid lens, in part, because it's not really Medicaid money. I don't want that to detract from the importance of those programs and the overall economic well-being for really low-income older adults and people with disabilities.

The remaining 8.2 million or what we call full-benefit duals, that means they have access to the full Medicare and Medicaid benefit package for not all, but many of those people that means access to Medicaid-funded long-term service and supports and community-based behavioral health treatment.

That number of duals has grown modestly over time. I think it's important to just note, lest there be misconceptions, that the ACA eligibility expansion really didn't touch this population in any meaningful or direct way.

As you well know, it's a population with high rates of chronic illness and disability. I urge us as always to remember that it's a heterogeneous group. It

fits not neatly into any kind of population box. It's people with serious and persistent mental illness. It's people with intellectual and developmental disabilities. It's older adults; it's younger adults. Forty percent of the population is under the age of 65. Close to 40 percent have diagnoses for mental health conditions. It is diverse in every way that it can be diverse, and I think that's really important when we think about interventions that may better serve this particular population, which, in fact, is many populations.

Finally, not least of which, collectively, the states and CMS spend about $300 billion annually serving these 11 million beneficiaries.

I want to touch on a few things that are, in some ways, like forever standing problems and in other ways have recent developments associated with them, and I want to start with long-term care.

You guys are very familiar with the fact that we just don't have a robust and mature set of quality metrics in the long-term care world in the same way that we do elsewhere, but I do fear that sometimes we miss the reality that we often have kind of like very basic and important

quality metrics. We just have to derive them from Medicare data, and it seems so simple but often overlooked that hospitalization rates and readmissions for long-term care users ought to be considered kind of a key indicator of how successful long-term care programs are.

We focus on that -- I think we can focus on that in both home- and community-based environments and institutional ones, but we, especially over the last several years, have focused on it in the long-term care facility-based setting.

Many of you are familiar with the fact that we have analysis from 2010 which shows us about 45 percent of hospitalizations of people in nursing facilities are for avoidable conditions -- 45 percent for avoidable conditions -- and I think we owe it to ourselves collectively to ask a little bit about how we can let that happen in a world that's largely government funded and very highly regulated.

And we can point to some obvious and really important structural factors in that. Medicaid pays for the majority of days in a nursing facility, but Medicare covers the acute hospitalizations, post-acute care. Profit margins for operators are wildly different between those

two programs, and the financial incentive structure is more toxic than it is rational and constructive.

We also know now, though, that relatively modest interventions can, very significantly, change that hospitalization. We ourselves have operated a project over the last several years aimed on that issue and have achieved very strongly statistically significant reductions in both all cause and potentially avoidable hospitalizations.

But despite years of work on that and, frankly, great clinical success, the relative roles of Medicaid versus Medicare in sustaining and spawning those types of interventions remain as murky as they ever were, and I hope the Commission won't shy away from that challenge. But that just is the tiptoe into the broader conversations about integrated care more broadly.

For decades now, many of us and many of you have focused on mechanisms to better align incentives and reduce administrative burden and improve beneficiary experiences through Medicare/Medicaid integration and integrated care, and the concept, of course, is a really simple one. It's find ways to eliminate the incentives for cost shifting

between the two programs, find ways to incent better outcomes for beneficiaries instead of volume, and find ways that the return, the financial return on investment is better aligned with those payers who help to make those investments.

Since the last time I was with the Commission a few years ago, the evidence base related to integrated care has expanded, and one of the biggest parts of that expansion was a study that HHS published last year focusing on one of the seminal integrated care programs called Minnesota Senior Health Options, or MSHO, and the results, even to me, were completely stunning. The researchers found that MSHO enrollees were 48 percent less likely to have a hospital stay, and those who were hospitalized at 26 percent fewer stays, there were 6 percent less likely to have an ED visit, and for those who ever went to the ED, they had 38 percent fewer visits, and at the same time, 13 percent more likely to receive home- and community-based services. So this is really -- it's like exactly the narrative that we think about in our heads when we think about integrated care interventions and exciting and important to note success in a mature and longstanding and

well-run integrated care environment.

The number of dually eligible beneficiaries nationally who aren't in any kind of integrated care setting by our particular way of counting has about quadrupled from 2011 to 2016, and that kind of growth has happened in multiple flavors of integration.

I'm sure you're all familiar with the programs of all-inclusive care for the elderly, which over and over and over, we tell ourselves, it's small, it's small, it's small. It's grown by 90 percent in the last five years, and that's remarkable and important. States like Tennessee and Arizona, there's been significant growth, and a number of people who are in aligned Medicare Advantage health plans and married with Medicaid MCOs.

And really the largest numerical driver over that period of time has been through what many of us call the "duals demonstrations" in which we created a common new product line called the Medicare-Medicaid Plan, or Ms. Perry. They currently serve about 400,000 people through partnerships that we have with 10 different states, in which we're testing -- we view as kind of a deeper level of integration in a capitated managed care environment.

We also partner with two states in a fee-for-service-based integrated care model in Washington and Colorado.

And while we've been talking about this for decades and while surely Toby and I feel like we started work on those demonstrations many, many, many, many years ago, now, in fact, several of them have started relatively recently. We are probably more in a state of adolescence than adulthood at this stage with the rolling start dates of the various demonstrations, the most recent of which began just last summer at this time.

But despite kind of being in formative stages, there are things that we have learned that I think are profound and important, and I find it useful to reflect back several years to some of the unanswered questions we had at that particular time.

First, we embarked on this work a little bit unclear about whether we could have a competitive market of health plans with meaningful choices for beneficiaries, even while we had relatively high expectations about both savings, but also clinical integration and care coordination.

And I think at this point, we're ready to say that the answer to that is yes, we can. And we have. We have over 50 of those MMPs operating across the country. It has been -- despite localized blips at times, it has been a relatively stable market now for some period of time. There were unanswered questions at the time whether or not we could get people into these types of products at a volume that made them sustainable, made it a viable business endeavor to hire what has now been thousands of care coordinators across the country, and again, I think the answer to that is yes. Most of those MMPs are currently experiencing incremental growth. Our experience really significantly varies from market to market. At the high end, though, now in Ohio, 70 percent of all of the eligible, dual eligible beneficiaries are now enrolled in fully capitated, fully integrated systems of care. And I think that important.

On a national basis where we have these demonstrations, it's more like a third of people who are in these models, and I still think it's important progress and certainly has proven to be of a magnitude that seems to be sustainable from the health benefit perspective.

Third, it was unclear to us whether or not we could find a way to more rationally regulate in an environment in which there are both Medicare and Medicaid rules, and again, I think this is a quiet but important success story for us in which we've developed new ways to kind of jointly monitor and oversee a health plan that's delivering both the Medicare benefits and the Medicaid benefits to the same individual who happens to be receiving both.

A fourth question still emerging a bit more than the others is that can we create integrated products in which people are reasonably satisfied and which their experiences reasonably improved, and at this stage, we're very happy with the progress to report on that. As with many programs, we administer CAHPS surveys and MMPs. We saw a very significant year-over-year growth from the first to the second year of administration from the surveys in rating of care coordination and overall rating of health plan and overall ratings of health care quality.

Where we have the least clarity still, the very most important questions, which is can we improve health outcomes and can we save Medicare and Medicaid money. It

will still be some time before we can answer those conclusively in any meaningful way. The first scraps of evidence have focused on, frankly, where the data availability is the easiest, and that's in our Washington State fee-for-service model, where we're happy to have about $60 million over two years in gross Medicare savings. And I emphasize gross because we have shared a significant amount of that back with the state of Washington with checks from the Trust Fund to the state for really the successful investment in a health home model.

Each of the demonstrations, of course, is subject to an external evaluation. RTIs are evaluated, where we have posted online some summary reports, so the early implementation experience of a variety of care coordination models that are in place and more in-depth experience in the earliest implementers, which were Massachusetts, Washington, and Minnesota. More of those reports will be available this fall, and we'll certainly share them with the Commission as soon as they're available.

In the meantime, there are other, I think, kind of important operational lessons, a fit lesson, any kind of evaluation bucket, but have opened our eyes to some of the

real-life challenges of serving this particular population, and the first is one that has come up with the Commission before. And it's the challenge that has been widely reported, especially for many of the health plans engaged in this work, the challenging of finding people.

And I will admit to perhaps naivety on this matter, but we got tens of thousands, hundred thousand people enrolled in products, and we told all the health plans to go out there and complete a health risk assessment, and came back quickly to say that the government's records of where people live are inaccurate. In many cases, it's difficult to find people. It's difficult to get them to answer a telephone call and difficult to get people to respond, and so we talked about this. That was presented as kind of a broad challenge.

I'm kind of thrilled with the fact that the states and the health plans have kind of rallied to that challenge significantly in many cases, really innovative ways of finding some tough populations, including people in states of housing transient, and so it is a place in which the challenge remains so deep, yet there's been significant progress.

Our collective rate of completing health risk assessments for this population has increased significantly year-over-year to the point we're well over 90 percent on the key metric that we tracked.

We've also found with increasing clarity that some of the hardest-to-reach people are the most important-to-reach people, and we see this over and over in which after multiple attempts, sometimes it's leaving a note at the pharmacy counter, where we know someone is filling a script. Sometimes it's through working with a transportation vendor that we know has picked someone up to give them a ride.

We find people with significant amounts of unmet need, and I will say that it is rarely a medical issue. It is almost always an unmet behavioral health or other type of social risk-related issue. Potential eviction from housing is a common example of that, care coordinators in the field, and I think one of the very difficult but important-to-measure benefits of integrated care approach.

We've also, I think, found important ways for CMS to be a better partner with the states, and as you well know, it's been an increasing priority for us to reduce

state and regulatory burden where we can, and we found several of those opportunities in these integrated care environments.

I am happy to come back to some of the testing and innovative approaches, but I don't want to do so at the expense of those opportunities we have for better program managements and many of the existing programs that serve dual-eligible beneficiaries, and I think that starts with modernization of the Medicare buy-in program for those people who need Medicare to buy into their premiums and improvements in the Medicare savings program.

Thanks to great work, again, from Commission staff. You guys are probably familiar with a recent report that showed that a very significant number of people are eligible for but not enrolled in those Medicare savings programs for the most generous -- so then the QMB program, it's right around 50 percent of people eligible are actually enrolled. There are probably many reasons for this.

Certainly, one of them is the fact that we collectively have made the application process far more complex and, in some cases, far more challenging than they

need to be, and we will welcome input from the Commission and others on ways that we can reduce the burdens associated for beneficiaries and for state eligibility techs to navigate those Medicare savings programs.

I think we also need to continue to find more ways to maximize the value of those programs themselves. Again, thanks to great work from the Commission and Commission staff. In 2013, the report to Congress helped us quantify for the first time ever, the number of states who take advantage of the legal ability to not pay the full cost sharing for those people who are dually eligible, and that is now the vast majority of states.

What that means functionally -- and it's important for us to keep top of mind -- is that many providers focusing on their Medicare line of business are paid 20 percent less for serving low-income beneficiaries than they are for all the rest of their Medicare caseload, and I think that's a reality we have to continue to grapple with.

The Commission's work and some of our own work at CMS helped to demonstrate that there, indeed, seem to be access-to-care implications at least for primary care

services and community behavioral health services in which we saw lower levels of access in those states, not covering the full cost-sharing amounts compared to those who do.

These are admittedly like dark corners of national health policy, and I'm self-conscious about that. In fact, some of this work helped shed light on it, and I hope you guys will continue to do that for years to come.

So we will wrap it up and then open it up to questions from self-reflection on my own remarks here, which, as always, have been a complete failure at, I think, adequately expressing the realities and challenges and great opportunities related to serving this population.

We see time and time again -- and I feel like I'm ill-equipped to be able to share it with people like you and others -- the stories and the anecdotes of people, not just whose blood sugar level changed a little bit or who got to see a physician when they couldn't find one before or whatever, but people for whom the trajectory of their lives changes. And that's I don't think an uncommon occurrence in a world that is showing us very high rates of substance abuse and homelessness and other incredible socioeconomic stressors in this population, and I find that

energizing and inspiring. And I hope all you guys do too.

So I'll stop there and welcome questions.

CHAIR THOMPSON: Thank you, Tim. Much appreciated.

I want to just give you an opportunity to talk with us about -- you know, you mentioned at the top of your remarks something that many of us have said to one another over the years, which is how long we've been grappling with this issue. And so just based on what you know about what the programs have been doing, where they found successes, in your view, are there some practices or authorities or activities which could provide a substantial inflection point to help expand the availability of integrated services to dual eligibles and improve these outcomes that we're all interested in seeing?

MR. ENGELHARDT: It's a broad question, Penny. I think of it in two tracks, and I think that the work over the last several years has helped to crystallize the duality of this thing.

First, we actually -- I think the testing and experimentation process frankly that has been stimulated with the CMS Innovation Center here has had these

incredible by-products that are, again, just so difficult to measure in the boxes in which we put some of this work. I'll give you a great example, really largely stimulated by the fact that we now had a growth of concentration of full-benefit dual-eligible beneficiaries in these consolidated products. It forced us to take a harder look at some of the ways in which on the Medicare side of the House we were risk-adjusting payment. Right? I mean, that was like an issue all along, but it created a new environment in which it mattered differently. And research done by incredible staff at CMS a few years ago found that we were missing the mark kind of significantly on some populations; and some we were overpaying, some we were underpaying. And I think the ability to kind of have the catalyst to find it and then the great people to fix it I think is one of those -- it's like one of those infrastructure things that becomes really critical to having kind of a vibrant market in which innovators are willing to go find tough populations and serve them.

I know it's Medicare-focused, but I point to that as just kind of these infrastructure examples of the things that we constantly have to find, recalibrate, and they're

really necessary to have a strong foundation from which to build real success.

I'll tell you another, and I think this is -- it's so sad and profound but important for us to recognize. And I'll confess again perhaps my naïveté. We, many of us, believe that one of the routes to better integrated care is through capitation. It just becomes the vehicle through which you can do things that are far harder to do in a fee-for-service environment with two different payers. And when we think about capitation, we think about managed care and we think about selective contracting, and that's like part of the magic.

What we find with dual-eligible beneficiaries -- and I have seen this with real-life market implications in diverse, different states -- is that you don't have the same ability to selectively contract that you do in commercial products in which you can say I'm not going to let you in my network unless blank, right? Unless you play ball with my new alternative payment strategy or whatever else. We find, in fact, the opposite in which a healthy system will only contract with you if you promise that you're contracting with all of the other health systems.

Why is that? They don't want -- this isn't the clientele that people are seeking in many cases. And I think we have to confront those kinds of realities that the tools that we often take for granted in health policy become tools at very different leverage points when you're talking about a population that oftentimes is more challenging to serve.

Well, let's dig a little bit deeper on that. Why wouldn't they want to serve a particular population? Well, there's probably stigma issues. There are plenty of other issues to consider. But let's face that financial fact again, that if I'm not getting compensated for any of the cost sharing for this particular population, you know, in many health systems I'm taking a cut already, I don't want a greater concentration of all of that population because I'm the one -- like I become the provider of choice.

So I think the work forces us to grapple with some of these realities that have been there forever, but in ways that take on different dynamics in that particular work. So I think there's just this constant maintenance and track that gets exposed by trying to do new things, and then we realize we have to fix them not just in some small

model in a particular state. We have to fix them as matters of national policy. And I'm proud that in some of them we have.

I think the other track, though, is that we need to continue to invest in trying new things and trying new models, and I think of all the conversations we've had with both health plans but also states who have found that, you know, we thought we had a strategy that worked, and we've had to recalibrate it or try new things. And I think that's the catalyst for innovation and advancement and serving this population. And I think we have to appreciate that that's an exercise in which quick successes are less likely than incremental success through our collective stamina.

CHAIR THOMPSON: Toby, then Marsha.

COMMISSIONER DOUGLAS: First, Tim, I have to say just thank you for your leadership in the office. We're so fortunate to have you there for what you've done.

MR. ENGELHARDT: Thank you.

COMMISSIONER DOUGLAS: And I would say just your example on the risk adjustment, you know, that wouldn't have happened if it wasn't for your leadership, and just

your ability to break down -- I mean, this is an issue of breaking down the silos, and it takes leaders like you to work across the area, so thank you.

MR. ENGELHARDT: Thank you.

COMMISSIONER DOUGLAS: The question is really getting at this issue -- you mentioned the success in Ohio, and then obviously we have really high enrollment there and lower in other areas. If you could -- you talked about one around the providers, but if you could talk about some of what have been the things that you see and states that have had higher enrollment versus those states that have had a lot higher opt-out and what are these barriers and what things that we as MACPAC could look at or examine in more detail in this area.

MR. ENGELHARDT: Thank you, Toby. We've struggled for kind of some silver bullet, like contextual factor or policy decision or something that makes something work very differently, one market and another, and always been frustrated in our inability to find it in any crystal clarity.

That being said, communications with beneficiaries and with providers have proven to be very

significant. Among them we have seen in some states where there's a mandatory managed care track already which everybody has to be enrolled in a managed care plan, that joining that same plan to provide the complement of all the rest of your Medicare services has been an easier sell to some extent. We've also seen the opposite phenomenon, a bit to my surprise, and I think that points us to, in fact, kind of really highly segmented markets, especially where Medicaid is really treated as a different market segment with different provider types.

So that has been an ongoing challenge and one that can be overcome with greater communication with -- partially overcome with greater communication with beneficiaries and providers, because despite what I said about selective contracting, in many cases we see providers who, you know, we really need to invest a lot of time and a lot of energy to bring them into a new model.

We've struggled in some with the hopes and expectations that we could simply say let's all create an integrated care team, and the primary care will be a big component, and we'll have a care coordinator, and they will all work together, and we will have a wonderful primary

care holistic experience.

I think that vision is real and important, and we've achieved it in some places. In many other cases, we have a one-off physician who has maybe two people who are in some kind of integrated care program for whom it's a tough sell to say we want you to change your business flow and the way practice and the way communicate and who you work with for these couple individuals in your practice who happen to be in an integrated care program, no matter how alluring kind of the opportunities for care coordination are.

So we struggle with all of those challenges still, and I'm not sure that we've been able to find the exact mix that kind of gets it most right.

CHAIR THOMPSON: Marsha, Sheldon, Chuck.

VICE CHAIR GOLD: I was wondering if you can comment -- and I'll say a few words first -- on where you see the priorities in this administration going with respect to integration and the duals. I mean, the way I see it, having worked on it from the Medicare and the Medicaid side, is it started out with Medicare Advantage and the dual SNPs, which weren't very effective at bringing

in the Medicaid part of the program. Then you had the financial alignment demonstration that started from the states with the idea of building on Medicaid and bringing in Medicare. And then that in turn may have pushed the SNP duals to do fully integrated plans. And I think most people would agree that under neither model are you getting as much bang for the buck as you might want, or at least as many people as you want. And so -- but there's been a fair investment, I know certainly on the financial alignment demonstration. I'm not sure there's been the equivalent investment on the fully integrated delivery systems.

Is it clear yet where this administration is going with its priorities and different routes and investments and interest in these strategies?

MR. ENGELHARDT: Sure. What is very clear is the broader kind of administration focus on aspects of state partnership and finding ways that exceed what we've ever been able to find before to kind of meaningfully partner on health care innovation and health care delivery and health care financing.

I think the spirit of that translates very cleanly and neatly into ongoing work with those states, the

increasing number of states that are really motivated to find better ways to serve this particular population. So that theme is strong.

Another has been reduced regulatory burden, and despite, I think, progress over time, we still have to face the reality that, whether your health plan or health system or other things, you're grappling with two different sets of regulations and rules between the two different programs, that we still haven't maximally kind of aligned in any rational way. And so it's very easy, again, to kind of translate that into better kind of programmatic alignment between Medicare and Medicaid.

And the third big theme, especially from the administrator, has been improvements in customer experience -- right? -- and how people interact with programs. And I think we can measure that through things like the CAP survey I talked about before. But I think also the core elements of how people interface with whether it's how you gain eligibility to a Medicare savings program or how you choose a particular health plan, I think I'd extend that, too, to what -- I think it's a wonderful and increasing development within CMS in which the Medicare leadership

over time has been increasingly receptive to those things that improve the collective customer experience through that Medicare Advantage lens, right?

So sorry to get in the weeds, but these really simple things like you get -- if you're in TennCare and you're in a health plan for your Medicare and for your Medicaid, that health plan still has to give you two different formularies and two different directories and two different handbooks and all this other stuff. And it's just -- so how will we do that to this population of all, right?

So in the demonstration environment, we've been able to test integrating virtually all of those materials in ways that -- we've done beneficiary testing. We know with great certainty that they value and appreciate and better understand these kind of products as we've been able to stitch them together. But over time, we've increasingly been able to simply move those kind of learnings into the Medicare Advantage environment. So it's the summer. We've kind of incrementally found different pieces of beneficiary-facing materials that health plans can newly kind of integrate such that you're getting your Medicare

and Medicaid information all in one place instead of from two different uncoordinated things.

So I think that investment is really -- again, this is like weedy stuff, but that's how people touch the system, and those things have moved very significantly both within a demo environment and out.

So I'll go back to one of the places I started, which is that the growth of integrated care has been on multiple tracks concurrently. They're not cannibalizing one another. They are moving in harmony. And I believe that that will continue for some time to come. I don't even know that we need to or when we will face any kind of theoretical day of reckoning when we have to choose, like this is the winner of them, because I think we're seeing good progress and results on multiple tracks.

CHAIR THOMPSON: Sheldon, Chuck, Brian.

COMMISSIONER RETCHIN: Well, this is really a great opportunity. I really appreciate your being here to discuss something that the Commission has really been tossing around for a while.

I have lived in Virginia and Ohio through both of these -- through this transition. In Virginia, I ran a

provider-sponsored HMO that participated in the early days -- and I mentioned this yesterday -- was facing incredible losses through going in it. So one of the frustrations I had there was we couldn't get risk corridors because -- so that one, I guess, opportunity here, I think, is the patience that's going to be needed just to get a network of nursing homes and home care providers. It's just an arduous task.

And then I moved to Ohio, and it's just a different world. And the one thing that I would say contrast -- and I'll just be interested in your own assessment of that, Tim, that the difference in the two -- and Darin and I were talking about this yesterday. It's sort of a behavioral economics problem. That the MA penetration in Virginia is about 17 percent. In Ohio, it was 40, 41, 42 percent. Do you think that maybe that explains some of the differences in opt-out rates?

MR. ENGELHARDT: Yeah, I do. I do, although in some cases it's not simply the existing level of penetration. It's who the penetration is with and whether those are actors who are also serving Medicare populations. So where we've got a significant number of people enrolled

in those plans who don't also contract on the Medicare -- I'm sorry, on the Medicaid side, it creates another actor in the system who has every incentive to prevent functional kind of integration. So I do think that matters.

I think there are contextual factors, too, about why that was the case and, I think, different kind of market factors between Virginia and Ohio that were the reasons for that grave discrepancy.

I should note and thank Dr. Retchin, too, for his own perseverance at Virginia Premier who has, frankly, I think, emerged from some really early challenges and become a great innovator and somebody who wasn't in the Medicare space, really came out of the safety net side, and now just a really important contributor.

COMMISSIONER RETCHIN: Well, Tim, I really appreciate the compliment, although my perseverance was pretty short. I actually left the state.

[Laughter.]

MR. ENGELHARDT: I appreciate the perseverance of those you hired.

[Laughter.]

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: I just want to start, Tim, by saying it's a pleasure to get a presentation from somebody so devoted to the public service and the mission part of what you do, so thank you for that.

MR. ENGELHARDT: Thanks, Chuck.

COMMISSIONER MILLIGAN: Two questions. The first is you referenced Washington State and kind of the shared savings and the treasury cutting a check, and I'm curious about kind of -- we had a presentation yesterday first thing about the potential barrier of the Medicare Trust Fund sharing savings with states where a lot of the state investment is kind of what produces the Medicare savings. I'm curious about kind of the current state of play of that possibility and how, you know, the authorizing approach for other states to consider that path.

MR. ENGELHARDT: Just to elaborate because I failed to give any meaningful context. We kind of operate the duals demonstrations with a couple different models, and one of them is what we call managed fee-for-service, right? And the basic gist of it is that we come to kind of an agreement with a particular state who's making a new investment. If they meet certain kind of quality metrics

and achieve certain savings, then we'll give them a cut of those Medicare savings -- I mean, it's very much like the state kind of functioning as an ACO in some broader level. And when we started that opportunity, we had interest from numerous different states, and it dissipated to a greater extent than we saw relative to other models. And several came back and said, "We just can't" -- they couldn't get over the hump of kind of some of the methodological challenges of how we were going to calculate savings and how we were going to share back. And I think that was understandable and learned from it.

Washington and Colorado were the two that persisted, and Washington started earlier, and so we had more results for them. And they really built, I think creatively, around the 90 percent match available for the health home program for its first eight quarters in which that kind of initial investment was a lot, funded out of that enhanced FMAP, while they kind of built the experience on which they really relied, I mean literally relied on the ability to get Medicare dollars on the back end to make this kind of budgetarily make sense from the state perspective at what was then, you know, a really difficult

time.

So to best illustrate that, the state legislature literally terminated the health home program about a year ago at this time, about two or three months before we came up with the final Medicare calculations that we turned over to them and said it actually looks like you guys saved a lot of money and we're going to be writing you a check for several million dollars of that savings. And then a few months later, the state legislature un-terminated the health home program.

So it's a great illustration that this stuff matters -- right? -- if we can find the ways to rationalize this system. It doesn't change the fact that you have to -- this just doesn't fit neatly into a state budgetary cycle to tell a legislature we need $7 million more this year and maybe one or two fiscal years down the road we'll get something back financially in return. And so that was a challenging sell for us, and I think even where we got it off the ground, it became a challenging navigation for us, too.

So I'm thrilled with that early success. I think it's certainly too soon to really make any conclusive

statement about that, but Washington State's approach has dovetailed with what the literature tells us. They focus on the highest-risk individuals through a predictive scoring algorithm, and that's who they focus on, kind of a relatively high touch intervention, and it seems to have had really good both quality outcomes but also financial success.

We have not yet kind of crossed the bridge to open that up to additional states. I think that's something we'll have to consider as we go forward, and certainly we'll do so the more that we see that success.

But I'm proud -- like, we signed the checks. I swear to God this was true. We wrote checks and sent them to the state from the trust fund, and I think that was symbolically but, as that story indicates, really pragmatically important in that particular context, and I hope we'll find more ways to do that, whether that's in the fee-for-service context or in a different context.

COMMISSIONER MILLIGAN: So we'll be looking for the photo of you with the check --

MR. ENGELHARDT: The giant.

COMMISSIONER MILLIGAN: The selfie in your

Instagram account, Tim.

MR. ENGELHARDT: Yes.

COMMISSIONER MILLIGAN: The second question I have is, for the states that are pursuing integration through the marriage approach that you mentioned, the D-SNP plus the Medicaid managed care, I'm curious about the extent to which the duals office and the Medicare side of the Humphrey Building collaborate on the overall state vision for that in the process of dealing with the D-SNP world, and just if you could shed some light on how that particular state vision is kind of effectuated with your office on the Medicare part of CMS.

MR. ENGELHARDT: Sure. It's highly individualized based largely on state preferences. There remain several that for, whatever reason, don't want to work with me, which is fine, don't want to work with us as intensively on the stuff.

We had several with whom we plan and collaborate very frequently, even outside of any kind of demonstration context, and that's that multiple level. Sometimes it's kind of the higher-order planning ahead of, say, a procurement, about requirements in it. Sometimes it's the

really small but important stuff about notifications to beneficiaries and communications or having 1-800-MEDICARE equipped to answer questions from confused dual eligible beneficiaries who say, "I'm being mandatorily enrolled into a health plan. Can you help me?" And we have to navigate all that stuff.

So on the customer service end and many others, we've worked really closely -- that is, the kind of clubhouse leader on that has been Arizona, with whom we've done a lot of work related to enrollment issues, related to oversight issues.

We have significantly with Massachusetts and with Minnesota as well, too, and others.

We have been doing the -- several of the other small things that we never get to talk about, like literally can't talk about specifically, but they start with the most fundamental of sharing our audit schedules with each other, so the state and CMS don't both go and audit health plan at the exact same time, things like this that are just kind of like the basic blocking and tackling of collaboration.

So it's all over the map, and it's really based

on state interest. If any of them are listening, we're always open for business, and we would be very happy to work more closely with New Mexico and others.

CHAIR THOMPSON: Brian and then Darin.

MR. ENGELHARDT: Especially New Mexico.

COMMISSIONER BURWELL: Not to be too redundant, but I just want to join the chorus of those of us who commend you for your dedication to this issue and, I mean, just on two fronts.

On one, as you've pointed out, this is an extremely challenging population, one that is not well served by our current health system and in which there is an incredible room for improvement.

Second, just from the policy side also, integration of Medicare and Medicaid is an issue that people have been working on for years, and I think it's an area of small victories and many defeats, so I just want to thank you for that.

MR. ENGELHARDT: Thank you.

COMMISSIONER BURWELL: We're obviously a Commission that has acquired an interest and also the expertise around this issue and one that we feel is an

extremely important one to focus on, and that's just not an internal opinion. We get it externally as well, like when Andy and Gail were here yesterday. This is a very -- one and I think one that has -- can get bipartisan support, so it's kind of the environment is right.

And we have an outstanding staff, and we are in a position to do things that other organizations can't do.

This is a difficult question, but do you have any guidance to us on kind of ways in which MACPAC could move the policy narrative forward in our reports, in our recommendations? I know we serve different bosses, but kind of I guess I could also tie this into -- do you have ideas about where this whole issue needs to from a policy perspective? I mean, do we wait and see how the demonstrations end up and get more data on outcomes, et cetera? How do we move this forward?

MR. ENGELHARDT: So I'd say, again, down two tracks. It's both MACPAC's kind of analytic work, but also its role as a communicator to policymakers, especially on those dark-corner issues I talked about before. I still believe that there's a very incomplete understanding among policymakers about some of the very basic dynamics and

associated with refinancing for this population.

Again, I want to acknowledge that that's -- this is a complicated dance with the other commission, with MedPAC too, but I would hope that never became a barrier on things like recommendations about how we can improve the Medicare savings programs, whether from a financing perspective or a beneficiary experience perspective or others and those core maintenance issues that just both remain opportunities for great improvement, necessary improvement, but also places that are not area not fully understood, I think, by those not living and breathing this on a day-to-day basis.

I think on the kind of ongoing learning and diffusion and experimentation side, I call both upon the demonstration work that we've talked about here and some of the great innovations happening just outside of that realm, but I call back on a report that I didn't talk about, though I was tempted to do so, by our colleagues in ASPE in December. And its focus was really on Medicare value-based purchasing and outside of maybe the immediate focus here, but it had this really profound and important finding, which was of all the kind of social risk factors that we

can find in our administrative data -- race, ethnicity, where you live, disability status, and Medicaid eligibility -- it was the Medicaid eligibility that emerged as really the biggest and strongest predictor of poorer outcomes and ultimately penalties against providers in these value-based purchasing programs, and, man, that really ties in so many of the things we talked about here and it's important in so many levels.

But that same report ended by -- it ended -- I actually have it, and here's a quote, "In every setting, whether it's a hospital, health plan, ACO, physician group, or facility, there were some providers that served a really high" -- they didn't say "really" -- "served a high proportion of beneficiaries with social risk factors who achieved high levels of performance." This suggests that high performance is feasible with the right strategies and supports, and so it's telling us that we're not getting good outcomes across the board. But somebody is somewhere.

And while I feel like this is an endless treadmill, the ability for us to do more to find those -- find who's succeeding and bring those lessons to others and find the policy levers with which to make them more broadly

accessible and available is just a challenge that we're never going to escape and one in which I think this Commission could also invest really constructively. So I think of it in both those tracks.

And, again, some of the work done today has been -- I know it's not the highest-profile stuff this Commission does, but it's been hugely impactful and helpful to us, and we're like really grateful for all of that over the last several years.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: Tim, thank you. As has been said before, thank you for your dedication. I'd also say thank you for tolerating some of the times our folks would push and challenge and try to keep moving the system.

MR. ENGELHARDT: I saw Patty very recently too. It's still happening, and I still welcome it.

COMMISSIONER GORDON: Yeah. She will do that the rest of her life. She's very passionate, as I know you are as well.

We in Tennessee had done a couple different things to get to where we were, but we're still looking at really how to evolve those models.

Chuck had made a comment earlier about -- and it piqued my interest when I saw the article as well about the shared savings with Washington because there was a model that we had originally proposed that there seemed not to be the interest to go on that path because of some of the -- at that time, some barriers about paying states from the Trust Fund.

MR. ENGELHARDT: Mm-hmm.

COMMISSIONER GORDON: I'm curious, and I'm not asking you to say where this will end up, but could you shed some light on what Massachusetts recently proposed? Because it sounds like it's going in a path that we had previously considered, and just help us understand that in the context. There's so many different things going on out there. That's one that seems to be a bit different.

MR. ENGELHARDT: Massachusetts has approaches us with many ambitious things, as have other states very recently.

Darin, I think if I don't hit the aspect that you want, please tell me.

But among the things that they had proposed was can the state become the recipient of the Medicare dollars

that are ultimately being spent to serve dual eligible beneficiaries and, therefore, become the single entity through which we contract with, whether it's health plans or providers or other things, and give them ultimately better ability to stitch those things into their broader alternative payment models and other things.

That was actually an approach that had come from several other states earlier on. We've heard it from another state very recently as well and one that we, I think, considered with great intellectual interest and with an eye toward the fundamental nature of what a change that would be from the Medicare perspective and ultimately never able to fully grapple with what that would mean from a policy perspective, what beneficiary protections that are really integral to the Medicare program would convey with such a financing arrangements or others.

So it remains a place of great interest. As I said earlier, we remain open in new ways to try to find ways to collaborate with states, and so where that lands, I guess I don't know yet, but it is one that has come up many times. And it's certainly easy to see why it would be a catalyst to take on some of the challenges that we talked

about here today.

CHAIR THOMPSON: Tim, you guys have spent some time as well on helping states obtain access to Medicare data, and I just wanted you to comment, perhaps, on kind of where you think the state of play is in terms of having the right data, both Medicare and Medicaid, both for CMS and for the states in terms of being able to understand the whole picture for these populations and orient strategies accordingly.

MR. ENGELHARDT: We did something that is so simple and so important, and we've kind of taken it for granted. And I hadn't even brought it up, so I'm so grateful that you did.

You can trace this back to the implementation of Medicare Part D, especially where a lot of the states -- I mean, they had all of the pharmacy information, which is important. You use that for a lot of different purposes. They had all the pharmacy information on dual eligible beneficiaries until Part D was gone, and then, poof, it was like that was all gone.

And so that really meant that without pharmacy, you really had such little insight into what even services

your most expensive population segment in the Medicaid program was even using. You didn't know when they were hospitalized. You couldn't drive quality metrics off of that information. You couldn't use it for risk adjustment. You didn't have it, right?

So we developed ways several years ago to feed -- it's not real time, but it's regular. It's in some cases weekly and other cases monthly, and we've just with Washington State started to do it daily, to feed Part D encounters and Parts A and B claim status to states for the purposes of care coordination.

That would enable you to equip, say, a case manager in a home- or community-based service program with the knowledge that this person had been hospitalized or whatever, which theoretically -- but we know we missed that stuff in a model that doesn't have the data accoutrements with it.

Similarly, prescription drug stuff, one of the first things that Washington State piloted for us when they were kind of our test site when we fed them this data is -- it was so cool, and this was years before. This was the biggest thing we talked about. They said -- they pulled up

and they said, "Here's somebody who just went to six different EDs across town and got filled opiates at every single one of them in the last two weeks," which they could do because they newly had the prescribing information that was through the Medicare program. It allowed them to find interventions too.

So the state of play is that we now feed that information to well over half of the states. I'm sorry I don't have the exact number. I will confess to you that not all of them have found ways to use it really seamlessly and operationally, in part, because it's hard to work with, and we've made significant investments too with various different contractors to help states match the data files, to deploy it.

More recently, we did a call last week in which we had great turnout from a lot of the states about ways in which you can access Medicare claims and prescription drug information to identify and monitor prescription drug misuse and especially opiates.

We have also expanded the use cases for the states. They can use it not just for care coordination purposes, but for program integrity purposes as well, and

we've already seen some of that application in various states.

So that's -- like it's easier said than done, like we'll feed you all this data, and then you can do stuff with it. But I think it's an important infrastructure step.

Since you asked, it's important probably for me to note the flip-side challenge at the moment, which is that I presented to you some evaluation findings, all of which ignored Medicaid data, because we remain in a place of -- we remain expectant of T-MSIS advances that will newly expand our ability to do some of the Medicaid analysis. It's a really necessary complement to get a full picture of how these different interventions are progressing.

So I think the state of play is that we've made a ton of progress on both sides of that equation, and we just need to keep investing more and more with states who understandably don't have like tons of extra analytic capacity to deal with, with files that they can do the access.

CHAIR THOMPSON: Great. Well, Tim, this has

been, as we expected, a very productive and enlightening conversation. We were eager to have you here, and it's been proven to be as useful as we -- and enjoyable as expected it to be. So thank you for being here, and again, thank you for all of your work on behalf of us.

MR. ENGELHARDT: Thank you all so much.

[Applause.]

CHAIR THOMPSON: Okay. We'll just take a few minutes while we're getting ready for our next panel.

[Pause.]

CHAIR THOMPSON: Joanne, I'm just going to give people a few minutes here. I think people might need a moment.

[Pause.]

CHAIR THOMPSON: Okay. We'll give the one-minute warning.

[Pause.]

CHAIR THOMPSON: Okay. Let's go ahead and get started for our last session of the day, last but not least, Joanne. I know a number of people on the Commission have been eagerly awaiting this conversation, so let me let you kick it off.

TELEMEDICINE: POLICY ISSUES

* MS. JEE: Okay. So it's the best for last. We're going to turn to Medicaid coverage of telemedicine to close out the meeting.

Commissioners, you have previously indicated your interest in delving into this issue area, particularly to consider its potential for expanding access to care for Medicaid enrollees. So this presentation is really just meant to provide a high-level overview of the state of play of telemedicine in Medicaid and then to really just kick off your conversation.

I'm going to talk with you today about federal guidelines for Medicaid coverage of telemedicine, give you a very quick overview of the status of state coverage, and then touch on some barriers and considerations for the use of telemedicine, and then end with some questions for you to think about in terms of any future work that the Commission might like to take on in this area.

All right. So there is very little federal guidance on Medicaid coverage of telemedicine. Neither the federal Medicaid statute nor its implementing regulations specifically identify telemedicine as a unique service.

However, on its website, CMS does speak to telemedicine somewhat briefly. It describes telemedicine as a cost-effective method of providing medical care through use of two-way, real-time, interactive telecommunication between Medicaid enrollees and a provider.

This definition is based on the Medicare definition of telehealth, which is what Medicare covers. However, there are some differences between telemedicine and telehealth. So where telehealth is generally considered to be a bit broader in scope, it could include activities such as consultation, training and administrative meetings; telemedicine is a little bit more narrowly focused on providing clinical care.

The terms sometimes seem to be used interchangeably, but for the purpose of today's discussion, I'll refer to telemedicine, which is the term, again, that's used on the CMS website, the Medicaid website.

CMS also notes some general rules that apply in Medicaid as also being applicable in telemedicine, and that includes that providers must practice within the scope of their state practice laws and their state licensing rules; and that payment for telemedicine must satisfy federal

Medicaid requirements related to efficiency, economy, and quality of care; and, lastly, CMS states on its website that states should use the flexibility that exists within the federal law currently to develop payment mechanisms and methodologies for services that incorporate telemedicine.

So that is pretty much what CMS has said for telemedicine in Medicaid. So states have quite a lot of flexibility in terms of their telemedicine coverage. They decide whether they provide it at all and, if they do provide it, what modalities they want to cover. And, in addition, they can apply restrictions to that coverage and conditions of payment.

So this table is just a summary of where states are currently with coverage of telemedicine services -- or services provided via telemedicine, and there is a lot of variation. The information here comes from a compendium by the Center for Connected Health Policy, and they looked at policies across all of the states, and this is just, again, a high-level summary.

Live video is the first modality there on the first row there, and it's also referred to as "synchronous telemedicine," and that's real-time interaction between a

patient, a caregiver, or a patient's provider with another provider at a distant site using audiovisual technology. And you can see here that nearly all states cover live video. It's 48 states as well as the District of Columbia.

Next on the list is store and forward, which is referred to as "asynchronous telemedicine," and store and forward is the secure transmission of data so that could be photos, videos, sounds from a patient at a care site to providers, including specialists, at another care site for evaluation. And you can see that there are substantially fewer states that cover this, with 13 noted there on the table.

On the third row is remote patient monitoring. This refers to the transmission of patient health and medical data such as vital signs or blood glucose levels that are collected at the patient site, typically by the patient, and transmitted to a provider in another location. This modality is one that's commonly seen for chronic disease management, and there are 22 states that cover that.

The last row on this table is Mobile Health, sometimes called "mHealth," and this is the use of mobile

devices such as smartphones to provide beneficiaries or enrollees with health education or reminders to take medications. Now, this is a newer modality, and there isn't any data yet, at least collected by the Center for Connected Health Policy, on the extent of state use or coverage of this.

Okay. So as I said, states have a lot of flexibility in designing their coverage for telemedicine, and that includes placing restrictions on that coverage and the conditions of payments. Some states restrict the specialties for which telemedicine is allowed. For example, New Jersey covers only telepsychiatry, whereas there are many other states that cover many more specialties. For example, Arizona covers 18. The trend over the years has been for states to expand the specialties for which telemedicine can be used, particularly with respect to live video telemedicine.

With respect to the store and forward modality, states also seem to limit coverage there. For example, California covers store and forward for dermatology, ophthalmology, and dentistry.

States also limit what services are eligible for

coverage through use of telemedicine. Sometimes they're covering services such as office visits, inpatient consultation, screenings and assessments, therapies, and pharmacological management. So not all services that are provided on an in-person basis are also then covered through telemedicine.

Next on the list are restrictions on providers. Only certain providers are eligible for providing telemedicine in some states. The American Telemedicine Association, in looking at Medicaid policies across the states, created a list of 32 providers that are identified in Medicaid policy as being eligible. So, again, there is some state variation in terms of which providers are permitted. Examples include physicians, nurses, clinics, podiatrists, and substance abuse and addiction specialists.

The originating site refers to the location where patients are during a telemedicine visit. Traditionally, health care facilities are designated as originating sites, and places like homes and schools and workplaces are less commonly covered. In 2016, 36 states allowed homes to be covered and 18 allowed schools, and that's data from the American Telemedicine Association.

Some states also have distance and geography requirements on their coverage for telemedicine. This is not as common as in Medicare, which, of course, only covers telemedicine in rural areas. Some states do, however, have limits -- or limit telemedicine coverage in rural areas. For example, New Hampshire allows telemedicine in rural health professional shortage areas or in a county that's not a metropolitan statistical area.

Indiana has a different requirement where they set a minimum distance between the patient care site or the originating site and the distance site. So those have to be 20 miles apart in order for the service to be covered through telemedicine.

All right. So, not surprisingly, there are a number of barriers for use of telemedicine. The first on the list here is coverage and payment. I mentioned the limits that are placed on covered modalities, services, and providers that exist in some states. These often reflect, you know, state policy choices, but for some states, the definition of telemedicine itself might be limiting if it specifically says that telemedicine is defined as a live interaction. So that can prevent states from covering

other modalities, the asynchronous modalities.

And when telemedicine is covered, the payments sometimes are lower than for in-person services. And so this lack of parity in payment could affect provider willingness to participate in telemedicine.

The second on this list is connectivity and technology. It goes without saying that telemedicine requires access to reliable and affordable broadband connectivity, and in rural areas where telemedicine, you know, has the most -- maybe has the greatest impact or could have the greatest impact on access to care, there sometimes isn't the connectivity that is needed, or it's not affordable.

State licensure is also cited as a barrier to telemedicine. While specific state rules vary, many states require that physicians providing telemedicine services be licensed in the state in which the patient lives. And some providers are licensed in multiple states, but the process to be licensed in multiple states can be complex, burdensome, and costly and could impede a provider's willingness to pursue that.

There are some efforts to ease licensure

restrictions such as through interstate licensure compacts, but my understanding is that these compacts yet are not fully operational, although there are some states that have signed on to those.

And, lastly, there are concerns about cost and quality of services provided by telemedicine. In general, the research seems to indicate that telemedicine can be cost-effective for at least certain services, such as monitoring of patients with chronic conditions or for some mental health services or dermatology. However, there are some concerns that the expanded access that telemedicine affords could lead to overuse of services and, thus, increasing costs. Cost-effectiveness is commonly cited as an area in need of greater research.

And, lastly, with respect to quality, there are some concerns about the potential for duplication when telemedicine services are used. There are some patient safety concerns and some concerns about the ability to preserve the relationship between patients and providers.

Okay. So that is a very high level overview of telemedicine in Medicaid, and as I said, it's really just intended to jump-start your conversation this morning. As

we look to any future work in this area, it would be very helpful to hear from you today on whether your interest in telemedicine is sort of a general interest and a broad interest in this topic, or if there's some narrowing of focus in telemedicine that you would like to do. For example, are you interested in certain modalities? Are you interested in certain services such as behavioral health or dentistry? Or is there some other barrier that you're interested in looking at?

The next on the list is: What are the federal policy levers to encourage greater use of telemedicine in Medicaid, to encourage greater adoption by states, or to encourage participation of providers? And, lastly, what additional research on Medicaid coverage of telemedicine do you think that the Commission ought to pursue?

Lastly, I'll just mention there is a draft of a brief or a fact sheet in your meeting materials, and if you have any comments on that, I'd invite those as well.

CHAIR THOMPSON: Thank you, Joanne.

So Chuck is going first because he has to run.

COMMISSIONER MILLIGAN: Thank you.

CHAIR THOMPSON: And then we have Martha, Peter,

Toby.

COMMISSIONER MILLIGAN: Thank you. I appreciate it, Penny.

Thank you for the presentation, Joanne. My own view is that I think this would serve for a good chapter in the June report, think that as kind of a comprehensive backgrounder I think to kind of build on what you've already started as opposed to kind of weighing into the policy stuff yet. I think we need to do some level setting first. It would be my preference personally.

I think that in terms of issues and barriers, I would identify a couple of other things for consideration. I think one of the issues -- and I'll just -- on the managed care side, health plans that are pursuing telehealth in various forms, to kind of get credit for it, so to speak, with building into the rate-setting process, there needs to be a mechanism by which the state recognizes, accepts encounters or that there's a work-around to address it. And I know that one of the emerging barriers is if the state itself doesn't have a code, doesn't pay that modality in telehealth in fee-for-service, that typically the state system doesn't accept encounters.

And so that discourages use of telehealth and/or it makes it an admin sort of value-added expense.

So I think there's an interplay between the IT framework at the state and encounters and rate setting that ought to be considered when this applies to the managed care part of Medicaid.

I think in the backgrounder or, you know, the chapter that I'm proposing here, I do think that it's also helpful to elaborate on not just the modality portion of it but the Medicaid population portion of it that is served by telehealth, and I'll just mention a couple.

One is I do think that things like remote patient monitoring really help support community-based long-term services because rather than having some of the electronic diagnostic stuff need to occur in a facility, you can do some of that early-warning system stuff with somebody in an HCBS setting. So I think that that population focus would be helpful, and the other population focus I would propose are people with behavioral health needs who often in their patient communities don't have access to a provider that they can get to, but if they can find the originating site, they can then find probably the specialist or psychiatrist

who might be practicing in an academic medical center or other setting and allow, therefore, the delivery of the access of care for that particular condition in somebody's local community.

So I think I guess what I'm proposing is to also think about it from a population perspective, not just a modality perspective.

Thank you.

CHAIR THOMPSON: Thank you, Chuck.

Martha.

COMMISSIONER CARTER: Joanne, thank you for your baseline work on this. I think it really opens the conversation for us, and I think telehealth, telemedicine is definitely the wave of the future, especially for the populations that we're particularly interested in here.

I want to highlight this issue in the context of the community health centers, which are also FQHCs. The health centers serve 26 million people, 92 percent are under 200 percent of poverty, and about almost 50 percent of Medicaid or CHIP.

And, at this point, the health centers are authorized to serve as originating sites, which is where

the patient sits, but we're not authorized to serve as a distance site. So while the health centers have received bipartisan support and funding and have been encouraged to grow, this is a barrier for the health centers in terms of reaching the populations that we are charged to reach.

So I think that some of the states have -- I'm not sure exactly what the states have done, but I think it would be interesting to see. I heard that Georgia has done something around telehealth, telemedicine for community health centers, so that they can be reimbursed as a distance site.

In my own little part of the world, I'm in a rural state and four counties. So right now, I can have a psychiatrist in one county needing -- I mean a patient in one country needing a psychiatrist, to echo what Chuck said, and we can't provide that service within our organization, even though we've got the capacity, we've got the staff. We can't get paid for it.

So I think it's a real barrier to serving the populations that we are trying to serve, especially as we look into substance abuse services and mental health services.

CHAIR THOMPSON: And just to clarify that point, Martha, so is that a prohibition associated with the community health center definitions or if it's not Medicaid --

COMMISSIONER CARTER: It's a CMS -- it's a CMS FQHC ruling.

CHAIR THOMPSON: So it's about the provider type rather than as a Medicaid policy coming from either CMS or the states.

COMMISSIONER CARTER: It's CMS. So community health center is a HRSA designation.

CHAIR THOMPSON: Right.

COMMISSIONER CARTER: FQHC is a CMS designation. And so it's a CMS FQHC issue.

CHAIR THOMPSON: Yeah. Okay. Good. All right. Thank you.

COMMISSIONER CARTER: Not in the health center, HRSA definition.

CHAIR THOMPSON: I see. Okay. Thank you. Thank you.

Peter, Toby, Brian, Kisha, Marsha. Did I miss anybody?

COMMISSIONER SZILAGYI: Thanks. I'll be brief. This is very good, and I would also support what Chuck and Martha said about this would be a really great chapter. I think this is an example of where sort of a broad initial chapter demonstrating variations, demonstrating variations across states.

I do think we could increase the focus of the benefit to the rural population. We haven't really focused that much on rural populations at MACPAC, and I think this could be a good example.

So I would think sort of a broad chapter, and then in future chapters and other types of topics, telemedicine could be a component of that, but I think it would weave that very well.

I do think the example of improving access in certain specific areas is really, really important in telemedicine. Take dental where we know that the access in quality of dental care is really low. There's now new types of dental providers, like dental hygienists, which may be available in underserved areas, and telemedicine would be a wonderful way of improving access to care in certain rural areas.

And Gustavo had to leave, but he actually wanted me to also point this issue out about dental hygienists. But it's not just dental care. In the pediatric world, pediatric super-subspecialists are rare, and it's very difficult for people who are hours and hours away from these super-subspecialists, which are almost always in children's hospitals right now, to access the pediatric -- so this is another great example. So dental care, pediatric super-subspecialists, ophthalmology, and behavioral health, I think, are great examples.

I also think this foundational chapter could start delving into cost, as you talked about, in a balanced way. It's not that obvious that telemedicine will reduce costs. It may improve access and improve costs at the same time, and I think that's -- and it may sometimes improve access at a lower cost. But I think we could really do a balanced view of cost.

There is this concept in telemedicine of drift, and we may drift toward more and more and more telemedicine services, some of which are not so necessary and some of which are necessary. So I think sort of a balanced look at costs would be really great, but I would support sort of a

foundational chapter. I think this is a really good start.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: Definitely the same support for a chapter on this.

I'd say the other context is the managed care regulation goes forward on network adequacy. For plans as well as states using this as an alternative access standard, it's going to be really important, and so having clear guidance on this and providing it.

In terms of the -- a couple comments on the modalities. I mean, there are so many definitions, but I would add one important modality that is emerging is around e-consults, so provider to provider -- not just education, but consultation from a primary to a specialty within a visit. And this is one area, back to Chuck, along with remote monitoring is the complexity of -- there aren't codes, and so managed care plans that might be trying to use this as a way to both improve access, reduce cost, aren't able to build it back into the rate setting. So I just want to call that as one modality.

The other, which New Mexico gets the biggest credit, is around Project Echo and the focus on kind of

provider education is becoming more and more of another area of telehealth, so just a couple areas to focus on that need to be done.

The other is just the intersection with Medicare and making sure if we're -- a lot of states say, well, Medicare doesn't have a code, and Medicare hasn't really made much focus on this. And a lot of that has to do with the fee-for-service focus within Medicare and fears of just program integrity, but if they could even just look at it within a Medicare Advantage environment, so that then the Medicaid plans -- the Medicaid could look at it within their managed care plans, where there is really more of a -- you know, this is a shifting of services rather than the fear of increasing, but it's a capitated environment, I think that would help. So something -- this might be again of how do we work with MedPAC on having a discussion around the alignment of codes here, so I'll stop there.

CHAIR THOMPSON: Good.

Brian.

COMMISSIONER BURWELL: So I would like to broaden the focus beyond telemedicine to include kind of an LTSS prism on this as well. In the LTSS space, the focus is

much more on remote monitoring, and we've actually done some work in this area for CMS. And the commercial development of remote monitoring devices for people with chronic conditions is just exploding. I mean, this is going to be huge over the next five years.

And there are all kinds of devices. I mean, there are devices that people can wear that detect whether somebody is at risk of falling, you know, that monitor their gait, so not really -- and it's amazing how much technology is being applied to this area, because, I mean, everybody sees the senior market. Technology is better. Companies see this.

An issue is, in my mind, that the primary target market for these technologies is the high-end market, because these things are not cheap, particularly when they first come on the market, so then there's going to be a Medicaid -- it's going to be almost like the drug thing. Well, these things are good and they can help people, but can we afford them? Are they worth it for Medicaid?

Obviously, to have monitoring devices in people's homes so that case managers don't have to go out -- and there's a huge potential cost savings in there, but the

whole financing and cost-effectiveness equation becomes much more complicated. You have a centralized station where those monitoring impulses come in, and does the state do that? Does the plan do that, et cetera? I think it's going to be a very interesting development over the next few years.

CHAIR THOMPSON: There are places where this starts to bleed into medical technology, and so I think we're just going to have to think about this, some of those devices --

COMMISSIONER BURWELL: I mean, we might want to draw some lines. Right.

CHAIR THOMPSON: -- that we're talking about that are assistive devices, for example, and so forth.

COMMISSIONER BURWELL: Exactly.

CHAIR THOMPSON: So we probably just need to make sure we don't make this too big for you.

Kisha.

COMMISSIONER DAVIS: Sure. So I'll keep echoing the excitement about this and wanting to move in this area. When I think about kind of where our focus should be, it's really about how this can open up access for folks in rural

and urban communities, also, but really how does this change the access game for patients.

Also, when we're thinking about cost, the telemedicine model leads very nicely to a more comprehensive payment model. You don't save much if it's just you're substituting a 99213 in the office versus at home, but if I am getting a comprehensive payment and I can then say, well, I can see that patient on the phone or via video or in the office as opposed to having to say within this rigid fee structure, then it makes it -- you know, there's just not as much of an incentive to do it that way, and it really helps to kind of get off that hamster wheel.

Just a couple more points about the licensure issue and how sticky that can be. Just thinking about in my own areas of -- my practice is in Maryland. I have patients who live in Virginia and work in D.C. I have a Maryland license. I can see them in the office in Maryland, but I can't do a telemedicine visit for them in Virginia because that's where they live, so where is that ease of flexibility? And so when you're thinking about something, trying to make things more flexible, some of the licensure issues actually make it more difficult as you're

looking across state lines.

And then just the importance of distance, thinking about it not just about the rural areas, but even the inconvenience of a mom having to bring all of her kids across town on two buses to get to a site.

And I did just want to highlight this e-consult idea, and so some practices are even trying to do the e-consult with the primary care doc in the office. So if you can have the specialist and the primary care and the patient all together and find a way to bill for that, that's really powerful for the patients and allowing that ability to coordinate care.

CHAIR THOMPSON: Good. I have Marsha and Sheldon, but before I jump to you guys, Leanna, as we're here talking about what this does from a patient perspective, especially in some areas of the country where there may be some access challenges, have you had any experiences or can you speak to what this means for beneficiaries?

COMMISSIONER GEORGE: I haven't personally had the opportunity to participate in telehealth/telemedicine. However, I can say that when my daughter was coming out of

the Murdoch Center, Development Center, in North Carolina, we were waiting like three or four months to find a psychiatrist to be able to serve her in the community. That's an area where telehealth could possibly have brought her home sooner, saving money for the government, because it was obviously Medicaid paying for the institutionalization at that time.

Also, even with just routine medical checks with my son, you know, usually a very quick in-and-out, maybe ten minutes at the hospital -- or at the clinic, but it's 40 miles away from where I live. So if you consider that round trip, if you had to take your child out of school, you're missing half a day of school just to take care of a 20-minute medical recheck, medication recheck. So this really affects a lot of different areas for our kids, not just for parents, too.

CHAIR THOMPSON: Thank you for that.

Marsha?

VICE CHAIR GOLD: Yeah, I think I want to support and expand on some of what people have said.

First, I don't see any reason not to go forward with the brief, which is prepared that way, but I also am

in favor of expanding on that information and knowledge for a more in-depth chapter in the June report.

I like the idea of going back to sort of a population focus, and I'm reminded that in the early years -- we have an access framework that the Commission has developed, and we even talked about the determinants of access in each of those things in one of the early reports. And it seems that what a lot of people are saying are the ways in which telemedicine may or may not interact with that access framework and its determinants.

So, for example, we know in Medicaid that access to specialty services is a problem. Some of that is just pure availability, especially in rural areas. But it also is provider participation and patient convenience. And so the question is, clearly, when you can use telemedicine, you expand the geographical area so you can deal with patient convenience and availability, but then does it make physicians any more willing? Can you get specialists who are willing to do it? And so some of your findings on where specialist participation is a barrier even with this become relevant.

I think some of the other modalities that you

talked about get into quality and chronic disease management and the extent to which these may or may not contribute to better outcomes. So I think putting that in context is helpful.

The cost issue, I think that recognizing -- there are cost tradeoffs and some of the concerns that you're using it where you might not need to or it's just duplicative, but also realizing that in a lot of situations, you're in a managed care environment. So, presumably, there's some, you know, tamped on the health plan side to figure out what is a cost-effective use or what isn't. So when we're talking about this, I think it's important not to assume a fee-for-service application, but that a lot of these applications occur in a managed care environment, which may also be best able to figure out some of these tradeoffs. And so some of the barriers Chuck talked about, or others, fit in there. So I think that may help create some better package.

In the materials you gave us, you talked about some of the AHRQ studies of what's effective. I think a bigger -- all this occurs in a context of, you know, what do we know about what is and isn't effective at this point

in time with telemedicine. I assume what we're talking about is promoting things that we believe are effective ways of using that modality to address some of the existing access dimensions and outcome needs that exist in the population.

CHAIR THOMPSON: Thank you for that, Marsha.

Sheldon and then Fred.

COMMISSIONER RETCHIN: I have to admit I'm a little naive about the telehealth technology. I've never used it -- I mean, I Skype with the twins but --

[Laughter.]

COMMISSIONER RETCHIN: Actually, I'm having problems collecting their co-pays.

So I'm curious a little bit about some of the technology barriers, how easy it is to use and then bill for it. There are some private or public companies out there, and the marketplace response has been a little sluggish, but Teladoc, American Well, they've not really taken off, and I wonder if there's a barrier there.

But there is a moral hazard in fee-for-service that I think is real, whether this is cost-effective really or not. I actually think it fits a lot better in a

capitated environment where people will use it as they like. But I echo what Marsha said, and that is that I don't think we should assume that telehealth is going to solve the low participation rates of some specialists and providers everywhere in Medicaid. Witness -- boy, if you look at participation rates nationally on psychiatrists in Medicaid, it is startlingly low. And I think offering this, unless there's a huge boost in payment, is probably not going to help.

But just two more issues. One is I don't know if you mentioned, Joanne, the issues of broadband Internet access in remote rural areas is, I think, going to be an issue. So the very population you want may or may not have access to streaming.

And then the one area where historically it has been very cost-effective is with prisoners, and that's something to note, particularly with regard to evolving Medicaid policies on the inclusion of prisoners for Medicaid. So just a thought.

CHAIR THOMPSON: It's an interesting thought.

Fred?

COMMISSIONER CERISE: Just a couple of comments.

One, I agree with the general approach that an informational piece would be interesting. I'm not sure from a policy perspective how much we could expect to introduce here because it does become, I think, a question of how do you -- it's a technology that works to provide access, and then how does that translate into the delivery system. Kisha's point I think is spot on, and that is -- and others have echoed it -- a comprehensive payment system is where it might work best because of the concerns on generating demand with ease of access and you start generating activity, either on the provider side, a real concern there, or just, you know, ease of availability that you access services that ordinarily you might not.

It's interesting. Where you've seen more development is in those areas where you don't have a payment model to worry about, prisoners, for instance, some very advanced models in working with jails and big delivery -- some of the universities have done that work and worked out the models and shown where it has worked across a number of specialties, including things like orthopedics when you're preventing transport of prisoners back and forth.

I think just a couple others comments. E-consults is another area of extreme convenience for patients. This morning, the grand rounds I'm missing at our place is on the presentation of e-consults in our GI Clinic, and we've been able to deflect 70 percent of the referrals for GI Clinic. And out of that 70 percent, 70 percent of those never result in a specialty visit. And so when you think about it from the beneficiary's perspective, you know, you're talking about people taking off more work, transportation, all of those things, that if that could be handled from a primary care to a specialty through email.

Now, that implies a lot of connectivity with those systems, right? You've got to share the same electronic record. You've got to have access to images and labs and things like that. And so there's degrees of integration that the more integrated comprehensive payer system, those models I think are real strong, the more fragmented you get, the more opportunities you get to just further fragment care and lose control of costs and down a path that's probably not going to be a good path.

CHAIR THOMPSON: Well, as always, what a great conversation, and, you know, we didn't run out of energy at

the end of the meeting. Certainly, this topic is being enthusiastically received. I think that we do see a desire to have a brief chapter.

I think I may be still holding out hope for some particular recommendations, at least insofar as we identify barriers that we think ought to be taken down to allow people, whether that's codes or Martha's point about, you know, the treatment of health centers and some things like that. Maybe this is one of those areas apropos of our conversation yesterday where there should be some explicit invitation to experiment or innovate or test some different kinds of models.

So we'll see where this takes us, but I think there's a great appetite here for continuing this conversation, and thank you, Joanne, for a wonderful presentation.

We are now open for public comment at the end of this meeting on this topic or any others that we have been discussing over the last day and a half.

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: And seeing none, we are adjourned. Thank you.

[Whereupon, at 11:45 a.m., the meeting was adjourned.]