PUBLIC MEETING

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

Thursday, April 19, 2018
9:30 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[9:30 a.m.]

CHAIR THOMPSON: Okay. If I can give the one-minute warning and ask everyone to make their way to their seats so we can get started.

[Pause.]

CHAIR THOMPSON: All right. Good morning, everyone. Welcome to day one of our April MACPAC public meeting. We are very pleased to have this panel to kick us off. It's going to be twice the goodness, because we made an attempt at this once before, and I want to particularly thank Kevin and Arlene who came from out of town. And we're here when our last meeting was cancelled due to wind, of all things, not something that we had foreseen, and we had been talking, even the day before, about how much we have been looking forward to this discussion. So we are very pleased that you were willing to give this a go again, and really eager to have this conversation.

So as is often our practice, we'll hear from the panelists, we'll let them each go through their presentations, and then have an opportunity for Commissioners to engage with the panelists and ask

questions. Then we'll take a little break and let our panelists go, and then we'll have a Commissioner conversation discussing the implications of what we've just heard and what that might suggest for future work for the Commission.

So I'm going to ask Rick Van Buren to kick us off and introduce our panelists and get us going. Thanks, Rick.

PANEL ON STATE APPROACHES TO FINANCING SOCIAL INTERVENTIONS THROUGH MEDICAID

* MR. VAN BUREN: Thank you, Penny. Good morning. As Penny said, we'll now have a panel to discuss how state Medicaid programs can finance social interventions. This panel is the first of several planned efforts underway to explore Medicaid's role in addressing the social determinants of health.

Social determinants of health, which can include a person's economic stability, education, housing, transportation, and local supports are among the most influential factors affecting the health of individuals. Accordingly, states are increasingly looking to incorporate consideration of the social determinants of health into

coverage, payment, and delivery models intended to reduce costs and improve health outcomes in Medicaid. This panel will discuss different strategies states can use to leverage Medicaid funds to address the social determinants of health within existing Medicaid laws and regulations.

Our first panelist will be Jocelyn Guyer, Managing Director at Manatt Health. Ms. Guyer holds policy expertise, strategic advice, and provides technical support to states, foundations, and a range of clients on Medicaid and CHIP. She has co-authored several papers that examine social determinants of health, including a paper included in your materials that discusses how states can use different Medicaid authorities to address social issues.

Our next panelist will be Dr. Arlene Ash, Professor at the University of Massachusetts Medical School. Dr. Ash led a team of researchers who analyzed program enrollment and claims for Massachusetts' Medicaid program to identify social variables that influence medical costs and compare different payment models, including one that accounts for social determinants of health.

Our final panelist will be Kevin Moore, Vice President for Policy with UnitedHealtcare Community and

State. Mr. Moore focuses on the development of sustainable interventions that improve the health of UnitedHealthcare enrollees by identifying and addressing social, economic, workforce, and transportation and nutritional barriers. Prior to this role, he was appointed by Governor Scott Walker to serve as Wisconsin's Medicaid Director and Administrator of the Division of Health Care Access and Accountability.

And with that I will turn it over to Jocelyn.

* MS. GUYER: Good morning. Thank you so much, Rick. So what I'm going to do is walk through for you some research that we recently completed on behalf of the Commonwealth Fund on practical strategies for integrating the cost of addressing social determinants of health into Medicaid managed care.

I will acknowledge, up front, that we skipped over, in this analysis, lots of the conversation about is it appropriate for Medicaid to address social determinants of health? How far should it go? Are the community-based organizations ready to tackle this? Lots of important issues that I'm sure is part of what you're talking about, and we took, as our charge, let's assume that there is

agreement, at least in the states that are interested, that they want to figure out how to finance appropriate social interventions consistent with Medicaid's mission. And so let's look at the tools that are available to do that. So I will acknowledge there is much more to say and debate, but this was the task before us.

The way that we went about it is first we worked with an actuarial firm, Milliman, that is not here today but that was central to this analysis and helped us think through, really from an actuarial perspective, how do we make this potentially real, what tools are available to states.

We did a comprehensive literature review to look at ideas and options. I will say there is not much in the literature. There's a lot about the importance of social determinants, much less on, okay, given if you accept that, what do you do about it? But we certainly did review that. We had a chance to talk to 25 experts, and we had an advisory committee, and I want to acknowledge right off the bat that we had the opportunity to have both Stacey Lampkin and Toby Douglas as part of our process, and so we very much appreciate all of their contributions, although they

hold no responsibility for an errors or any problems that you see in the analysis.

The context in which we did this work was, as I said, a knowledge, and as Rick already outlined, the clear evidence base that socioeconomic factors are key in driving health outcomes, and that was an underlying premise and foundation. We focused intensely on what are the tools in the Medicaid managed care context, simply because we are, at this point, seeing a vast majority of states rely on Medicaid managed care and increasingly Medicaid managed care for those populations where social issues are even more of a challenge, including severely mentally ill folks, people with disabilities. And so that was our frame -- what can we do in the managed care context?

I think the other key frame to mention is all of this discussion and the effort to identify tools occurs in the context of states increasingly looking at how to use alternative payment models in Medicaid managed care, and so we thought there were some interesting opportunities to explore there, and, in fact, that is one of the areas where we heard some key ideas coming out of the leading edge states.

The backdrop for the conversation about tools and options, in order for them to kind of make sense -- and I'm sure that all of you know this well, but we felt in the analysis we needed to outline the key steps in the Medicaid managed care rate-setting process, because that's the framework against which we needed to identify tools.

As I think folks know, and this goes through -- and somebody told me I think we brought a MACPAC beautiful chart, possibly, for this. At the heart of it, actuaries start with the claims experience, and so right off the bat one of the questions that comes up is if a Medicaid managed care plan has made investments in social interventions; is that considered a claim that is then used as a building block for Medicaid managed care rate setting, and we'll talk about that a little bit.

Actuaries start with the claims, make all sorts of magical adjustments. The other key piece of the rate-setting process that we needed to tackle in this analysis is the CMS regulations are clear that when actuaries and states set rates, they need to be sure that the projected medical loss ratio for the rate is 85 percent or more. And that's a super-technical issue, but it comes into play very

much in the context of the conversation about social determinants, because plans need to care about how their investments in social interventions factors into the medical loss ratio, and so we'll talk to you a little bit about that as well.

So against that backdrop, those are the key questions. Where are the costs of social intervention showing up in the rates? Can we have them show up in the rates so we can pay plans for them? Where did they show up in the MLR calculations so that plans don't need to worry if they make these investments, they're going to miss their MLRs? And then, finally, another issue that we heard about, and I would say there's a little bit of controversy on it, is when we spoke with plans, some of them said, "Even if you can fix those first two problems for us, we're pretty concerned that if we make super cost-effective investments in getting people into housing and food and get their medical costs down, we're still going to end up with a lower claims base and lower rates over time, and that's premium slide, and that's a problem for us."

I will say it was controversial, in part, because actuaries and others pointed out that that, in fact, is a

purpose of Medicaid managed care, is to drive down costs, and that that should be considered a good thing, and as long as plans have appropriate profits that should not be an issue. But it was something that we certainly heard about.

In terms of the specific options, the first and the most straightforward one is that there is some flexibility in the current Medicaid statute and regulations to classify some social interventions as Medicaid benefits. So states can submit state plan amendments to cover, in Medicaid, the cost of case management, much of which is linking people to social supports. And so very straightforward. There are, however, federal regulations around how that's done. It's not carte blanche flexibility for states. And, of course, the existing benefit options stop short of states being able to really dive in and use Medicaid in any way to finance social supports directly. So you can connect someone to housing but you certainly can't pay for housing. You can connect someone to food but you can't pay for food under the state plan benefit option.

We've certainly seen states look at waivers as a mechanism for securing federal Medicaid matching funds and

for building the cost of social interventions into their Medicaid managed care rates and their programs. Oregon is the best-known example, which has gotten a waiver that allows its MCOs -- and they have a different name for them in Oregon -- but essentially it's MCOs to finance health-related services and to have that be part of the rate-setting process in Oregon, and we can talk more about the details on that if folks are interested.

I think one of the more leading edge, kind of interesting ideas that came out of states, and I would point you -- we have an appendix to this slide. It's a discussion of Arizona, which I think has comprehensively thought about a range of strategies to address social determinants. One of the things Arizona does is use value-based payments. It directs its plans to make value-based payments at a certain level, and then what it is finding is that its plans will turn around and make payments to Medicaid providers who then have the flexibility, because it's a value-based payment, it's not linked to a specific service, to decide, I have this resource to figure out how to best serve this individual who is maybe homeless, who maybe has a severe mental illness. Some of what I'm going

to do is pay for health care for that person, and maybe some of what I'm going to do is invest in connecting them to housing and getting them stable housing so they are not going in and out of the ER.

So the value-based payments, in some ways, create more flexibility for frontline providers to decide to invest in social interventions when that's cost-effective relative to more traditional medical interventions.

The other kind of thing we've seen in Arizona is another place we see it, is there's flexibility for states to provide Medicaid managed care plans with either incentive payments, up to 5 percent on top of their capitation rates, and if they want to, states can structure those incentive to be linked to plan performance on addressing social determinants of health. Or even we're starting to see ideas like incentive payments linked to plan performance on social determinants and the plan's willingness to make a specified level of investment in social interventions, and that's an idea that is increasingly under consideration in the states.

I would note, back to that rather technical MLR issue, one of the things that became apparent in our reg

review is there is a fair amount of flexibility for states, at their discretion, to decide that a plan's investment in social interventions should be considered on the same status as medical costs, should be part of the numerator of the MLR, should help a plan meet its MLR. And so one of the things that we talk about in our analysis is the federal regulatory structure that allows states to go ahead and do that.

And then, finally, the last option that we're seeing states look at takes advantage of the fact that when setting Medicaid managed care rates, states typically build in a profit somewhere between 1 to 5 percent. They do not have to provide every plan with the same uniform profits. A state could decide to reward a plan that is meeting its objectives with respect to social interventions with a higher profit margin, and this is something I want to acknowledge Oregon has done some of the lead thinking on this and is looking at this and looking at implementing this now.

This is one of the few options that addresses that premium slide issue that we heard about at the beginning. So you could potentially say to a plan, "You

did a great job. We know you're worried about your rates going down, because you were so cost-effective. But we can compensate you with a somewhat higher profit margin if you've met our standards."

Those are some of our ideas and options, and I'm happy to talk after the rest of the panel.

MR. VAN BUREN: Thank you, Jocelyn. We'll now hear from Dr. Arlene Ash.

* DR. ASH: Good morning. I've made too many slides so I'm going to whip through. I've been working for several years with Massachusetts Medicaid and CHIP plans and building models that incorporate social determinants of health into our payment formulas, and working also with the state to incorporate social determinants of health into some of our quality measures, and to pay attention in evaluating our most recent five-year waiver.

Okay. So I'm just going to tell you what we did and where we're going with it.

So when I started working with the state in 2014, they had already been using, as many, many folks have since the turn of the century, have been using claims-based medical risk models. We were using a commercial version of

the same model that our team built decades ago for CMS, the HCC relative risk score. So we basically take age, sex, and all the medical problems observed during a year on medical claims and create a summary measure of expected health care costs, and then it's relativized -- that's the first R in relative risk score -- so that a 1 means average, and if the state is planning to spend $5,000 on average per person in the Medicaid program, then a 1 means the provider who agrees to care for that person will get $5,000. It's a little more complicated than that. There's adjustments for geography, et cetera, but that's the idea.

So we were told that the state is about to embark on this whole thing, to get a new waiver, to move lots of people into these alternative payment mechanisms, to create ACOs, accountable care organizations, and we'd like a better model. We'd like to find new variables that will help us really characterize risk. And there was a very, very long, large, open stakeholder engagement process.

So the model that we built for them, Version 1, went into effect October of 2016. Version 2 actually went into effect last month. And we do use social determinants of health data as well as age, sex, and diagnoses. And the

thinking was that, to the extent that we could surface the actual cost associated with these social problems that it would facilitate activities to address them. And whether we'll get there, I don't know, but that's the experiment on which we are embarked.

So we had a very simple constraint. We were not going to be able to go out and collect any new data. We had to work with what was there. And our way of looking at models and asking if they were good enough was to say, "You name a vulnerable subgroup that you're worried about. We'll see how this model pays for that group and whether that payment, the expected payment under the model, is in line with the historical payment for that group of people."

So we had claims data. We had enrollment files, MassHealth's medical information system. We used address data and we used address data in two different ways. One was to say if a person had at least three distinct addresses during the year, that's probably not going to their home in the Hamptons over the summer, and that's probably a good marker for instability in somebody's life. We also found that there was a code, among the ICD codes, for homelessness, and it was certainly underused, but

actually when it was used it was a marker for people who were substantially more expensive than they would be expected to be, based on their diagnosis -- their medical diagnosis codes alone.

We also wanted to introduce some differential payment based on disability. I learned that not everybody who is disabled is entitled due to disability, and not everybody who is entitled due to disability has a disability which has substantial medical costs. So we created a hierarchy in which we recognized people who were clients of the Department of Mental Health, clients of the Department of Developmental Services, and if not either of those then people who were simply entitled due to disability. And each of those factors carried costs, the mental health client being the most.

And the relative risk score that we were using out of the box does have age, sex modifiers as part of it, but we found that it didn't work well and it underpaid for kids, so we threw in, in addition to the relative risk score, the new variables that we added age, sex categories to tune and improve -- actually increase the payment for kids.

We also, in this exercise of asking people who they were worried about, people with serious mental illness, people with substance use disorders, they were a special concern, and when we built the model the first time around we noticed that unless we put in separate markers for those problems we were not getting the payment high enough. I will tell you that for reasons we don't understand in Version 2 we no longer need those extra markers. So they're not just there because, ideologically, we think they should be there. They were there in Version 1 because they proved needed to get the payments right. They are not there in Version 2 because the other information that's in the model already captures their costs and gets it right.

Lots of things we would have liked to have addressed, but we didn't because we couldn't. There were several reasons why we couldn't do some things. Limited English proficiency has the problem that the cost of dealing with that is not part of the claims data, and so if you actually put in a marker for limited English proficiency into your model, it will come up with a negative coefficient, which probably reflects both the fact

that the real cost of caring for these people is not fully reflected in the data and also the fact that it is likely that there's an access problem. So we couldn't deal with that this time around.

There's a bunch of other things on this slide, which we didn't put into the model. I say we didn't address race ethnicity, but actually, we did pay attention to it in the sense that over 60 percent of our people had identified race ethnicity. And we made sure that even, although we did not put that factor into the model, that the payments at the level of racial or ethnic subgroups were right.

So the model was allocating the right amount of money. We didn't need to have a variable like that, which is politically touchy and also which we don't have on everybody.

The first time around, we built the data on 2013. We built the model on 2013 data. Our Version 2 has now been built on 2015 data. The model that will go into effect in another two years, we're building on '16 and '17 data. And it's based on claims and administrative records.

Anyway, the details here are we did not model

people's costs unless they were there for at least six months, and we didn't model the costs of long-term supports and services, which for now are not in the bundle, but the goal the next time around is that they will be.

So, as I've said, we have the relative risk score, the age/sex indicators, the markers for unstable housing, disability, serious mental illness, substance use disorder. And we also used the address to locate people in a Census Block Group and develop a neighborhood stress score, and the neighborhood stress score didn't -- let me get there. I'll show you what it is. It's based on Census data.

We found that a parsimonious model looking at only seven variables of socioeconomic indicators, which tell you how tough the neighborhood is, that --

Oh, got one minute. All right.

[Laughter.]

DR. ASH: We turned this into a standardized variable, mean zero, standard deviation 1, and each unit of standard deviation increase was associated with about 50 bucks, about 1 percent of total cost. People said why even bother with such a small number, but if you have 2,000

people and you're getting an extra 60 bucks each, that's real money.

So we believe that these new dollars could support interventions. We'll be looking to see if they do support interventions. We do know that putting an extra $600 for coded homeless into the model is changing the interest of organizations in seeing that it gets coded when it's present, and we'll be looking to see if the changes that we made actually do lead to innovative ways to address these problems.

So the new model, as I said, was introduced in October of 2016, and we have high hopes.

We're working on other models. We have improved our model.

There's one other thing that I think is fun. Time is up, but I'm just going to tell you this because it's fun.

MR. VAN BUREN: Go for it.

[Laughter.]

DR. ASH: Which is that we've added an interaction between having a housing problem and a relative risk score, which gets rid of that shelf, where there's a

huge jump if you have a housing problem. That doesn't really apply to everybody.

The people who aren't very sick and have housing problems, it doesn't add much money, but the people who are very sick and have housing problems, it adds a lot of money. So we're happy with that improvement.

Okay. So the last comment is we're looking forward to seeing whether or not we can get people to use the new Social Determinants of Health codes that are available in ICD-10, in which case we could envision using them in our models.

Thank you very much.

MR. VAN BUREN: Thank you, Dr. Ash.

And now, finally, we'll turn to Kevin Moore.

* MR. MOORE: So thank you all for allowing me the opportunity to come back to D.C.

[Laughter.]

MR. MOORE: So it's fantastic.

The benefit about going last on a panel is I get to kind of say what they said and agree, so I'm going to take a little bit different tact because I do agree. This is a very challenging space. It is very complicated, not

just from the prospect of how are we trying to figure out theory, how are we trying to put together complex ideas, and how are we ultimately trying to come up with models that differentiate people that need different levels, but then also how do you actually turn it on. How do you get from a theoretical and actually go to a Medicaid director, which I hate to say it, but we all will always end up being Medicaid directors at the end of day. But to be able to have a Medicaid director talk to a governor, to talk to a member of a legislature to say, "This is an investment that makes sense. It may be a little bit longer than your term. It may be a little bit longer. It needs a 10-year outlay to be able to make that happen." And I think for us, we're looking at the sustainability quotient as a real important part.

So I'm going to paraphrase my old mentor, who used to say the -- I am paraphrasing it heavily, but she used to say, "The easier the game, the more people play." And I think in this particular space, when you're looking at, in the state that I served in, 1.2 million people, you have 1.2 million stories that you're trying to figure out how to connect people with. So the simpler the game, the

easier it is to get managed care organizations to be able to engage.

Community partners in this particular instance, I think is another important part, as we're going to see as we are engaging, trying to get on the front lines to do this, and not only trying, but being on the front lines, realizing that there are whole new partners out there that we have to engage with and help them understand what's going on.

So just real briefly, United HealthCare Community and State, we are the Medicaid arm of the United HealthCare Group, and just as a quick overview of where we serve members across the country in a number of different areas, from your traditional TANF populations all the way to LTSS services in a number of states.

So not to tell people what they already know, but fundamentally, when you're looking at SDOH and social determinant issues, the problem is really it's a fragmented system, and people's lives are fragmented. I have trouble getting to work. I have trouble holding down a job. My housing situation is unstable. For those that ever heard of the book, "Evicted," again, a great story from my home

town of just what $50 can do in terms of not just an in but that person's life, their children's life, moving from community to community. It's hard to get any of these particular things stable when one thing, all of a sudden, gets thrown out of whack.

And so, with all due respect to my good friends over at the House Ways and Means Committee, here's the solution, and I say that tongue in cheek, but the challenge is, as a former regulator, I can appreciate the fact that you do have siloes for a reason. There's an accountability provision. There's a population that you're targeting to.

So the challenge, I think, in moving forward is each one of those programs has an infrastructure and has a fidelity and has a population that they're trying to serve. How do you start to collapse that so that as we look at a member, that those dollars and those resources are being aligned properly? And that's really what we're looking to do, even outside of the siloes, to try to aggregate them at a higher level.

So two initiatives that United HealthCare has engaged in -- and I'm actually going to go backwards here. I'm going to start with Arizona because that's actually --

it's actually in Jocelyn's paper, embedded in the paper, actually, is the work that we're doing in Phoenix. And this really surrounds around an investment that we have made in two housing units in the Greater Phoenix Area, really to upgrade it.

We're using a local partner to renovate the 500 units, of which 100 of those units are being set aside to provide supports for United HealthCare members. In those particular units, generally speaking, we are talking about -- and I really want to appreciate Arlene's point on identifying individuals in that the fact that we really rely heavily on Z codes, but a lot of providers aren't coding for Z codes. So it becomes very challenging. So there's a lot of science and a little bit of art in terms of identifying who those people are.

Ultimately, super utilizers, we see them on the piece of paper, but our challenge is also how do we engage with them. How do we find them in some instances? How do you get community health workers and other folks on the ground to be able to help these people get into whatever services that they need, but some type of stability? So that either they're acute care and/or their behavioral

health component can be engaged with, and that they can receive the services that they need.

So, again, right now, we have this particular project; like I said, two units in Arizona. We have seen some very positive results in terms of drops in utilization at emergency rooms, adherence, quality of life. We have a lot of different vignettes about individuals who have flat out said, "Because of the housing, I'm able to start thinking about going back to work. I'm able to start thinking about how do I start to improve my life." Now, these are high-utilizing individuals, so the trajectory, again, is a very long one, and we want to make sure that we're there for that long haul. But again, it's a very challenging population and one that we're seeing some good results on.

The other one is kind of a pilot that we're working with through the CMMI Accountable Health Communities grant in Hawaii, and here, we've got a proposal where at three different locations on Oahu, we are set up to screen 75,000 individuals, regardless of payer, over the course of the next two years and essentially using the data and information from CMS and CMMI, using a screening

template to identify, essentially to fill in some of those gaps that you can't find in traditional claims data. We'll have a very robust set of information to help us identify and triage individuals at the point of sight of knowing do you need services, when do you need services, where do you need to go for services, and a hierarchy.

So for certain individuals, it may be something as simple as "Are you aware that you're eligible for SNAP?" "No, I'm not." "Okay. Let's get you eligible. Let's figure out what that process is." That low-hanging fruit, get them the services that they need and also that they're also highly motivated, so that it doesn't need to have a wraparound support system or a navigation system.

On the flip side, people that may have three, four, five identified social barriers, those are the individuals that we want to have a navigation system built out for them, so that we're not only helping them understand where they need to go, but actually helping them close that loop.

Again, at a high level, that makes a lot of sense, but from an operational day-to-day perspective, first of all, 75,000 is a lot of people, and I think one of

the questions is what is going to be that unmet need that's embedded in that population.

The other part of it is just that translation to community-based organizations. Do they have capacity? Do they know what to do with these folks?

There's an educational curve that we're actively engaging on and partnering with these folks to let them know, "Look, we're going to identify people. Can we count on you? Do you have the resources? Do you have the capacity to be able to basically provide basic services? Can you handle home housing navigation, or are you at your full capacity right now? If so, how do we build that capacity? Through investment or through partnerships as well?" So this is going to be going live.

The reason why I bring up also this CMMI Accountable Health Communities grant is you are seeing other states also going down this path of trying to find a tool. At the grass roots level, FQHCs have been using tools like PRAPARE for a number of years to be able to identify key measures.

You are starting to see some states that are taking that local or provider base and really escalating it

to "We want to do a statewide screen," again, not only valuable from understanding what the needs are for the population, but also thinking about how do you stratify from a financial perspective or also from a clinical perspective, to be able to understand what are those core needs, so that you can add it into a clinical model of care that includes behavioral health, acute and primary and social. And again, that's another area that United is very excited about working with as well.

I've got two minutes left.

So looking forward, we've got two minutes to look forward, folks.

[Laughter.]

MR. MOORE: So I mentioned briefly the supply and demand, and I think this is just a general issue that collectively, as we look at Social Determinants of Health -- I recently read a story that -- and some of you may have read this too that -- I believe it was the Alliance for Health Communities and Families did a report that said about one in eight community-based entities are financial insolvent.

I hope that those numbers may be a little bit

more generous, but fundamentally, when you start to think about the mom-and-pop shops that have been community based that have been driven by grants, there is going to be a lot of people that may need services, and the question is, Is there going to be that community-based infrastructure to be able to handle them? And I think that's kind of our biggest issue as we move forward is being aware, eyes wide open, and how do we provide supports not only from us as a health plan but also going back to our state partners, our federal partners, and saying, "Look, this infrastructure is not as strong as we would like it to be," to truly meet the needs, so that we can truly bend the cost curve in other areas.

Sustainability. I don't want to lose sight of this issue, which is you heard a lot about the --

I've got one minute. Okay.

You heard a lot about kind of the impact of social determinant investment on rates, and the one thing I -- the one caveat I kind of twist on here is, yes, managed care, our goal is to lower the cost of health care. The challenge is some of these investments are long-term investments, and that's going to -- how do we reconcile

that with either a state provider, how do we reconcile that with CMS, so that we understand that that longer-term investment is going to be there, and that the resources are going to be there to be able to support whatever that intervention is.

Again, looking at housing, that's not -- permanent supportive housing has the word "permanent" in it for a reason, and I think that we have to understand that that's a long-term play. Same thing with food, same thing with workforce training, being able to support those over the course of a long time.

And then again, we talked -- again, great. I really want to appreciate the work on Medicaid capitation rates. Setting the paper, I thought really provided some really good outlines on where to go and opportunities for states and for health plans.

And then I don't want to lose sight again. I'm an old Medicaid guy, so I want to make sure that we keep in mind the budget reality of states, and that regardless of what may happen from a federal policy perspective, I just -- as a side note, I knew that I got a lot of phone calls from my governor's office asking about where we were going

because I was the $9 billion piggyback, and so the reality is that as we look forward into making these types of investments, how do you find enough liquidity in your financial situation so that you can make investment, be able to test new models, and then figure out the longer-term game plan, so that as us as a partner, as a health plan and partnering with the state, that we're able to really change how we provide services to the members that are both our members as well as the states' members.

So, with that, I think I just slid in right under the wire. Thank you very much.

CHAIR THOMPSON: That's fantastic, and Rick is a terrible task masker. We always tell him to take it easy on people, and he just -- no, we appreciate your keeping to the time. There's so much material here, and we want to be sure the Commissioners have a chance to interact with you.

So I know we have Martha and Darin who want to jump in.

Let me just first ask a couple of quick questions.

Arlene, you talked a couple of times about the model, getting it right. Can you just explain what that

means? How did you decide that the model had gotten something right?

DR. ASH: Yeah. We have a very simple tool that we use, which is looking at predictive ratios. So we look in the historical data, and we say, "Here's a group of people, people with serious mental illness, and if we use the model that we're intending to use, what would be the predicted payment for this group? What would be the payment for this group, and how did that compare with the actual dollars spent on the group?" So we look at that ratio as actual spending to what the model predicts, and it's easy enough, if you have failed to recognize some important factor that the observed spending could be very different from the predicted spending, which will be the payment if you adopt the model.

CHAIR THOMPSON: Okay. Got it. Thank you very much.

And then I just wanted to ask Jocelyn and Kevin, if you could maybe comment on this. A couple of themes of both time and money in both of your presentations, and I, for one, tend to be somebody who worries a little bit about Medicaid-izing the world and where to draw these lines, and

so I'd like to kind of take it maybe from the opposite angle and ask about states that may be successful in capturing other non-Medicaid streams of funding and incorporating that into a capitation rate or a supplemental payment to a plan and having the plan have access to more of those resources in terms of providing whole-person care and perspective.

Have you seen that? Is that something that any states are experimenting with?

MS. GUYER: So just to say right off the bat, I think as we spoke with states and plans, their focus was on using Medicaid dollars when it's cost effective to do so, so it was a little bit less of the longstanding and traditional conversation we all have about maximizing federal Medicaid revenue, which I'm sure -- I'm sure continues to this day.

I'm just going to guess that there are states that are still looking at doing this, but this conversation was really about when is it cost effective to make sure that providers have some flexibility to decide what I need here is a medical intervention versus what I need here is to get this homeless person off the street so that they

don't get infections from their wounds.

So the conversation we have in the paper is very much about when it's a cost-effective time to do a social intervention.

MR. MOORE: I agree. Again, that is why I always go last, right?

I want to just maybe think of a couple of things. I think in the paper, there was a good example of Arizona, again, providing general purpose revenue kind of outside of the traditional Medicaid model to really drive a particular value or a policy objective, so I think there are examples, state to state, where you have got those dedicated pots of money. Medicaid directors are probably trying to match as much of that as they humanly can, so I do think that there's examples there.

I also think that in this new era that we're in right now, I'll just use kind of the cross of SNAP and SNAP E&T, employment and training dollars, with the populations that are being served in Medicaid, and that if you look at kind of a Venn diagram of are these the same populations, there's a lot of overlap for those populations. And so is there an opportunity for either states or federal

policymakers and us as health plans that are really designed to help coordinate numbers, different types of disparate services, to think of how do we leverage an individual so that they're able to access that in as few of those siloes as possible, so that they're navigate?

Just going back to my time in Wisconsin, we were a mandatory SNAP E&T state, a lot of overlap between the Medicaid population and the SNAP population. Our benefit was we had an integrated eligibility system. Again, the policy lever, not a cheap one necessarily all the time, but it is a policy lever to be able to know where those overlaps, so that you have new cohorts of populations to know that there's different resources that are available.

It's not pretty. I think the phrase would generally be "bundled." That's usually -- you know, that's the nice way of saying it, but it's basically what are those -- how are those resources being used, and then being able to articulate back to groups like this, policymakers at federal and state levels, to show the person is utilizing all of these. To be able to streamline that is going to give you an ROI. It may be longer than two to four years, but it's still going to be something that's in

the best interest of the member.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: Thank you for that very rich presentation. There's a lot to think about there.

At the community level, as Kevin indicated, you know, we're working on screening for social determinants and also ACEs, adverse childhood experiences, and trying to blend that screening into then a strategy to help people.

One of the challenges in getting providers to actually do the screening and code it right is that they need to know that there's some place to send the person, and you all have talked about that to some extent. You know, they're reluctant to ask the question if there's no resource.

So that kind of gets to another issue, which is sort of how do you -- I'd like to hear more about how do we talk about this in a longer-term time horizon, because any intervention for these kinds of things isn't going to have immediate -- well, maybe a few would have some shorter time horizons, but most of the interventions, like with, you know, screening for diabetes, are going to have a much longer time horizon. And how do we put that into the

conversation, especially because there isn't a lot of research on cost effectiveness and outcomes?

So I'd like to hear more about how do we talk about this in the longer time horizon that you really need for these kinds of interventions.

MR. MOORE: I appreciate your comment about you don't want to ask the question because you're afraid you might get the answer and you may have to do something with it, and I think that's part of this edge that we continue to move forward on and why we really view the partnership element of this to be so important, being able to partner with maybe groups that aren’t traditionally in the Medicaid space, thinking back to my old days as a Medicaid director, I would never have expected to partner, but thinking about when you realize the role of adverse childhood experiences, you realize the role of trauma, you realize the role of housing, all of a sudden that sphere of influence becomes a little bit larger and that partnership becomes more important. So, again, maybe it's a difference of I'm getting referred to the wrong people to really do what I do best, and you're maybe a better provider at the community base level, and there's an ability for us to do those

short-term things to kind of make sure we're maximizing capacity, but then also building out the argument through investment, strategic, both from philanthropy, from health plans, investment from government entities, to continue to bolster that, because as the evidence gets better, I think that it will show that there are gaps in the system. Similarly to, you know, just thinking about what is first and foremost on a lot of Medicaid programs, it's how do we bolster our infrastructure for substance abuse disorder or behavioral health, right? We know that there's an issue. How do you start to fill that? I think it's the same basic blocking and tackling. Now we're just working in a different sphere.

So not to say it's easy, but the awareness is, I guess, the first obstacle.

DR. ASH: Yes, and. I noticed when you brought this up, you were knitting your fingers together kind of like how do we put this stuff together, and that's the question. We have to recognize the intense interdependency. So in Massachusetts, for instance, we have a neat program called Healthy Incentives Program whereby folks who are in the SNAP program can take a

voucher -- up to $40 a month, one for one dollar match, the state adds to it -- to go shop in farmers' markets. It's fantastic. Everybody loves it. There's a lot of anecdotal evidence that it turns around the lives of some of the people in our Medicaid programs.

It sustains the local economy, so the state is in a unique position to benefit from saying, wow, we're supporting our farmers, we're supporting this.

What's the problem? It's too popular. It's so popular that it's running out of the funding. Now, the funding is a pittance. It would take less than one dollar per person in the entire state to support this program fully at $6.2 million, and we're only supporting it right now at $1.35 million. It will run out.

So we just have to build -- we have to build the trust. We have to build the relationships across the silos in which we can get the place where the money is to the place where the money is needed, and as a data person, I would say one place to do this, which also requires trust building -- it doesn't just happen -- to get all these agencies to share their data. Everybody is very, very nervous about losing control. Sometimes they have a

concern about privacy, but I really feel that we have to get privacy basically by guaranteeing that nobody gets access to the data who is going to use it badly, not by seeing to it the data can't actually be used.

MS. GUYER: And I would just say in terms of the long-term sustainability, I do think we're going to need to keep a solid eye on building the research base on what are the cost-effective interventions, what are the ones that make sense, in part because of the issue that Penny raised at the beginning, which is there is a fear that there's an effort to Medicaid-ize everything and we're going to try to solve poverty from Medicaid, and I don't think that anyone believes that that's going to end well. So I do think that there needs to be ongoing research on, okay, what is the appropriate role for Medicaid in the social determinants? When is it cost-effective? When does it really improve outcomes? And one state I would encourage folks to keep an eye on in this regard is North Carolina, which has a Medicaid waiver request -- and I'll just acknowledge we've done some work with them -- that is looking at building the research base of which of the interventions are cost-effective. And I think that that piece does tie back to we

need long-term sustainability in part to deal with the other piece of that challenge you raised, which is this isn't going to work if we don't have community-based organizations on the ground that are financially stable, able to do this. And I think in order to have that, we're going to need systematic efforts to connect Medicaid with those community-based organizations, and that's only going to happen if we have a long-term sustainable financing mechanism.

CHAIR THOMPSON: Okay. We have lots of folks who want to jump in, so we have Darin, Peter, Fred, Chuck, and Stacey. Have I missed anyone who wants to -- all right. So, Darin, go ahead.

COMMISSIONER GORDON: Thank you. Great presentations. A question and a comment

Arlene, I appreciate the work you are doing. The question I have is: Is it more appropriately assigning the right amount of funding to an individual more than it is adding more funding to address the social determinants with that person? Because there is -- as I understand your risk model, as most risk models are, it's shifting -- so you may have some people without these added data points that were

being paid for at a higher rate that weren't necessarily right. And you're more accurately reflecting the need of certain individuals through the social determinants. That doesn't necessarily mean that then there's more funding to address those social determinants so much as it is it's a more appropriate designation for that person's level of need. Is that correct?

DR. ASH: So you are flagging a very important point, and let me state it very explicitly and clearly. The state's deciding how much money they're going to put into the Medicaid program. What we do is we decide the relative allocation of those funds. So we use the language which makes everybody feel nice about more money for this, more money for that. But it means less money for other things.

So, I mean, let's be very, very clear. The function here is to create some clarity and fairness around the known difficulty of caring for people with social needs as opposed to people who are similarly sick without those social needs. But it in no way actually adds money to the system.

COMMISSIONER GORDON: And it's a very important

thing to do. I just want to make sure we all appreciate it.

DR. ASH: No, I'm glad you pointed it out, because I think we've got to face that. That's exactly what's going on.

COMMISSIONER GORDON: So then kind of to comment, both Jocelyn and Kevin were addressing about, you know, the premium side, more investments, and we struggle with this. We looked at it in our state, thinking about some of the interventions we had, because oftentimes the administrative cost was a percentage off of what the medical spend was. And so as the interventions that we were asking our plans that other plans were doing were driving down the cost on the medical expense side, which we all were glad to see that they were doing that while increasing some of our quality outcomes. The administrative cost would decline as well, therefore stressing the ability to continue those interventions. And so I think that's a little bit of the fear on the premium side. Some people could perceive that as, well, they just don't want to hold down the cost. It's like you have to -- we have to think about the interventions that we're asking our different partners to

do to make sure that the way that we account for those things can continue to be sustained to get the results that we're wanting, as opposed to putting the pressure and reducing. We saw that, and we had to start thinking about that as how do we prevent that downward spiral, because we want those interventions to continue while lowering our overall cost.

And the last comment, you know, we were talking about -- and, Jocelyn, you were talking about raising the research base and evidence. It goes back to a comment that Kevin made, and I always bring it up. We had 1.5 million people in Tennessee, and when you look at even just from a health care perspective their needs, we had 1.5 million different situations. Then you lump in their social stressors and needs, that only compounds that.

And so what I'm a bit concerned about -- and this is, you know, the model that we had in Tennessee was allowing plans a lot of flexibility because you may find in some research at a high level across all of that that there's limited results or outcomes from it. However, in certain situations, you know, the research is going to have to be done so thoughtfully that it gets into that there

could be some cohorts within that to where that particular intervention was, in fact, effective.

CHAIR THOMPSON: Peter?

COMMISSIONER SZILAGYI: Thank you for delving into this. I think this is really the next frontier for improving the health of this country.

I have a question that's a variation on what Martha asked, because I think as a provider, this is really sort of at the heart of it, and it's related to something that we do in traditional medicine. So in traditional medicine, we have CAHPS measures and all sorts of measures that identify the need and the unmet need. And then whether it's value-based payment or other mechanisms, we have ways of incentivizing the system.

So now, switching to the social determinants, there are better and better instruments. Now we can pretty accurately measure food insecurity and housing insecurity and adverse childhood experiences. These instruments have been developed. They can be scaled up. So we can actually determine unmet need as well as determine who might be eligible for certain programs. And then we have a clear gap between people who are eligible and not receiving the

program.

So we're going to be grappling with this clearer definition of unmet needs for certain programs and how do we get -- how do we scale up both the screening and the incentivization of coordinating care or managing so that the population that has an unmet need for these programs can actually access and get these programs? Are any states really delving deep into incentivizing systems, managed care programs or other systems, to sort of reduce that gap between eligible and enrolled in these programs when we have clear instruments to identify who's eligible -- or who should get some of these services?

MS. GUYER: Yeah, so I can jump in here, and just to say -- maybe one second on Darin just to say all of your comments directly reflected some of the difficult conversations we had in the advisory committee, and I think we didn't have good answers to any of them but just to validate and say -- and acknowledge there weren't good answers to all of those, but there was a lot of wrestling done, and we can talk more about that.

On the scaling up, just some thoughts on specific states where we're seeing this, because I do think it's the

next frontier. We're seeing states start to look at how to be more systematic about their screening, about how to integrate addressing social determinants into their Medicaid managed care contracts, the rate setting that we talked about, but more generally Medicaid managed care contracts.

Two that come to mind that I think are leading the way is -- one is Oregon, which has long been looking at this, and I know, for example, that looking at food insecurity is a part of what they may start evaluating their MCOs on. I think they're debating that at the moment. Other folks may have a more recent update. And then the other one that may be interesting to look at is North Carolina, which is transitioning to Medicaid managed care but has started to put out some public papers. And so, for example, you can see they just did one on their plans for what they expect MCOs to do with respect to care coordination, and in that paper it's very apparent that they view addressing social determinants linked to potentially specific outcome measures as a key part of care coordination, a key part of what they expect their MCOs to do, but just to acknowledge and validate, I have the same

sense as you, which is this is starting to happen, we're starting to see the efforts to scale up. But I don't know that we have great examples as of yet.

MR. MOORE: I think the -- I want to echo especially North Carolina as they've done not only looking at a statewide -- just coming up with a statewide screening tool so that you have -- you don't have kind of the hodgepodge of different screening tools, or at least if you do, that you're tethering them back to some core domains that we at least know, you know, food insecurity, interpersonal violence is the other one that really kind of came up through both the CMMI grant as well as the -- in North Carolina. But there I think that one part about North Carolina that's very unique is that -- and correct me if I'm wrong on this, but almost every state talks about SDOH. I think North Carolina has also gone and with their 1115 they've asked for resources to be able to support efforts within the state. And then they're also looking to build data platforms to be able to allow providers to bring that information in, and then for the community to be able to push that out. I would concur, the paper that they put out -- not that I may have read it on the way here, but it

was April 5th, North Carolina put out a very comprehensive paper, and they've also done things with their Institute of Medicine to make sure that -- their institute has got a task force dedicated to accountable care communities, which in full transparency I sit on that, but they're clearly looking at the role of data and then how do you build partnerships with -- partnerships that traditionally have -- to your point, they've been there, but maybe it's not as formalized as we're going to need to in the future.

DR. ASH: I'd like to add Massachusetts. Okay. I should be left to talk about Massachusetts. So there's some very innovative aspects to the current 1115 waiver, including money to build community partner organizations and community service groups that can implement some of this connecting and supportive work.

I'd like to sort of echo what Kevin said about Peter's comment, which is, yeah, there's all this screening, but everybody's using their own tool and it's a mess. And we're trying to institute a certain level of uniformity at least the level of some questions relating to each of these domains. So, yes, it goes back to the fact that providers just really feel it's practically unethical

to ask about problems that they're not able to provide any solutions for, and whether it's ethical or not, it's certainly very uncomfortable.

So this is -- and I'm glad other people brought it up, but the thing that I really do as my purview is to make sure that we have the database so that we can start to answer questions like which of these really work and really deserve to be supported.

CHAIR THOMPSON: Fred, Chuck, Stacey.

DR. CERISE: First a comment and then a question. And my comment is around, you know, one thing we could do, first, is just to stop making it worse, and in some of these value-based payments that look at outcomes and do not consider the factors that you guys talked about in terms of, you know, if 20 percent of the outcome is impacted by health care and then there's a lot that's impacted by environment and socioeconomic factors, we then end up disincentivizing providers that focus on this population. I know Medicare has done some stuff with that, finally. But Medicaid, on a state-by-state basis, where you're making these payments based on outcomes and there's not the sophistication to include the impact of these socioeconomic

determinants, that becomes problematic. That's my comment.

And then the question is, for Arlene, I love the analysis. It's just so thoughtful, and you look at -- and you can measure it, and, you know, it builds to the body of evidence. And when we looked at predictors of readmission at our place, around heart failure, and you think, you know, it's around did they get their drugs or did they get follow-up appointments, and did they get good instructions, and you found the same thing you said, and that is if they had more than three addresses in the past year, that was the powerful predictor.

And so knowing that, and also knowing that you ran out of money when you give food vouchers, I'm just interested in your opinion on, you know, when you run the risk of Medicaid-alyzing all of these factors, you know, where do you think you can focus? Is it populations? It is a combination of populations and high utilizers? You know, is it substance use, SMI, and high utilizers? You know what I mean? Do you allow Medicaid spending in that population or do you target on the connections in making sure, you know, as you look at alternative payment mechanisms, perhaps what you do is you require providers to

really have those serious connections with social service agencies and demonstrate that they're doing that, as a threshold for being eligible for some of those payments. I mean, I'm just curious, as you think about this, where do you make the impact?

DR. ASH: Boy, that's a simple question.

[Laughter.]

DR. ASH: So, first of all, I agree. Stop making it worse. And I sit on innumerable panels, technical or expert panels, to talk to various quality measurement groups about trying to introduce social determinants data into quality measures. So we can stop punishing safety net providers for taking care of poor folks.

Then it seems to me that some of the problems are well addressed with medical system taking the lead, the medical health care delivery system taking the lead, right? So I think targeting high utilizers and seeing that somebody sits with each of those individuals and figures out what the problems are and works on that, that's well recognized to actually have the kind of rapid return on investment that everybody ought to embrace. I mean, there's other stuff that they ought to embrace too, but the

short-term benefit, who has to spend money to save money for somebody else, that makes it much more difficult.

It also seems as if recognizing that some neighborhoods are tough, could help in thinking about dealing with people's health problems as public issues, as opposed to purely medicalizing them. And so we kind of hope that if a group of health plans that are dealing for people in some tough areas see that there's real extra money flowing because of that, they might put their heads together and say, "Can we figure out some community-wide interventions?"

So the answer is, everything that you've said is part of the solution. It's very much a question of finding the right entities to work with the right part of the problem.

MR. MOORE: I think even just having this discussion, though, I think is very important. I think the line of, is it Medicaid-izing? Is that the new phrase?

CHAIR THOMPSON: I think it's a very old phrase.

MR. MOORE: Okay. We just called it Medicaid gets the first draw and everybody else didn't get anything. So I think the reality, though, is that if you take a look

at the populations now that we're serving, I think it's a question of how are you measuring things, because the value-based is a very good example. But I go back to how do you measure keeping three kids out of the foster youth system. You know, we know about adverse child experiences. We know about the ability to effect change. So how do you start to have a broader conversation on what that measure is, so that that investment, maybe on the many versus the few, because that's essentially what happened with the food program, is that the many saw a great opportunity to be able to improve their life.

So I think that's another ongoing struggle, on the Medicaid-izing side of it, but also just what is that long-term return on investment. I pick on Evicted, but a $50 ability to pay rent has a huge trajectory in terms of keeping people off of Medicaid, maybe keeping them in work, keeping the kids in school. How do you measure that? And again, I'm not saying that I know the answer to that, but the fact that we're asking the question, I think it allows us to continue to propel that line of thought.

CHAIR THOMPSON: Chuck.

MR. MILLIGAN: Great panel. Thank you for coming

back. Rick, thank you for making them toe the line about minutes so that we can have a great discussion. I'm teasing.

I have a series of discrete questions, but I wanted to ask Arlene, you, the first question, and kind of piggybacking on what Darin had said. The rate base that you're working off of, I assume is the medical spend, not social spend? When you did the rate base development, which was then allocated using relative risk scores, what dollars were in the rate base? And my follow-up question to that, Arlene, is going to be, if the medical spend successfully goes down, is the rate base, over time, shrinking? So, in other words, is it a redistributive model that you're taking about, but the rate base is still a traditional medical dollar rate base?

So that's, I think, what I wanted to start with.

DR. ASH: So at the moment we're talking about the medical spend, and the particular payment formulas that we bill ask for the traditional medical part of the medical spend, and, as I said, we have haven't even tried to wrap in these long-term services and supports, not to mention housing and food and stuff like that.

MR. MILLIGAN: That what I had assumed. I just wanted to validate that.

Jocelyn, about the VBP, or the value-based purchasing, you had mentioned that it can incentivize providers to do some of the social determinant interventions. Were the successful -- and you had mentioned, I mean, really clearly, that it doesn't -- that there's still this premium slide risk. Because if the rates are built up from encounters and encounters don't include some of those provider social determinant interventions, I'm wondering whether you, in your advisory group or for your interviews, found any workarounds whereby some of those investments that produced the savings but that weren't traditional encounter data things, whether they were captured in the premium development so that the premium slide issue was addressed?

MS. GUYER: Yes. Yeah. This came up a bunch during our advisory committee conversations, and, fortunately, Tom Betlach, the Arizona Medicaid director was on the phone -- and we keep citing Arizona as an example of a state that's doing a lot here. And so what they do for their rate-setting, at least for now, is they essentially

add back in value-based payments. They become treated in the same way as a medical claim, another medical claim. It gets added back in. I'm looking at Stacey.

MS. LAMPKIN: That's consistent with my recollection of how they described it.

MS. GUYER: Yeah.

MS. LAMPKIN: It's essentially locked in, at least in the short term.

MS. GUYER: Yeah. So I think out of concern about the premium slide, and recognizing that providers would be concerned and plans would be concerned if the value-based payments weren't recognized in the rates, so they're essentially added back into the rates.

I would also say, though, and I think both of you are raising the premium slide issues, a very real concern, I do think that's part of why we saw Oregon reach for that option that is looking at essentially potentially giving a higher profit margin to plans, I think essentially compensating for some of the reduction in rates that they might see if they're making cost-effective investments in social determinants.

MR. MILLIGAN: Thank you. That's helpful. I was

going to ask, actually, about Arizona, because -- and, Kevin, kind of pull you into this too. I don't -- this is really a true question. I'm not using some kind of inside information about any of this stuff. I work at United as the New Mexico health plan Medicaid lead.

Is Arizona considered sustainable right now? Because I worry about the short-term, long-term issue. I worry about whether the workarounds have addressed it. Is it considered to be sustainable? We're among friends.

[Laughter.]

MR. MILLIGAN: It's all private. Not really.

MS. GUYER: I mean, I can say from a state perspective they have thought about it an enormous amount. They seem relatively confident. They have such a sophisticated approach. We certainly didn't get any sense of warning signals.

One thing maybe to add about Arizona is it is a state that, while it does everything it can that's appropriate in Medicaid, it does also recognize that it needs some investments that are just not Medicaid dollars. So they have some housing investments that are entirely state and locally funded that support housing for some of

their SMI population in Medicaid.

So just to acknowledge that, that they're not trying to do everything through Medicaid. They've kind of figured out an appropriate role for Medicaid. I think they feel like -- and I really shouldn't speak for Arizona, but my sense was they feel like they have a rate-setting process that appropriately acknowledges the value-based payment. And, so, but do also want to acknowledge that they have -- they see themselves as needing to have some resources outside of Medicaid for some of the -- I don't know, from a plan perspective.

MR. MOORE: I'll put it this way. I want to just echo, and I'll call him Director Betlach so that you all can go back to him and tell him. I think Tom has done a really good job of being aware, and I think that Arizona is on the, if not the cutting edge, they're way in front in not only just their plan design but also allocating non-Medicaid dollars to fill in that hole. They recognize that there needs to be an investment, whether it be through partnership with their plans or what have you.

I also think that the relationship, from the plan perspective, with the state is really critically important

to be able to address these issues, to be able to show, you know, the goal here on permanent supportive housing is to make sure that it's there, not just for the high utilizer today but also how do you start to -- we haven't even talked much about upstream and being able to get into some of those prevention categories. That takes investment and it takes partnerships, and almost a brand-new style of network that is going to really require an open relationship. I mean, for the directors in the room, the providers that came in, we all had the same conversation of "It ain't working. I don't have enough money."

That transparency, think, between plan, provider, and in this particular instance I'll use Arizona, not just because it's Tom but I think that they've been very open to understand, okay, what are the pressure points, what works, what doesn't work, and making pivots in policy, and finances, to be able to make sure that -- the goal is success. They want their members to get taken care of. Whatever that may look like, that's what they want to do, and that openness and transparency, I think, makes Arizona -- if anything, they're the ones that are probably on the cutting edge.

MR. MILLIGAN: I have one more question and then one comment. The question -- and, Arlene, it's coming your way. When I'm thinking about this, I think of where Medicaid was with home and community-based long-term services 35 years ago. And at the time the issue was paying for non-medical things on the theory that it's going to avoid medical costs. And so whether it's community-based services for people with, you know, aging with disabilities, you know, support and employment day programs, attendant care, homemaker services, environmental modifications, all that stuff, what made it an easier policy discussion was that there was pretty tight predictive modeling between who would otherwise be in a facility, that you might want to serve in the community, and you're avoiding the nursing facility or ICF/MR, or hospital costs. And you could use -- for residents that you're moving to the community, you know one for one, but there was also, in some ways, tighter prediction around assessment instruments, levels of care, that sort of thing.

And so to invest in social determinants, and not just the case management but the actual housing dollars, or the actual food dollars, on the theory that it's avoiding

medical costs, the tighter the predictive value the more the policy argument is advanced. And so if you can say -- as opposed to say, "I'm going to pay for these 1,000 people," we know that these four people are in and out of the emergency room, the persistent homeless, et cetera, et cetera, the more predictive, the more you can maybe make the policy argument and start thinking about it that way.

So I guess my question, Arlene, is, in response to Penny's question at the very beginning you said the predictive power of the tool is pretty strong. I'm wondering how tight you think the predictive value is that we can invest in discrete people and know that we're saving medical costs for those discrete people as a way of advancing the social determinant investment discussion analogous to HCBS.

DR. ASH: Wonderful question, and we've been thinking about it. Perhaps you're not surprised.

So one of our next projects is to look at the states' nursing home-certifiable population, in which, in the past we've just sort of, if you go over certain threshold with respect to your problems with activities of daily living and instrumental activities of daily living

and a few other items, then you become nursing home certifiable and you fall into a very high rate bucket. And you wouldn't be surprised if I tell you that very few people fall just below that threshold, and quite a few fall just above that threshold.

And so a project that we're working on right now is to look much more carefully at the data that's collected, to determine nursing home certifiability, and to really spread that group out and try to understand who are the people who really have heavy needs and really do need supportive services in a big way that needs to be -- you know, needs to be compensated.

The other question that you've asked is a deeper one. It's a causal modeling question. It's what can we say about how much this person would have cost had they not gotten this service, as opposed to what they did cost when they got the service. And what I can say is this is really an exciting and important area of research. I am on the team that is evaluating the waiver that Massachusetts now has, and we're spending a lot of time looking at how we can address those questions.

We have a little bit of a recognition of this

issue as we talked about introducing these interactions between people who have housing problems and their relative risk score. You know, we're not just going to say if you're homeless there's going to be an extra $10,000 paid. We're going to say there's a very different amount of money paid for people who have really complex medical problems. But that's just a baby step in the direction of recognizing what you've said.

MR. MILLIGAN: And thank you. My comment is playing off of, I think, Jocelyn, something you had said earlier about Oregon and margin and that sort of thing, is presumably you could also just put it into rates as an admin component, if there's MLR space to do so. So it doesn't need to be differential margins as much as it could be an admin load. Like if an actuary otherwise would put in an admin load of 8 percent or 7 percent or 9 percent, you could put in half a point or a point of admin load if there was confidence among all the players that the MLR would, nevertheless, be met.

And, Rick, this is where you pass me the note to stop talking. Thank you all very much.

CHAIR THOMPSON: Well, we are over time. If you

guys will allow us to continue with this conversation for a bit longer, I think there's a number of other Commissioners who want to still jump, or jump back in. So I'd like to at least give us another 10 minutes to continue this.

So I have Stacey, Martha, and Toby.

COMMISSIONER LAMPKIN: Thanks, and thanks, Chuck and Arlene, for giving me a lovely segue to my question, because I'm listening to all this, read the white paper, and participated in those conversations. I'm thinking a lot about our recent conversations in this group about the use of waivers, when it's a good time to use a waiver, when maybe a waiver shouldn't be required. And it seems to me like in the absence of a larger social services solution to the challenges that we're talking about here that waivers are a nice spot to possibly balance that tension between Medicaid-izing stuff and helping us -- having some level of rigor around what is a cost-effective cost savings intervention for Medicaid, for both the federal government and the state government.

So we talked about North Carolina has a waiver in, I think you mentioned, Jocelyn, and Oregon's using a waiver. But LTSS being kind of an analog for this, why is

there not more use of waivers with their research and evaluation components to test coverage of the non-medical services as cost-effective solutions? What are the barriers to the waiver use? is my question.

MS. GUYER: I'm happy to jump in on that. First, there probably are additional states. Those are the two that I lifted up. We have seen in earlier years other states coming forward, and, in fact, I'm looking at Chuck because it's his old state. Maryland recently got approval of a waiver that has a relatively small but notable initiative that is looking at connecting people to housing and a second related one that goes back more, I think, to the ACE's conversation that's aimed at kids, the Nurse-Family Partnership. We've seen Washington state. So I probably should have opened it up a little bit broader. I think, you know, just to say the current context is -- first of all, waivers can be a fairly cumbersome tool, take a number of years to negotiate in some instances, need to be budget-neutral to the federal government, and then there needs to be alignment between the state and the federal government's priorities and what they're most interested in.

I think kind of a question at this point is the current administration has actually cited and looked at the research on the importance of social determinants of health and, in fact, is part of why -- that research is part of what they cite in terms of their interest in the work requirements waivers, so there's certainly strong awareness of it.

To date, though, they've said that they're not interested in using waivers to open up Medicaid matching funds for the supportive services that go with work. And so I think there's probably a question as to just alignment between the state interest and the federal interest in opening up Medicaid dollars. And there may be. I mean, clearly, North Carolina is going in to talk to them about that, and it's in the waiver application. But that may also be a feature of why we're looking for states and trying to figure out whether or not they're going to come forward on it.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: I've got what I hope is a quick question for you, Arlene. On one of the slides you didn't get to, I was looking at the age categories, and the

last age category is 60-plus. So I was wondering if you had extended your model to those who were dually eligible.

DR. ASH: Short answer, no, not yet. We are starting -- in the new work that we're on, we're looking at the senior care organizations, SCOs, and so we will be looking at that population. But that'll be the first time.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: Great presentations. So the question continues I grapple with is how far Medicaid should go, both whether as a state as well as MCOs, and really solving it directly versus indirectly. And, Arlene, you talked a lot about the predictive value, yet it's not additional dollars going into Medicaid. And I wondered how much this has facilitated or will facilitate predictive value as it relates to a lot of these social determinants, better direct integration or involvement of housing, of SNAP, of other systems and working not in silos but really integrated. I think Arizona is a good example of where -- we have to realize what Arizona is doing is using non-Medicaid dollars, but in an integrated fashion.

So if you could talk a little bit how this may have spurred those types of ways of breaking down silos or

what could be done to use these types of predictive values as ways to then bring the different entities together to work more in an integrated fashion.

DR. ASH: Great question. Our waiver involves support for these community partners who will get referrals from the state or can make their own referrals, or the ACOs can make their own referrals. And, fundamentally, these community partners are supposed to facilitate access to existing programs. So to the extent that we bump up against the reality that Massachusetts doesn't have -- certainly certain parts of Massachusetts doesn't have any affordable housing, it's not so clear that we can make much progress unless we have the agreement of other state agencies and the governor to actually, you know, put more resources into there being more affordable housing.

So, I mean, the short answer is this -- what we're doing I believe will be a spur to surfacing the problems and perhaps getting people talking to each other about how to solve them across silos.

CHAIR THOMPSON: All right. We're going to do Marsha, then Kit, then I'm going to finish this off.

VICE CHAIR GOLD: Yeah, this is more a comment.

I think it pulls some of the questions and answers together. I'm trying to figure out what question we're trying -- or which issue we're trying to deal with, and it seems that there are at least two, or probably more, but, you know, one of them, which is not really the focus, but I think it's the focus of the work you presented, Arlene, is how to adequately pay providers who serve people who are more expensive because of all these social conditions. I mean, that's what you were saying with the risk adjustment -- with the quality metrics. And I think it's pretty clear that's within the scope of Medicaid to have to really adjust that so that it's treating people equitably.

The other question then is how can we avoid keeping paying so much money to treat these people if there's better ways to get them better. And that was sort of the focus on the panel, but it's not -- you know, then there's the question there of to what extent should Medicaid pay, should other people pay. If you break down silos, which I think Toby was saying, that's good. But then what happens? Does Medicaid -- should it spend less if we got all these things working? But no one wants to pay for the other things, and, in fact, if anything, people

are cutting those monies down.

So it's a conundrum, but I think some of the issues are easier to deal -- you know, to at least deal with than others, and maybe being a little clearer as to when the issue is whether Medicaid should pay for something or whether one should just somehow look broader and try and reduce costs systemwide or increase costs there to save money there or something else to improve care for people.

DR. ASH: Yes.

[Laughter.]

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: Just a quick clarification on Toby's back-and-forth with Arlene. It's not that there's not new Medicaid money going into the Massachusetts waiver. There's a billion and a half dollars worth of DSRIP money that's paying for those community partners to get up to be able to actually submit a clean claim. There's just a host of money that's being pushed out in a variety of creative, innovative, and some people think questionable ways. And the bet is that at the end of the five years, that supposedly one-time funding will be able to go away, and what we will have is a sustainable system

that we have built in order to do all of this new good stuff in Massachusetts.

So while the managed care rates, in fact, are operating under the zero sum game that Arlene very accurately described, all this other money is getting put in and, you know, DSH money is getting moved around, other supplemental payments that I know we're going to talk about later are -- so there's a host of money being shifted around, and it's not as simple as Arlene's very elegant model and trying to get the data to drive that in an individually focused way.

COMMISSIONER DOUGLAS: But is it changing housing policy or getting that to be more in a line --

COMMISSIONER GORTON: People are nibbling at that around the edges, right? There's a separate SIF waiver. There's other stuff going on that are trying to look at those things. I think Massachusetts, you know, the most popular governor in the nation leading one of the most progressive states in the nation, you know, there's tension there about how money gets spent. You know, are we spending enough on schools? Are we spending enough on roads? Are we spending enough on shoreline protection as

the tide comes in? There's a lot of tension going on in Massachusetts, and, quite frankly, I don't think you would see in Massachusetts the level of interest and commitment to this, one, if the state hadn't bet the ranch on this waiver; and, two, if the federal money hadn't come flowing in and everybody was incentivized by that.

CHAIR THOMPSON: Hear, hear.

Let me ask one final question, which is about time. We've talked a little bit about money. Some of what we're talking about here seems to be very difficult, as we discussed, to address issues that are facing people and communities. There has been a fair amount of research and discussion over time about -- and, Arlene, I think in your model you even assumed that a plan was going to have hold of an individual for a certain amount of time. And so I'm just wondering if you have any observations to make about that issue, about if you were really going to ask plans in some way to address social determinants of health, even more so than purely medical or clinical dimensions of health, then is there an implication for continuity of care and the need to keep people enrolled, covered, and under the auspices of a single plan even, in order to plan those

interventions and refine those interventions in terms of how they're meeting the needs of the individual, certainly to the extent that there are investments being made in communities. I just wonder if any of you would like to make comments on that element that we should also take into consideration.

DR. ASH: So my comment about time was that actually it's silly to try to pretend that you have an accountable care sort of situation for somebody you see only two months. You know, so the state really has to think about making payments for those people that are not based on my model, which has to do with having somebody for a while and it being plausible that you are accountable for what happens.

The second thing about time is that in our state, because we have a relatively generous definition of who we're trying to cover and who we are covering, we have a lot of continuity. Unlike the historical wisdom on what does a Medicaid population look like, it's people bouncing in and out, 85 percent of our person-years of coverage are for people who are present for an entire year. So we have a lot of people who we're actually dealing with day in and

day out.

And, of course, the other question is continuity of care. In our waiver evaluation, we're going to be looking very much at the extent to which people do continue to stay in the plans that they're enrolled in. But, again, historically we can say that people -- you know, people find the plan that suits their needs, and they stay there. So we think there is that continuity, and -- yes.

MS. GUYER: I think your comments raise and reinforce the importance of continuity of coverage. We all know it's got a value when you're looking at the payoff for medical interventions, but I do think as states increasingly look at social interventions as well, it becomes even more important that people have some continuity of coverage.

MR. MOORE: And I'll just -- yes, but I also think the other issue to keep in mind is that because of the nature of the investments that are being made, I think that kind of that -- the water line needs to go up across the board, and the policy and the partnerships with the state to ensure that investments are being made, that you don't have the ability to have adverse selection that

allows what is at this stage a very cutting-edge type of model, regardless of what it may be, that it doesn't cave in on itself. We are still -- we're building this as we go, and we're learning as we go, whether it be -- you know, we're stealing from different states to be able to cobble together the best practices, knowing that they don't always speak the same language. But are there different themes that you can use, and I think the ultimate goal is we've got to allow that to grow, both from a systems perspective but from a financial perspective as well. And I think it's an education process, but you raise a very valid point, that if you go too fast, you may actually create a disincentive for investment, which right now is really what needs to be made across the board.

CHAIR THOMPSON: Thank you. Well, this was worth the wait, and as you can see, we could probably keep you here for another hour or so. We really appreciate your coming to share your experiences and your expertise. It has been invaluable to us, and we appreciate it very much.

We are going to break for ten minutes and come back at 11:15. We'll pick up a little cross-talk among the Commissioners reflecting on this panel before we move into

consideration of our draft June chapter on substance use disorder treatment.

Thank you very much.

* [Recess.]

FURTHER DISCUSSION ON STATE APPROACHES TO FINANCING SOCIAL INTERVENTIONS THROUGH MEDICAID

* CHAIR THOMPSON: Let me go ahead and give the 30-second warning so we can reconvene.

Okay. Commissioners, I thought that was a really productive conversation and a really good panel, Rick. Thank you very much for organizing that for us.

Let's just take about 10 minutes here to help solidify our thinking about where this Commission may want to go in the future with this topic and conversation, so that we can give some guidance to staff about things that we might ask them to look more deeply in or think about constructing some methods and approaches for us to provide some additional insight or lines of thinking.

There were a few topics that I picked up on, so let me throw these out and see if we are grooving to these topics or not.

So one is the area of rate setting and MCO

incentives including how to account for and capture spending and savings. Another is what is actually -- what are actually cost-effective ways to think about addressing Social Determinants of Health, how do we think about reflecting Social Determinants of Health in quality measures, and how do we think about organizing for the integration of programs in a way that ensures that we tap into existing streams of funding that could be combined with Medicaid dollars in order to address person and community needs relating to SDOH.

Any reactions to those topics or different topics or thoughts?

Sheldon.

COMMISSIONER RETCHIN: I don't know if I'll address exactly the topics. Maybe I'll be a little tangential, Penny, but let me start off by saying I've been on the Commission for three years. I have never, ever heard the term "premium slide," which sounds like a dance from the seventies.

[Laughter.]

COMMISSIONER RETCHIN: It just seems to me that the same thing would apply for the concern over a premium -

- I'm going to use a little more -- premium adjustment, that if we didn't treat congestive heart failure, then we would worry -- well, the cost would be lower, so that the premium might be adjusted. I thought that was a little odd.

But I do want to bring back -- since there was evidently a betting pool that I would bring this up -- so there's several ways I think to deal with Social Determinants of Health. This was terrific to have Arlene here paired with someone from one of the MCOs. I thought that was terrific.

You can stratify. I mean, these are the things you deal with -- confounders, stratify, exclude, adjust. I just wondered if there was anybody else who feels an incongruence when we're talking about Social Determinants of Health at the same time the biggest rush on the 1115s are on work requirements.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: Yeah. Let me react to Sheldon and the premium slide.

I think it's a real issue in the sense that we often have payment policies that in some respects, at first

blush, are targeting the right incentives, and the idea of having 85 percent of the premium dollar go to benefits seems like a very good thing. But what it also creates is -- remember, if we're going to attract people, plans to sort of a business, their interest is the return to them. The return to them is net 15 percent. So the bigger the base, the bigger return to them. So we have got to be thinking about how do we create incentives over time that are beneficial both to us as the payers as well as the people that we're trying to get to participate. I mean, there's got to be some balancing there, or we're not going to gain over time, and we're not going to get enough participants sort of over time.

COMMISSIONER RETCHIN: Oh, I get the concept.

COMMISSIONER SCANLON: Yeah. Right. No, I know, but it's -- and I think --

COMMISSIONER RETCHIN: I just thought it was being applied to social determinants.

COMMISSIONER SCANLON: Well, I'll come back to this. Even if we don't talk the social determinants discussion, we should be having discussions about our payment policies and what kinds of incentives they're

creating over time, and this was kind of an example today of sort of one of those.

I got very nervous -- or I do get very nervous about sort of this question of things being cost savings, even though sort of sometimes they may and sometimes they're not, and sometimes they're not because we're dealing with situations where we've underinvested. And I think there are elements within Medicaid. It can be services. It can be some segments of the population where we've underinvested.

And to think we're going to get savings from doing something about the social determinants, which may be good for those people's lives, I think it's a false hope, and so it's much more important for me to be thinking about what are going to be the returns when I think about what base I'm starting from because I don't want to set it up for failure. That's the thing that sort of concerns me.

We often are looking always for savings in a very narrow area. We've done something for this person, this service, et cetera, and it should yield savings, but the reality is maybe it doesn't. Maybe our savings should be coming from somewhere else so that we can fund the

underinvestment over here, which will have social benefit that's much more broad.

CHAIR THOMPSON: Yeah. There was a comment. I can't remember who made it, but I wrote it down. It was who has to spend money to save money someplace else, and so it's also -- are you reacting in part, Bill, to the phrase "cost effective"?

COMMISSIONER SCANLON: Well, cost effective is different.

CHAIR THOMPSON: All right.

COMMISSIONER SCANLON: Cost effective is I'm going to do this, and what's the cheapest way to do that?

CHAIR THOMPSON: Yeah. Because it makes sense, and then I might take in a different view of how I measure that cost effectiveness. And it may not be one to one, one program spends, one program saves, et cetera.

Kit, then Alan, and then Darin and then Chuck.

COMMISSIONER GORTON: So, first, I'll agree with Bill because I had the same sense of unease when we started talking about savings.

With respect to your themes, I do think there's a role for the Commission to potentially eliminate the

problems in the way the rate setting is done, right? So there is this divide between program dollars and admin dollars.

If you go a level deeper, there are states that budget those in different ways. Alabama literally has a constitutional limit on what they can spend on administrative expenses, and if it's an administrative expense, don't talk to them about return on investment because there's a cap, and they can't get past it.

So I think it's worth thinking about -- and Darin talked about this a little bit -- how things bucket out, and another place that I think makes sense is to compare and contrast with the rest of the world.

So the NAIC has a very specific set of criteria that they've built in terms of what is medical expense and what is not, what you can attribute from quality measures and care management and other stuff that you can count as a medical expense when you calculate your MLR and what's admin.

And I think when we get into this realm, what we're starting to do is get crossways with that, and if you have organizations that are trying to live in multiple

ecosystems -- they're trying to sell employer-sponsored insurance, self-insured. They're trying to sell ACA plans and individual policies. They're trying to do Medicare, Medicaid.

When the rules shift, first of all, the state regulations may not allow for that. State insurance regulations may say this -- "We've adopted the NAIC model definitions, and so this is the way it is in our state." So it seems to me that there may be some regulatory constraints and some arguments against maybe as much flexibility as might be required for some of this.

The last piece I want to just say out loud -- and it sort of bounces off of your Medicaid-ization of everything -- is the budget allocation decisions belong to the political branch, and so this Commission needs to focus on that for which there is an evidence base that can be evaluated and opined upon.

I think what we heard is that there's great interest in figuring out what to do about social determinants and how to deal with. There's all sorts of demonstrations and experiments and research going on, but I think we heard each of the three panelists say to us, "But

we don't have a body of evidence yet to say anything particularly definitive." And so I think that it's important that the Commission constrain its eagerness to deal with this to those things which there's a body of evidence that we can comment on in a politically neutral way.

CHAIR THOMPSON: Alan?

COMMISSIONER WEIL: I want to follow up on Marsha's comment earlier that it's sort of there were -- coming at a number of different questions, and I think this is my effort, Penny, to respond to the four that you set out.

I do think there is an issue not just of rate setting for MCOs, but trying to overcome potential disincentives to providing care to certain populations. This is something done around the world, where you actually overpay for people with social disadvantage because you know it's going to cost more. That's how you address social disadvantage. We do the opposite here.

I think it would be worth taking on -- and this is more what Arlene talked about -- this notion of the risk adjustment role here, which is really quite different from

the investment role.

The second is what I would loosely call, with an emphasis on loosely, addressing the market failure problems. When you used the term "cost effective," if there is a financial return to health care for a non-health care investment within the period someone is enrolled, the incentives are aligned with the health plan. In theory, they'll do that if they know when they're acting in their best interest.

But there are a lot of market failures here. There's the long-term, short-term problem. There's the externalities problem. There's the funding stream problems. There's where you measure the cost and the benefits.

So I guess rather than sort of saying what are the cost-effective ways, I would say how do we overcome the systemic underinvestment in addressing social determinants due to the way we structured our programs, and that then I think leads to a policy response as opposed to listening to what are the cost-effective interventions, which I do think is a part of that. But I'd rather put it in the broader context.

And then I see a role here for the infrastructure issue, which again was addressed by the panel. I think about where we started and where we are now on the opioid epidemic, and a lot of what Medicaid does is weave things together that were created separately for lots of reasons. And I actually think that's a lot of what's going on here, is you've got -- someone has to decide that we're going to do a better job on these issues if we weave together these disparate programs and different provider systems and community-based and where we have electronic health records and billing capacity and where we don't.

And lo and behold, because Medicaid has the money, Medicaid is the one who can do it, and some of that might be at the plan level. Some of it might be at the statewide level.

So to me, the questions are sort of how do you build an infrastructure that weaves together the service delivery systems that people need to address.

CHAIR THOMPSON: Thank you.

I also think some of your discussion about the infrastructure -- there's a part of me that when we talk about integration of programs, that that feels exhausted

almost immediately.

But I think that sort of the way that you've described how we could think about that question maybe gives us an avenue into sort of where are all those interests and activities coming together, and I think about the chart that we saw with a very complex ecosystem that's attempting to in various ways address these different problems, and maybe there's some different apertures that we could open up to think about how that could be simplified and made more effective and strengthened with Medicaid at the core, but not necessarily Medicaid taking over all of those responsibilities and activities.

Okay. Darin and then Chuck and then Brian.

COMMISSIONER GORDON: So one thing that I think would be helpful and fits within your category of cost-effective interventions, but also I think along the lines of what Alan was talking about, we heard a lot of discussion. And I've heard this across the country on social determinants, about all the different screening tools and how we should identify these gaps.

I hear far less discussion about how do we capture the data that when I do connect or refer that there

was an intervention or there was contact or that something happened. Hopefully, people are thinking about that next a little, but if there are states or if there are solutions out there that do get at that, I think that's going to be a necessary element. Otherwise, we're going to be making decisions based on referrals versus any kind of substantive intervention. And so that would be an added element that I think should bring color to the analysis.

CHAIR THOMPSON: That's an important point, which is even if it isn't in the control or the rate, we need to have the data and the evidence to know what occurred and how that might have contributed to the result that we're seeing on the health side.

Chuck. I have Chuck and Brian. Did I miss anybody else who wants to jump in?

[No response.]

CHAIR THOMPSON: Okay.

COMMISSIONER MILLIGAN: Just first, my apologies about going on too long with the panel. I lost track of the agenda, so my apologies about that.

I think, Penny, to me, two buckets align really nicely, one having to do with rate setting and the second

having to do, I think, with kind of what Stacey mentioned, which is just paying attention to the waivers that are kind of happening and what the evaluation and data elements are about all this. So I think, to me, those are two buckets.

I do want to comment on the rate setting component for a second. To me, the premium slide -- so the premium slide or the downward spiral, to me in managed care, when I was with state government -- and now I'm at an MCO -- it's been pretty well understood and pretty recognized that you want to do good prevention, and there's a recognition that the rates will be affected if you're successful.

And, Bill, MCOs don't, I think, have an incentive to like spend a lot of medical to grow their admin. I just don't think that is -- I've never seen that as a strategy at a state level or an MCO level.

To me, the premium slide issue or the downward spiral is, unlike a flu shot where the investment cost and the savings are both in the math, what we're talking about here is the investment isn't in the math, but the savings are deducted from the rates. They're deducted from the rate base.

So Jocelyn talked about that a lot, but to me, the market failure element is -- unlike a flu shot or immunizations or prenatal care or name your thing, the medical prevention producing the savings, here the preventive intervention isn't captured, and so the premium slide is the savings come out, but the investment isn't in.

CHAIR THOMPSON: Yeah. So that's both -- and I've heard some of that discussion before, even with respect to in lieu of services and how they get captured. That a decision can be made to make an investment and to carry an expense. It isn't recognized. It creates savings. So it's kind of a double whammy.

It's not that you've actually created efficiency through your ongoing activities. It's that your ongoing activities aren't properly calculated and captured, and that affects sustainability.

COMMISSIONER LAMPKIN: And just let me interject here. It's actually a broader problem than just Social Determinants of Health. It really applies potentially to other aspects of value-based purchasing as well, where you're looking for investments that cannot legitimately be built into the capitation rate.

CHAIR THOMPSON: Right, right.

VICE CHAIR GOLD: Maybe Stacey can come up with a term that sounds better than "premium slide" because I have that same reaction as Sheldon.

COMMISSIONER LAMPKIN: I'll work on that, Marsha.

[Laughter.]

CHAIR THOMPSON: All right. Stacey will report back at our next meeting on a better term.

Brian, do you want to jump in?

COMMISSIONER BURWELL: I'm definitely in the camp where this whole area makes me very uneasy. It's extremely complex, and people have talked about there's theory and implementation part to this. I don't think -- I just don't understand what the theory is. I don't understand what we're trying to accomplish. I mean, it gets into what is Medicaid and what isn't it. Are we trying to solve all the problems of very poor people? I don't think we can do that.

I feel like we need some kind of construct a conceptual framework in order to have more fruitful discussions about policies around rate setting. Are we talking about a fixed resource environment, where we're

trying to figure out how to spend a fixed amount of resources more efficiently in terms of medical care versus not medical care? Medicaid is not a fixed-resource program either.

I find before we get into very specific things around rate setting and so forth, I feel like there has to be a more conceptual discussion around -- you know, this is, to me, Social Determinants of Health is like duh. I mean, you know, right. It's really about population management, and do we have a policy around population management? Is that the direction that Medicaid is going? So, I mean, that's kind of where I --

And I also feel I've been in this place way -- I mean, I grew up with the HCBS waiver program, and that program went through the exact same thing: "This is ridiculous. Medicaid is a health insurance program. Why are we spending all this money on these nonmedical services? It's going to blow the bank," you know.

It got started during the Reagan administration, and there was a lot of controversy about the expansion of Medicaid into nonmedical services. But now we don't even think about it.

So I just -- that's my uneasiness.

CHAIR THOMPSON: Okay. Fred, you wanted to jump in and respond to that?

COMMISSIONER CERISE: Yeah. Put me in the uneasy camp too.

The problem is to think that we can run a health care system to fix this huge social program -- we already spend a lot in health care, but the problem is it's in your face every day, right? So when you see plans and providers see the person who is in the ED every day, real cases, and you know that there's an intervention there that you can do, so you're the one seeing it every day is I think what drives it.

So my mind, you would think about, okay, what may be in between rather than owning all the problems. Is there a connecting piece? Is there something that we can hold plans, providers accountable to, to not ignore, and just keep submitting the bills, but to try to make some connections that make sense without assuming that Medicaid can fix all the problems?

COMMISSIONER BURWELL: See, that to me would be an effective construct. Let's go after the high utilizers.

We're not going to solve everybody's problems, but here's a group, population management approach.

CHAIR THOMPSON: Yeah. Well, I think the idea of some of these topics is that we can't boil the ocean, and we can't say that we're going to figure out how all of these connecting pieces work together in everybody's lives and make that all part of Medicaid's coverage policy. So I think if we try to tackle some of these things in the way that we've been describing, it will allow us to parse out some of those issues a little bit more clearly and to kind of understand what we know, what we don't know, what we think makes sense in light of what we do know, at least to avoid the circumstance that we've described in some cases.

And we've heard from the panel, where we know that there are particular kinds of Social Determinants of Health that are affecting what's happening inside of the Medicaid box, and we want to find a way to get the right levers of action on those social determinants, because it has a direct impact on what's happening inside of the Medicaid box and for the Medicaid beneficiary.

And we're also wanting to avoid creating a system that incents people to not address those issues very

specifically because they are outside of that Medicaid box.

So I think maybe if we test that proposition a little bit with respect to some of the topics that we've discussed, that might turn out to be a constructive way to go about it.

Toby, you can get the last word.

MR. DOUGLAS: Sure. Really a great -- I loved, both, Penny, yours as well as Alan's constructs and I think it well for us who have concerns about how far we go, from a Medicaid standpoint.

The other piece is I think it would be good. We're going to talk later about MLTSS, but just to highlight, because that's an area of longstanding social determinant before we were even talking about it, of what have been the practices, whether just from Medicaid as well as an MCO standpoint, and it gets to Darin's around data capture, around true, using different sources, bringing it back to outcomes to care management so that we can see the whole picture. I mean, that's one.

Another, I would say -- you know, again, back to public health intersection, home visiting programs for new moms. I mean, there's been a longstanding, in other areas.

If we can distill some of those as best practices too, and then use those as kind of where is Medicaid's role and where it shouldn't be, I think would help.

CHAIR THOMPSON: Done.

Okay. All right. Let's go ahead move on to our next topic. Thank you, Rick, very much. Obviously a complicated, complex topic that we'll continue to spend time on, but I think this has been a great opening salvo for us.

CHAIR THOMPSON: All right. We will now move on to consideration of the draft chapter for our June report on access to substance use disorder treatment in Medicaid, and we have Erin to lead us off.

REVIEW OF DRAFT CHAPTER FOR JUNE REPORT: ACCESS TO SUBSTANCE USE DISORDER TREATMENT IN MEDICAID

* MS. McMULLEN: All right. So good morning. Today I'm going to run through the draft chapter on access to substance use disorder treatment in Medicaid. Much of the information that I'm going to cover today is drawn from materials that were presented at the March and the January meeting.

The chapter opens by summarizing Medicaid's

response to the opioid epidemic, and that includes describing findings from the Commission's June 2017 report to Congress. It was noted there that gaps in the continuum of care create barriers to treatment for Medicaid beneficiaries. This year's chapter further analyzes those gaps. It also assesses the adequacy of the care delivery system and identifies areas that could be strengthened to support Medicaid's response to the opioid epidemic.

While the opioid epidemic is affecting a lot of states, in some areas overdose deaths are occurring due to other substances. Although the chapter focuses on the treatment of opioid use disorders, many of the concerns and the continuum described throughout the chapter do apply to other substance use disorders. So with that I'm going to summarize the chapter sections that are listed under the second bullet, and then we'll conclude with Commissioner feedback on the draft chapter.

So the Commission has discussed the importance of providing access to treatment services along a continuum of care to assure effective treatment and promote continued recovery. The chapter describes how the severity of an individual substance use disorder influences the type and

intensity of services that they need. This necessitates a continuum that offers progressive treatment, such as outpatient services and medication-assisted treatment, and non-clinical supports including recovery services, to enable individuals to manage their substance use disorder over an extended period of time and as their health care needs change.

The chapter breaks up clinical components into two different sections. The first part includes the levels of care defined by the American Society for Addiction Medicine, or ASAM. ASAM offers nine different levels of care, and each level represents a separate service such as intensive outpatient treatment or partial hospitalization or low-intensity residential treatment.

The second clinical component is medication-assisted treatment, or MAT. For individuals with an opioid use disorder, evidence-based guidelines suggest that the use of medication, combined with counseling, is an effective treatment modality.

And then due to the chronic nature of substance use disorders, individuals may need additional non-clinical services to support their recovery, and the chapter

highlights how those recovery support services are a critical component to the continuum of care. Recovery supports include peer support, supported employment, or mutual aid groups such as 12-Step programs.

So the chapter, then, offers a framework to assess access to the components of the continuum of care that were highlighted on the previous slide. All three of the bullets listed here are important factors that influence a beneficiary's ability to access substance use disorder treatment.

The first component of this framework does look at coverage, and then in order to assess coverage at the state level staff did review documentation including Medicaid state plans, 1115 waivers, provider manuals to determine what sort of services states were covering. In instances where we were unable to determine that, we did reach out to states directly.

And then the second area we used to analyze access was provider supply. And in order for these services to be accessible, a delivery system must have an adequate supply of providers that are located where beneficiaries live. And then the third component is

provider participation. Providers must be willing to participate in Medicaid and accept new patients. So for those last two bullets, provider supply and provider participation, we largely drew from a federal survey that captures 90 percent of all specialty substance use disorder facilities.

All right. So many of the coverage findings we did talk about last month, so I'm only going to highlight some of the key takeaways that we offered. Many state Medicaid programs don't cover all the levels of care that are identified by ASAM. On average, states are covering just six out of those nine services. And coverage also varies greatly by state.

The largest gaps do exist for partial hospitalization and residential treatment, partial hospitalization being a covered benefit in 33 states. And then 38 states do cover some form or residential substance use treatment. However, only 17 states cover all four levels of residential care identified by ASAM.

Assessing gaps in residential treatment is of particular interest, given that Medicaid programs can't receive federal payment for inpatient care provided to

individuals over the age of 21 but under the age of 65 who are patients in an institution for mental disease. So while residential substance use treatment facilities may be IMDs, states can still pay for residential substance use treatment for this population under their state plan, but many choose not to do so.

CMS has recognized that the IMD exclusion does present as a barrier to substance use treatment and they have offered two different pathways for states to pay for those services. The first is in managed care settings, as an in-lieu-of service, and the other is through 1115 waivers.

Our analysis of state coverage doesn't include which states do have arrangements where residential substance use treatment is being paid for as an in-lieu-of service, but it does include a discussion of how the states are using substance use disorder waivers under the Section 1115 authority.

So this map shows the states with approved or pending Section 1115 waivers. It does include states that were approved under the 2015 guidance that CMS issued, as well as states that have approved or pending waivers under

the updated guidance that was issued back in November. Overall, 21 states have sought this authority and roughly half of those have been approved.

In addition to seeking relief from the IMD exclusions, states have to demonstrate that they will offer the full continuum of care, and in some instances, states have taken an incremental approach to those waivers to cover services that are currently lacking from their continuum.

So the second coverage component is of the medication-assisted treatment. All states do offer a prescription drug benefit which would include some coverage of medications used to treat opioid use disorder, and all states pay for buprenorphine and 49 states pay for naltrexone. However, states aren't required to pay for methadone treatment but 38 do.

While much of the policy discussion of MAT coverage does focus on the drugs itself, drug coverage must be viewed in tandem with treatment settings paid for by the state, which largely influences the availability of the counseling component of MAT. The chapter highlights two settings that medication-assisted treatment can be

delivered in, opioid treatment programs, or OTPs, or office-based therapy.

And then the final coverage component is of those recovery supports. For the chapter, we did not look at state-level coverage of recovery support services. We drew from a compendium that MACPAC issued in 2016, that is based on 2015 state level data. And we did find that 14 states covered peer support services and 9 states and D.C. covered supported employment. The Commission is conducting additional research in this area to determine if states are paying for recovery support services and how they do complement that broader ASAM continuum of care.

So the second component of the access framework evaluates provider supply. Substance use treatment facilities providing more intense ASAM services, such as intensive outpatient treatment, partial hospitalization, and short-term residential services less often than they cover outpatient treatment. Services that are provided less often correspond to service levels where Medicaid payment is also limited. And then access to these services also varies greatly by state. Some states have very few providers while others do have more residential treatment

facilities than others.

And then providers offering medication-assisted treatment is also limited. A recent study found that only 2.7 percent of specialty substance use facilities do offer all three forms of medication-assisted treatment. And then OTPs are also generally located mostly in urban areas and require patients to visit pretty close to daily to get their medication administered. This creates, you know, limited access for patients that do live in rural areas or places where transportation is a challenge.

In addition, few providers are authorized to prescribe buprenorphine. The prescribers that have obtained the federal certification to prescribe buprenorphine are heavily concentrated on the East and West Coasts, leaving kind of bigger gaps in the provider supply in the middle of the country. And there has been an increase in the number of waiver providers in recent years. However, a lot of those providers are only prescribing -- are only capable of prescribing up to 30 patients, and a lot of them aren't even prescribing up to that number.

And then the last component of the access framework does relate to provider participation. Sixty-two

percent of all substance use facilities do report accepting Medicaid, but that varies greatly depending on what state you're in. It ranges from as low as 29 percent in California to 91 percent in Vermont.

Approximately 60 percent of counties in the U.S. do have at least one outpatient substance use disorder treatment facility that accepts Medicaid, but this rate is a lot lower in Southern and Midwestern states. And then counties with a higher percentage of black, rural, or uninsured residents are also less likely to have one of these types of facilities.

So while about half of these specialty substance use providers report that they accept Medicaid for outpatient treatment, providers of those more intense service -- residential treatment, partial hospitalization -- accept Medicaid at a much lower rate. And then in regard to MAT, additional research is needed to find out how many physicians or nurse practitioners participating in Medicaid are also providing buprenorphine services.

The chapter then kind of switches gears to talk about opportunities under those 1115 waivers and how they can be used not only to pay for IMD levels of care but how

they can be used to kind of address these different issues that we talk about throughout the chapter -- coverage, provider supply, provider participation.

States seeking a waiver must demonstrate how that inpatient and residential substance use care can supplement community-based services, and that it's part of that broader continuum that we have discussed in the chapter. States must also implement provider requirements and meet significant reporting requirements that are also further outlined in the chapter.

And then there have been, as I noted earlier, you know, 10 states have these approved waivers, 11 are pending. Few have been implemented long enough to be evaluated, so the chapter highlights the two different states that we've talked about previously, California and Virginia, and what their early findings are from their waiver evaluation. The strategies they used to address these issues -- coverage, provider supply, and provider participation -- are also highlighted.

The conclusions and next steps offered in the chapter don't include any recommendations but they do offer a few key takeaways. First it notes that an effective

Medicaid response to the opioid epidemic requires payment for a full continuum of care, access to specialty substance use providers, and that these providers also are participating in Medicaid.

The second conclusion comments on gaps in coverage. Medicaid's response to the opioid epidemic is limited in several states. In part, that is due to narrow payment policies. We only have 11 states that pay for that full continuum of care. While policymakers have focused on the IMD exclusion as a barrier for paying for residential substance use treatment, there are other gaps in coverage that aren't affected by that policy, such as partial hospitalization, a level of care that is critical to support individuals that are ready to receive treatment in the community.

In addition, several states don't pay for methadone treatment and opioid treatment programs. That is a study that's needed for individuals who do need that daily interaction with their treatment provider to support their recovery. And then for many levels of care where gaps in Medicaid coverage exist, the supply of substance use facilities offering that type of care is also limited.

That creates additional challenges for beneficiaries when they're trying to access services.

And finally, even fewer specialty substance use providers accept Medicaid. In some states, Medicaid provider participation is so low that it might not be enough to facilitate access to that full continuum described by ASAM.

So the Section 1115 waivers do provide an opportunity for states to comprehensively improve access to clinically appropriate care but many states have chosen not to seek that opportunity or other Medicaid authorities that could be used to offer these services.

And then, finally, there were two areas that were included as next steps for the Commission. First, we noted MACPAC was interested in better understanding the extent to which states are providing those recovery support services to Medicaid beneficiaries with substance use disorders, and right now we have already a project with a contractor underway that focuses on identifying state-level coverage of these types of services.

Second, we noted that additional work can be done around MAT. The degree to which state policies including

preferred drug lists, and prior authorization requirements, how they influence MAT utilization among Medicaid beneficiaries is unknown. A more nuanced understanding of MAT utilization at the state level can help the Commission in determining whether there is appropriate access to MAT for beneficiaries.

And then, finally, the Commission will continue to monitor the Section 1115 waivers that are approved or pending. Looking for those evaluations would help the Commission understand the successes and challenges that states are facing when they're implementing these new benefits and whether it is driving change within opioid use disorders, individuals seeking treatment in their state.

So that concludes my presentation on the chapter and I look forward to Commissioner feedback. Thank you.

CHAIR THOMPSON: Thank you, Erin. Great job on this chapter and pulling together a lot of disparate pieces in order to give us a little bit of a better view on what's really happening in terms of access to services.

I'm going to ask Kit to kick us off.

DR. GORTON: So I agree this is a great, well-constructed chapter. It takes some very complex stuff and

makes it really quite clear, and I think it's another huge contribution that the Commission makes to helping people understand the program.

In the chapter itself, Box 4-1, there's the ASAM special adult populations. For all the appropriate reasons, I understand that the access work -- the beginning access work that you've done doesn't double-click into these populations, and I'm not suggesting that we change the chapter. But I would suggest that, going forward, we think about whether or not it's possible to address the same access questions at the level of these specific populations.

And then the other piece that the chapter doesn't address, and I don't know whether there should be a sentence thrown in or not, is for children and adolescents, these services are all covered under EPSDT. And so there the question is, do access to appropriately specialized pediatric providers and facilities that are willing to treat children and adolescents, does that create access problems? And again, I don't think that's for this work, but I'm suggesting that maybe for future work.

And a hypothesis that we might look into there is

since you eliminate the coverage piece through EPSDT, my hypothesis would be that when kids really need services then what happens is if the intermediate levels of care are not available from an access point of view, they default to the higher levels of care. So they end up in inpatient for as long as it takes to get them back to the community, because the intermediate level of care.

So there may be some way to look at utilization and expenditures, and it's possible -- I don't know if this is true or not, but my hypothesis would be there may actually be an opportunity to spend more effectively and deal with the throughout problem of having all the inpatient beds filled for kids by having intermediate levels of care. So I just flag that as a potential future area for exploration.

But nice job. Thank you.

CHAIR THOMPSON: That's an excellent -- both excellent points, both about EPSDT and about the other, which was one of my questions, too, that I don't think we have a way of addressing necessarily, but just to flag it, which is there's been a lot of discussion about the IMD exclusion, for example, which you could potentially solve,

if you care to, by eliminating that barrier to care. But if you don't have these other places to get treatment, does everyone default into that setting? Or are we setting ourselves up to put people in a much more intensive and expensive setting than they need to be because of the absence of these other avenues for more appropriate treatment. And I think Martha has made the point as well, which is that you need to have community-based providers helping people in order for them to maintain their employment, in order for them -- you know, a lot of people can't find their way into a residential treatment setting for long periods of time and still keep the rest of their life intact, which is very important for their ongoing recovery as well.

So I didn't know if there was anything that we could say about why -- are the gaps in the continuum there because states feel like some of the other avenues of care are acceptable or because they don't feel like they have a supply -- is there anything that we know about state decisionmaking and thinking with respect to these gaps in the continuum?

MS. McMULLEN: So I do think there's a lot of

different variables at play. From the few states that we talked to when we were looking at what their coverage looks like, you know, a lot of them did have a couple holes in the different levels of care. But they were already working closely with sister agencies that were already paying for those levels of care using different dollars.

CHAIR THOMPSON: Okay.

MS. McMULLEN: So that type of partnership did seem like it made it easier for some states to jump on this opportunity to expand their continuum to Medicaid beneficiaries.

I think part of it, too, is probably just the competing priorities of state Medicaid programs balanced against state budgets and other coverage policy decisions.

CHAIR THOMPSON: Right, although it may be penny-wise and pound-foolish if you're driving people to a more expensive setting because you don't cover a less intensive but more appropriate setting. Maybe that's something we can just bring out and acknowledge. Again, I don't think that it's a big part of the chapter.

VICE CHAIR GOLD: But actually I think -- that's one I was thinking of, too. I mean, there's no discussion

of cost here, and it seemed to me that there were a lot of gaps. I don't necessarily know that there's no cost implications to filling gaps or there are. Some of them, if it's a more effective way of treating it, it's likely it could save money. My guess is a lot of it would cost money because it was raise rates to get providers to be adequate or better fund benefits. That may be fine, but I didn't know what -- it seems like not to mention or provide just any kind of discussion about just how this affects state budgets and how -- not that that would be bad -- I mean, I'm in favor -- it seems like a lot of interest in dealing with the opioid problem, which is fine, but not acknowledging that it costs money to do that, if, in fact, it does. I wonder, you know, if that's a gap.

So I was sort of interested where Commissioners came down on this and what you thought we should do and what evidence we have or what we think -- how we think we should address it in the chapter, because I'm a little concerned with just not addressing it at all.

CHAIR THOMPSON: Martha, did you want to jump in on that point?

EXECUTIVE DIRECTOR SCHWARTZ: Can I --

CHAIR THOMPSON: Go ahead.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, I just want to throw in here what we were kind of struggling with on this front. We don't have a comprehensive view into, for example, for the states that cover few services, what are their reasons. As Erin said, it could be a range of things; those services could be in another bucket and people are getting services, and so maybe don't worry about it so much. And it also could be they haven't paid any attention at all to it, and there could be huge need in those places that is unmet. We were trying not to be too judgey about it. So we could have some more discussion about that in there?

CHAIR THOMPSON: Yeah, I think it's just a matter of acknowledging a number of factors could play into this and it could have a number of different implications for both the state programs and for beneficiaries. Maybe they have access and they're using other funds. Maybe they believe that some of the settings that are available are sufficient to meet the actual need. And maybe in other cases, people are being driven to more expensive need, and sometimes people are being untreated. I mean, all of those

things could be, you know --

EXECUTIVE DIRECTOR SCHWARTZ: Okay.

CHAIR THOMPSON: -- right, just acknowledging all of that, because what we don't really have is we're -- and we just don't have it at this juncture, is that we're not -- we don't have a map of all of the needs to where all the coverage and settings and providers are to meet those needs. And so we can't make broad conclusions on that score.

So we have Toby and then Martha.

COMMISSIONER DOUGLAS: Excellent chapter, really comprehensive and touches really well on the issues.

The only points that I'd bring up that, you know, maybe it's for further analysis or in previous -- we can tie in from previous -- this is question one around the carveout, and the question of, you know, as we think about comprehensive continuums and the role of primary care versus substance use of how states that -- how this is working in states that have -- you know, very much substance use has been kind of an afterthought, and it usually has been stand-alone programs outside of the rest of the Medicaid continuum whether in a sister agency. So

how does that impact? And is there any way to weave that into the report or for future -- and then the other, which you just, you know, touched on, Erin, is around other funding streams, and SAMHSA and SAPT block grants and how that plays into, you know, both -- again, this almost goes back to the social determinant discussion of the role -- either things need to change, thinking about policies, and this matters more in Medicaid expansion versus non-expansion, but of how those funding are blended together to address most effectively the continuum of services.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: In the section on provider participation, I'm not sure that we don't have sort of a false concern here, and MAT authority, you can't start -- you can only start out with 30 patients. That's the license. So that wasn't really clear. You know, after a year, then the clinician can ask for additional license to treat 100 patients, and then they can go to 250. So you kind of have to look at the whole picture in the state.

Nevertheless, looking on the SAMHSA site for number of data-certified physicians, I'm seeing -- I've picked seven or eight randomly, and the numbers between

2017 and 2018 have dropped dramatically. So I think we need to understand what is going on. Is that problem -- is that causing a problem with access? Is it because of payments? Is it because of additional regulatory requirements or compliance requirements that are putting up barriers to providers to provide these services? Maybe we had an oversupply to begin with. That's hard to believe, but, you know, just -- it's something to think about.

And I'm also -- although you did include nurse practitioners and PAs, I would love to see some more in-depth reporting on how those types of clinicians are being used in this context.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: I would just want to reinforce what Martha was saying. The one thing that I wanted more out of this excellent chapter is kind of more detailed information about access to MAT. You know, there's been a large -- there was a large increase as reported here, but there's nothing geographically. How does it vary across urban, rural, or across states? And if there -- and I've heard anecdotally -- I don't know if it's true -- that there are a lot of waivered physicians who

never submitted -- who don't prescribe. For some reason they got waivered, but then they decided they weren't going to do that for other -- I don't know, liability or whatever. And if there has indeed been a drop, is that because they were waivered and they're -- do you have to get recertified every year or something? I don't know. I mean, that's a very distressing trend if that's true when access to MAT is considered, you know, an essential part of the continuum.

CHAIR THOMPSON: Toby -- I'm sorry. Darin, you were going to jump in.

COMMISSIONER GORDON: Is that because we have similar haircuts? Is that why you --

[Laughter.]

CHAIR THOMPSON: What's that?

COMMISSIONER GORDON: Is that because we have similar haircuts, you confused us?

EXECUTIVE DIRECTOR SCHWARTZ: At least you're in the same room at the same time so we know that --

[Laughter.]

COMMISSIONER GORDON: Great chapter -- we communicate. One of the things that, you know, I think is

worth calling out is that we need to be careful of confusing quantity with quality. There may be X amount of MAT providers, but I know looking at this in a variety of different ways that the treatment that actually occurs is left wanting. It's not of the highest standard or expectation. We've seen that when we looked at some of these providers.

So I just think it's worth pointing out that there's still a lot of work that needs to be done, and I would hate for someone to claim success because they have high numbers. And, quite frankly, I think that's actually -- I think many people have done that over the years and are just now realizing that, just as it is in every other part of the health care system, we don't have as good enough information on distinguishing those who are practicing and providing those services in the best possible way versus those that aren't.

CHAIR THOMPSON: And, you know, maybe we even should acknowledge that the information around the clinical evidence about the efficacy of different treatments, I mean, even if you have a high-quality provider, but they don't have the science behind them, those are both --

COMMISSIONER GORDON: There's gradations within that, but, you know, we know -- we've seen very many instances where there's medication distribution without any kind of counseling component or any other type of follow-up in support around that which would --

VICE CHAIR GOLD: And that is in the access framework. I mean, it's not in the chapter, but I think that point you raise is an important one.

CHAIR THOMPSON: I'm just referencing back to that. Okay. Any final comments on the chapter?

[No response.]

CHAIR THOMPSON: Okay. Erin, thank you very much. Again, great job in pulling this together. We look forward to seeing the final version.

We'll open it up for public comments on any of our discussions this morning. Marielle, hello.

PUBLIC COMMENT

* MS. KRESS: Hi. I'm Marielle Kress from the American Academy of Pediatrics, and I just wanted to flag a new funding stream for substance use disorder and mental health treatment in the newly passed Family First Prevention Services Act. This pot of funding basically

helps families avoid having their children go into foster care, and I believe that the population that can benefit from this new pot of money will have a lot of overlap with the Medicaid population. And so I think it would be really helpful, given this incredibly helpful digest of what Medicaid programs are covering in this area, to think about also how this new funding stream fits in with that.

Thank you.

CHAIR THOMPSON: Thank you for drawing our attention to that.

Okay. We will adjourn, and let me just check the calendar for when we are back. We are back at 2:00 p.m. to pick up the rest of our public meeting today. Thank you.

* [Whereupon, at 12:19 p.m., the public session was recessed, to reconvene at 2:00 p.m. this same day.]

AFTERNOON SESSION

[2:03 p.m.]

CHAIR THOMPSON: Okay. I'll give the one-minute warning for everybody to assemble themselves and get seated, and we'll pick up again.

[Pause.]

CHAIR THOMPSON: All right. So we're going to start off this afternoon with Martha leading us through a discussion of the proposed rule methods for assuring access to covered Medicaid services, exceptions for states with high managed care penetration rates, and rate reduction threshold.

REVIEW OF PROPOSED RULE: METHODS FOR ASSURING ACCESS TO COVERED MEDICAID SERVICES – EXEMPTIONS FOR STATES WITH HIGH MANAGED CARE PENETRATION RATES AND RATE REDUCTION THRESHOLD

* MS. HEBERLEIN: So thank you for saying that so I don't have to.

[Laughter.]

MS. HEBERLEIN: So I'm going to be discussing the proposed rule today, and I'm going to begin by highlighting some of the findings from the Commission's March 2017

report chapter, the chapter report that examined the role of monitoring access.

I am then going to go through a quick review of the current requirements for monitoring access in fee-for-service before I discuss the proposed rule changes and some potential areas for the Commission to comment.

So beginning with a March 2017 report, we noted that although managed care is now the dominant delivery system in Medicaid, monitoring access under fee-for-service remains important for a number of reasons.

States and the federal government have an obligation to ensure that Medicaid beneficiaries have sufficient access to services and must balance the need for ongoing accountability with administrative pressures.

Monitoring access can be used to support assessment of program value, act as a mechanism for accountability, and help identify problems and guides program improvement efforts.

However, the chapter also discussed that data limitations and administrative capacity are major challenges for states and CMS in monitoring access.

In addition to the program accountability

reasons, more than half of Medicaid spending nationally is for services provided under fee-for-service. In addition, the populations that remain, that are most likely to remain in fee-for-service, such as individuals with disabilities, are among the most vulnerable, and ensuring their access to services is particularly important given their high health needs.

Finally, even in states with high managed care penetration rates, some services, such as long-term services and supports and behavioral health services, continue to be carved out of managed care contracts and are provided through fee-for-service arrangements.

So the obligation to monitor access to care stems from the so-called equal access provision of the Social Security Act, which requires that states set Medicaid provider payment rates, so that they are consistent with efficiency, economy, and quality of care, and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Until 2015, there was no federal regulations that

existed to guide states in complying with the equal access provision, which led to substantial state variation.

Payment rates were primarily determined to be too low to ensure equal access as the result of lawsuits that were filed either by beneficiaries or providers.

In March 2015, in Armstrong v. Exceptional Child Center, the Supreme Court decided that Medicaid providers and beneficiaries do not have a private right of action to contest state-determined Medicaid rates in federal court. As such, federal enforcement is the primary mechanism for ensuring that Medicaid beneficiaries have sufficient access to care.

In November 2015, CMS published final regulations that described how states should monitor and report on access for care under fee-for-service. CMS noted that the goal was to provide a more transparent process for monitoring access and to CMS to make more data-driven decisions when considering proposed rate changes that could reduce a beneficiary's ability to receive needed care.

So the final rule required states to submit an access monitoring review plan to CMS by October 1st, 2016. As part of this plan, the state must conduct an analysis

once every three years for five services: primary care, specialty, behavioral health, prenatal and postpartum, and home health services. They must also examine access for any services for which the state or CMS has received significantly higher than usual call volume of complains as well as for any services for which the state has reduced or restructured payment rates where the changes could result in diminished access.

The rule includes additional parameters for the access monitoring plans. For example, they must include the measures and data sources used to analyze access. As well as when access issues are identified, states must submit within 90 days a corrective action plan with the specific steps and timelines as to how they will address the problem.

MACPAC reviewed the state plans prior to our March 2017 chapter finding that the current efforts to monitor access primarily relied on consumer complaint hotlines and advisory committee meetings.

Plans did include baseline data across the five required service areas, but overall, only a handful of states included explicit standards or benchmarks to which

they would compare their data; for example, a few said provider-to-enrollee ratios.

On March 23rd, 2018, CMS released a proposed rule to amend the process states must use to document whether their payments in fee-for-service are sufficient to ensure access. The proposed rule is designed to address the concerns of states, particularly those with high levels of managed care enrollment, regarding the administrative burden associated with the existing requirements.

The proposed rule makes three changes, as noted on the slide. I'll go through each of these in more detail.

The Commission may comment on proposed rules but is not required to, and comments are due on May 22nd.

So the proposed rule would exempt states with comprehensive managed care enrollment rates above 85 percent from certain fee-for-service monitoring requirements. CMS is seeking comment on whether the 85 percent overall threshold is appropriate, whether the threshold should be higher or whether the threshold should be lower but stratified across eligibility categories.

Under the proposed 85 percent threshold, 17

states would be exempt from monitoring requirements, but under any manner of determining exemption, some enrollees' benefits or spending could remain in fee-for-service.

As the Commission discusses whether states with high managed care enrollment should be exempt, it may be worth considering the populations and spending that remains in fee-for-service, balanced with the administrative burden that would be required to monitor access for a potentially small population.

If the Commission agrees that there should be an exemption from the monitoring requirements in these states they may wish to consider whether an alternative, more targeted approach to establishing the threshold succeeds in balancing the desire for ongoing accountability with limited state administrative capacity, and some alternatives are described in your materials.

States have also questioned the value of undertaking a review of payment changes for those that are nominal and therefore unlikely to diminish access. They also question the benefit of conducting a public process for every payment change when there has been minimal feedback over the past few years.

In response, the proposed rule exempts nominal payment changes from certain access monitoring requirements. Defining nominal payment change is those below 4 percent for a Medicaid service category, such as inpatient hospital services, within a single state fiscal year and below 6 percent over two state fiscal years -- consecutive state fiscal years.

CMS has requested comments on whether the payment change threshold should be higher or lower than these percentages. CMS is also seeking comment on the potential effect of cumulative rate reductions over more than two consecutive state fiscal years and how to assess the effect of year-over-year changes.

The Commission may wish to comment on whether the 4 and 6 percent thresholds seem reasonable, which may in part depend on the payment rates that currently exist in states. For example, a 4 percent reduction in a state with already low payment rates could have different implications for access than in a state with higher payment rates.

Under the proposed rule, states with managed care penetration rates above the threshold and those making nominal payment changes are not required to consider data

collected in the access monitoring review plans or undertake a public process on the effect of the change when reducing or restructuring payment rates.

They would, however, be required to submit alternative data to show compliance with the equal access provision.

CMS is seeking comments on the types of alternative data and analysis that these states should submit. The Commission may want to comment on what these measures should be, whether they should be measures states currently are collecting, whether they should be consistent across states, and whether they should be publicly available.

The Commission may also want to discuss what the role of beneficiaries and providers should be in these circumstances.

Finally, there may be additional areas that the Commission wants to comment on beyond those that CMS raised. For example, under the existing regulations, when a state submits a SPA to reduce or restructure payment rates, it must submit an analysis of the change's anticipated effects on access. CMS cites the difficulty

and uncertainty in producing these estimates as limiting factors in their usefulness.

Instead, the proposed rule requires states to submit assurances that the equal access provision is met and baseline data that supports this. CMS is not seeking comments on this change, but the Commission may wish to discuss whether this approach is sufficient to assess the potential for diminished access.

Another area for potential comment could be the exceptions noted in the earlier guidance. In a November 2017 letter, CMS clarified particular circumstances that are unlikely to diminish access and would therefore not invoke the monitoring requirements.

These include the following examples, such as certain reductions to implement federal payment requirements, reductions where payments are made at or above Medicare commercial rates, and reductions that resulted from changes to Medicare policy where Medicaid rates are tied to Medicare.

CMS did not explicitly include these and other exemptions discussed in the guidance in the proposed rule. As such, the Commission may want to request clarification

as to whether they still apply, and if so suggest they be included in the final rule instead of remaining in sub-regulatory guidance.

Finally, along with the 2015 final rule, CMS issued a Request for Information seeking input on the potential development of standards with regard to Medicaid beneficiaries' access to services.

In the March 2018 proposed rule discussed today, CMS reiterated its interest in developing and adopting meaningful access measures that could be used, regardless of the state's delivery system. CMS does not seek comment in this area, but the Commission has expressed interest in ensuring access to care across the Medicare program and may want to restate this desire as CMS considers finalizing the rule.

So as I noted at the beginning, the Commission can but is not required to provide comments on the proposed rule. I have listed on this slide the potential areas for comment that I just walked through. If the Commission does want to comment, staff can draft a letter based on today's discussion and submit it prior to the close of the comment period on May 22nd.

And with that, I look forward to your thoughts.

CHAIR THOMPSON: Thank you. There is a lot to unpack here. So let me just open it up and see if anyone wants to start to dive in.

Did I see Sheldon with not overly enthusiastic indications? And Bill. All right. So Sheldon and then Bill.

COMMISSIONER RETCHIN: Yeah. This, first of all, was really well written. I dropped a note to Martha. I thought it was a terrific effort, but it's a really important area. And I find it a little bit ironic that it's paired with the previous presentation, where you have CMS working really hard to get states to voluntarily report data, and then here we are looking at a set of rules or thresholds for exemptions.

So if I'm not mistaken, I believe this is a really big case of data slide.

[Laughter.]

COMMISSIONER RETCHIN: I know we're not really asked to comment on this. What I don't really totally understand -- I don't remember who asked the question or who made the comments about is this managed care or fee-

for-service on the dashboard, but this is a continued kind of -- I'll call it an ambivalence about whether it's CMS's responsibility to monitor managed care or access under managed care. And with the increasing penetration of managed care in different states, it's going to be more and more difficult.

So is it because that the reporting requirements are so difficult, they have dummy claims, or is it because we've delegated responsibility to the MCOs and so it's not really our problem? From a policy standpoint, I don't understand that.

CHAIR THOMPSON: Do you want to go ahead and jump in?

MS. HEBERLEIN: Yeah.

Well, the access monitoring review plans apply to fee-for-service and services that are carved out of managed care. Managed care has its own set of rules, and many of those monitoring requirements are delegated to the MCOs themselves.

And so I think there's a question of whether or not you have a lot of managed care in your state should you no longer monitor the populations and services that remain

in fee-for-service, and then I think there's a second question which you raise, is, well, what should we be doing in managed care, which I think is part of a larger discussion that the Commission could have.

So it's sort of today, do we want -- what do we want to say about monitoring in fee-for-service, and then are there things that we should also be doing in managed care, things that should be done differently in managed care maybe for the future?

CHAIR THOMPSON: I just want to clarify this point.

So these responsibilities exist for states because they are required under fee-for-service to provide equal access, and because the federal government asserted to the Supreme Court of the United States that as a private right of action, it was not necessary for individuals to protect those rights because the federal government would be actively monitoring whether states are meeting those requirements. And so that's, I think, the context in which to understand this part of the conversation, which is -- so if states have an obligation, as part of the Medicaid statute, there's --

COMMISSIONER RETCHIN: It's the Armstrong decision.

CHAIR THOMPSON: Yes. The Armstrong decision says individuals can't enforce those rights. The federal government asserts to the Supreme Court, "We will take care of this. We will ensure that these payment rates are set sufficient to provide equal access," and then issues a rule and says here's the method by which we will monitor and oversee that responsibility.

And then now comes this rule, which in my view responds to legitimate questions about how much work is involved for states to monitor over small populations, which may be vulnerable, which may still be significant. If we aren't using what had previously been required through the prior rulemaking to monitor for that access, what methods are we using to monitor for access?

So I think that's kind of the place where we're trying to have this conversation and then think about where we as a Commission may want to weigh in on those questions.

So Bill, Darin, Peter, Chuck.

COMMISSIONER SCANLON: Both Sheldon and you have said things that kind of relate to where I was thinking.

First of all, I think this is an excellent summary. It kind of gives me both a sense of where we are sort of on the issue and what the CMS's thinking is on the issue, and I think that's helpful but also troubling, in some ways.

This idea of administrative burden, I recognize that we really need to sort of be conscious of it and address it, but when I think about spending sort of more than half a trillion dollars and dealing with a vulnerable population, I feel like you've got to invest enough to know that your money is being sort of reasonably spent well and that these populations are being protected.

So, to me, there's a step back, which is sort of what exactly is the burden and what are the ways to sort of reduce the burden but still be efficient and effective about sort of knowing that your dollars are being spent well. And it applies not just to fee-for-service. It applies to managed care too.

I mean, it's like if 85 percent of the program is going to managed care, the idea of sort of getting reliable encounter data should be a given, not something that we throw up our hands and say this is not a possibility.

This is 2018. We're beyond the age where it's

hard to collect data and transmit data. So I feel like we've got to set some pretty significant bars and standards and say this is absolutely essential to know that the money is being spent well.

In terms of minor comments, I mean, my sense in terms of having absolute levels of like 85 percent, that might be tolerable as long as you're stratifying correctly. That you're identifying sort of a vulnerable population and you know that they are going to be sort of protected by the data that you collect, because it could be 5 percent of the people that are most at risk, and if I don't know anything about them because 90 percent of the population is in managed care, this is a problem. This is something that needs to be addressed.

Changes in rates. I mean, the base that you start with is also critical. I'm thinking about when you look at the distribution of rates across states relative to some other measures, either one Medicare pays or what sort of charges are, and you see this wide variation, you can imagine that a 4 percent change means a whole lot more, depending upon what state you're in.

And we've been blessed for, I guess, a couple

decades where we haven't had significant inflation, but an absolute number of 4, 6 percent when you've got some significant inflation, hey, it's not much of a protection.

So I think there's this issue of that we need to have sort of flexibility that things are relative to sort of what the situation is both for population or a subpopulation and a point in time.

CHAIR THOMPSON: Darin.

So, just to be clear, I have Darin, Peter, Chuck, Alan, Kit, and then Marsha.

COMMISSIONER GORDON: So, Penny, your clarification was one of the points that I wanted to make, but also I want to be clear. There are access requirements imposed on managed care. If you look at the managed care role, there are expectations placed on all states that do have managed care and what access monitoring and expectations they should have.

So this isn't like, hey, let's ignore access in managed care, as I think some were thinking this was like, well, let's just ignore that, if they have 85 percent of managed care.

The issue was you had that plus you had this come

out, and how did the two fit together, per se, managed care and may have very, very little fee-for-service? Do I need to do both of these processes to prove to you, or is there some way that -- and I think the example was it was less an issue for us into seeing we're 100 percent managed care, but we wanted clarification. Do we have to do this too on top of this under the managed care requirements?

But it was in cases of some states that had -- I think it was Arizona that had their Native American population was the only thing that wasn't in managed care, and there were all sorts of other expectations and requirements on what you do for services for Native Americans.

So I just wanted to clarify when we were going through this when I was in leadership at NAMD, and we were making the case that something needed to be done, some kind of threshold. It wasn't because, oh, please ignore managed care. There were legitimate things. It's you have requirements and expectations for me over here. Why duplicate them? Or do I have to set up a whole new apparatus for a narrow population that has other expectations or requirements for access already? So I was

trying to sort through that, and that was my experience.

CHAIR THOMPSON: Peter.

COMMISSIONER SZILAGYI: Yeah. I want to echo what Bill said, and I'm having a hard time getting my head around why would the administrative burden be very different if 30 percent of patients are in fee-for-service versus 10 percent of patients in fee-for-service. I would think that the administrative burden on the state would be relatively similar.

So I do worry. If I would need to set a threshold, it would be perhaps 99 percent or 100 percent. That would be my own threshold.

I do worry that the most vulnerable people are going to be left in fee-for-service, and if access is not monitored by the federal government based after Armstrong, then who is going to monitor? Obviously, the states wants good access.

And I also want to echo Bill's point about 4 to 6 percent if provider payments change by 4 to 6 percent. That might be the margin for some providers. There's an accumulating body of evidence that changes in provider payments do affect -- they certainly affect utilization,

but they also affect some measures of access. And that included the primary care bump, where there's multiple studies out there right now, not just Polsky's in the New England Journal of Medicine article, but others that did show improved access for Medicaid patients with provider payments. So there is a relationship between provider payments and access, although it's not a one-to-one relationship.

So I'm actually concerned, pretty concerned about this, and have no way in my own mind to try to figure out what would be the right number, whether it's the percent enrollees or the percent payments.

CHAIR THOMPSON: Chuck, Alan, Kit, Marsha, Stacey.

COMMISSIONER MILLIGAN: As I've been listening and as I've been thinking about this, I think we're going to be hard pressed to provide a comment because I don't know that we're going to get to a consensus without it being something that's just platitudes, honestly. I wanted to just contribute a couple of things.

I've spent most of Medicaid working career in two states -- New Mexico and Maryland. In New Mexico, the

percentage is 88 percent, something, from your work, Martha, which is really helpful. The lion's share of people who are in fee-for-service are Native Americans for whom it's optional to go into managed care, and a lot of that is derived from a sense of sovereignty and a sense that they don't -- there is a desire not to have access to IHS disrupted by managed care organizations. Whether that's a founded fear or not is kind of a separate issue. But it's not a population who are vulnerable in the way that Peter was describing. It's access to a different delivery system.

In Maryland, the percentage, depending on how you look at it, whether it's dollars or people, is lower, but, again, the lion's share of that are dual eligibles who are in New Mexico in managed care but in Maryland are not and for whom Medicare is primary. For the set of services that you listed in the rule, it's primary care, specialty care, home health, et cetera. And so I think one of the reasons that it's difficult to stratify and one of the reasons it's difficult to tailor is some of the variations -- and the dollars, I think dollars is the worst of all options here personally because a lot of the dollars in fee-for-service

might be nursing facility-related, which is -- I don't think the intention of the original rule is access to nursing facilities.

So I see where CMS is going. I think that there is a place to reach about kind of the tradeoff for efficiency and is it both for the exemption from the rule and also the exemption from rate changes. I just don't think we're going to be able to get there in this conversation.

CHAIR THOMPSON: And, Chuck, can you just say a little bit more about that? Are you hearing that people are, in Bill and Peter's case, for example, expressing concern about where you might draw some of these lines or what would happen if you didn't take at least account of what kinds of populations you're talking about, that that would be something that you think would be difficult to agree on?

COMMISSIONER MILLIGAN: I'll put it in my own personal terms. I have ambivalence about this, and Peter and Bill have captured some of it. But part of it is, you know, there used to be a lot of litigation when states changed rates, and Toby lived the dream because California

and the Ninth Circuit is where a lot of this stuff really happened and where providers and advocate groups opposed rate changes on the view that it would jeopardize access, and it constrained the state dealing with budget crises. And CMS then in the course of that said, you know, we got it, the courts don't need to intervene, we'll manage our oversight of the states. It kind of led to this, the Supreme Court weighed in.

I do think that in the absence of a private right of action for either beneficiaries or providers, it is incumbent on the federal government to honor that requirement. But I also do think that there is a way in which the portion -- that the -- is it a 1 percent rate change, that's okay, but not a 2 percent? Is it 85 percent versus 80 versus 90, and do we exempt duals, do we exempt Native Americans, do we exempt services for spend, you know, DD waiver services, nursing facility payments?

I think trying to find how to thread all of that is an endeavor that we would struggle to add a lot of specificity in the time allotted, so we would, I think, go to a platitude.

CHAIR THOMPSON: I see. So your point is if we

are a little uncomfortable with these 4 to 6 or 85 percent, our proposal is what in response -- 95 percent, 3 percent? How do we justify or --

COMMISSIONER MILLIGAN: I think we're going to have trouble getting there, and I think if we were to say something like we ought to reduce administrative burden and the federal government needs to monitor states, you know, I don't think that adds much to the discussion. That's my view.

CHAIR THOMPSON: Okay. Alan?

COMMISSIONER WEIL: I'm not sure I'm going to advance this much. Penny, your putting this in context was important. I don't know the answer to this, but there's one thing you said that I don't -- that didn't ring right to me, which is the equal as provision applies to everyone on Medicaid, not just if they're in fee-for-service. This approach is targeted at fee-for-service, and as Darin said, there are lots of measures, but this is statutory equal access language that I think is silent on, delivery system, but I don't pretend to be expert on this.

CHAIR THOMPSON: Well, it's a good question. Can you help us, Martha? Because it's in the context of a

payment rate, and the payment rate is in the context of fee-for-service, I believe to be the case.

COMMISSIONER WEIL: So it's in the rate-setting provision. It wouldn't be --

CHAIR THOMPSON: Yeah, it's about the fact that the rates must be set to such an extent as to provide comparable access available to others in a commercial -- and, therefore, it is a fee-for-service --

COMMISSIONER WEIL: So it wouldn't be --

CHAIR THOMPSON: -- because the federal government does not approve and the state does not submit state plan --

COMMISSIONER WEIL: Okay. Then I'm glad I asked, because it's always nice to get that correct. Thank you.

Other than that, I think I'm just going to line up a little bit where folks have already been. If you're one of the 15 percent of people in fee-for-service, it doesn't really matter that 85 percent of people are in something else. You're not in it. And although I agree with Bill that, you know, this is -- that there's a responsibility here, it's a big program, I think maybe I'm drawing a little bit in a slightly different direction, but

related to where Chuck was, which is that the practical application of what states actually have to do to figure this stuff out is, let's say, flawed, it's imperfect. Maybe we need an access scorecard that would answer these questions.

[Laughter.]

COMMISSIONER WEIL: That was an inside joke. But, really, in the end I'm where Peter is. You know, 75, 85, 4, 6, all of these to me are completely arbitrary. And I couldn't defend them, and I'm not really sure how CMS intends to do so. I do think, Chuck, despite agreeing with you that I don't think we can agree to 95 or I don't think we can agree to 2, I wonder if we couldn't agree that 75, 85, 4 and 6, and particularly when 85 is aggregated across the board, that the arbitrariness does not give us a lot of comfort. I mean, I actually think that's worth saying. I would say it. I'm not sure you all would. That's what I would say.

CHAIR THOMPSON: Okay. Kit.

COMMISSIONER GORTON: Okay. So like Chuck, I've done Medicaid managed care in multiple states. Every one of them had extensive requirements in terms of the plans

measuring access to all of these things. Most states have a pretty standard list of 18 subspecialties that they want regular reports on. Some want them annually. Some want them quarterly. They ask for them at the drop of a hat. You change your network configuration, you drop a big provider, they want a geo access, right? It's not a big freaking deal. You simply have to buy the right piece of software and load it into your core system and then push the button and mail the results off to the state.

So while I'm not generally a fan of administrative burden, I think it's a little rich to call this administratively burdensome. Of all of the things that states could ask to do, this one is not that big a deal. So that's my point number one. And the plans do it all the time. So that's point number two, which Darin made, which is, you know, the rules require that the plans do all sorts of measurement about this, and it all gets reported, and the states look into what the plans are paying, and if the plans -- so this is where I might quibble with your statutory interpretation, because states have to approve at some level the plan's rates, and if the plan's rates are inadequate to have an adequate network,

then the states beat up on the --

CHAIR THOMPSON: Yes, but that's just a different statutory provision. That's all.

COMMISSIONER GORTON: Yes. Okay. But my point being that the requirement exists in managed care. We're not talking about anything in fee-for-service that doesn't exist in managed care, usually in spades in managed care.

I agree with the comments about how do we arbitrarily come up with some small number, because if you're the only one who doesn't have access, then you don't have access. And that's a big deal for you.

I guess the last thing that I would say is I understand why this has gotten -- from a historical perspective has gotten hooked onto rate changes. Again, in managed care, we do this all the time. We don't have to change rates. You're just expected to assess the adequacy of your network on a periodic basis. I don't know any reason why states shouldn't assess the adequacy of their fee-for-service network. And I'm not talking about in every little, you know, subspecialty, although having been served papers on that when I was a state official in Pennsylvania, you know, people held you accountable. But

it seems to me that in these five basic things the states should have the discipline and the good hygiene in their program to be regularly assessing whether they have adequate access, and if they don't, to be trying to address that, whether it's through rates or -- the other thing I wanted to point out is there are lots of reasons why providers don't participate in Medicaid, and rates is just the most popular one to throw out on the table.

So, you know, I do think that it's -- I think it's reasonable for the federal government to hold the states accountable. I think the states could, in fact, come up with a reasonable way in these limited things to produce reports regularly. I think the numbers they've come up with are arbitrary, and I'm not sure why we wouldn't do it on a regular basis anyway. And I guess I would be willing to go where Alan is willing to go, which is to say we don't understand these numbers, we think this is important, and, you know, so maybe do -- take another swing at this.

CHAIR THOMPSON: I have Marsha, Stacey, Toby, but before I go there, let me just see if Martha can help us with something here. Nothing in this rule eliminates the

obligation of the states to set their payment rates to comply with the equal access provision, so that statutory requirement still exists. And they still have to provide a demonstration of that to the federal government, even if they don't submit the -- I guess we're calling it the AMRP. Okay. So they still have the obligation. They still have to provide the demonstration. The federal government still has to review that. The federal government still has to accept that. It's just a different form and format based on these thresholds. So I'm not defending the particular threshold or anything. I just want to make sure that point is clear.

But it does take us back around to kind of the initial point maybe that Bill started off and other people have echoed, which is what's the big deal about the AMRP. So what states are asking for -- I presume states are asking for this -- is some relief from the AMRP which is prescribed as having certain elements in it that need to be reported. So is it that those elements don't apply in certain circumstances given the fee-for-service -- I'm wondering if there's something here that we ought to be looking at a little bit deeper about why is it that the

AMRP represents an administrative burden, or something that the states don't think is useful or they don't think actually addresses the question of whether or not appropriate access is being provided. Can you help us with that, Martha?

MS. HEBERLEIN: So the AM -- the access monitoring review plan, which is too many words, but I don't like the acronym. It is prescribed on some level, right? And so they have to -- in their plan they have to look at the extent to which beneficiary needs are met, the availability of care through enrolled providers, changes in beneficiary utilization, the characteristics of the population, the levels of provider payments compared to others. They have to look at it for the five services. They have to do an anticipatory -- before changing a payment rate, they have to do sort of an anticipatory analysis. And so it is prescribed, but how you measure beneficiary utilization, for example, like states have flexibility with the particular measures -- they have to sort of meet these criteria, but they have flexibility in how they actually meet them. I hope that is helpful.

CHAIR THOMPSON: So it seems central to the

question Kit just finished, you know, sort of what is this thing that is so difficult to do, and what would you do instead of that in order to fulfill your responsibilities and your obligations to ensure that your payment rates are set at a place that provides equal access? And regardless of where you decide, 85 percent, 95 percent, no percent, 4 percent, 6 percent, whatever, at some point you still have to make that decision for yourself. How is it that I'm going to assure in a state -- again, separate and apart from the federal-state pieces here. A state wants to be sure that it can provide appropriate access under its fee-for-service program. So it's going to have to engage in some process to do that.

And so I'm just not clear what it is that's in the AMRP where states would say, well, I wouldn't do that, I would do that, and the reason is because fewer people are in fee-for-service or different people are in fee-for-service or -- I'm going to set aside the payment rate change question, which I think of as different about what triggers the need to go back and reevaluate all of your information. But I'm just trying to understand what the alternative would be, which they would be required to

provide, and CMS would be in some fashion required to prescribe.

EXECUTIVE DIRECTOR SCHWARTZ: And can I just add? I mean, what we intuit from our reading of the rule in response to what you say are two things. One is if you don't have a lot of people in fee-for-service, this is a lot of work for not much. That's what the exemption goes to. And the second being that we want -- you know, there must be some kind of alternative data and an attestation, not specified how, we're going to tell CMS in some way. CMS is asking tell us how you're going to do it, that's different from this monitoring plan.

So that's what we take away from the reading of the rule, that what CMS seemed to have heard from the states is if I have a small percentage of people in fee-for-service, it's a lot of work for that. I'm not making a judgment on that, but --

CHAIR THOMPSON: Yeah, but some level of work has to happen regardless. It doesn't matter how many people you have. You have to fulfill that responsibility, right? So then it's like what are you doing that's fulfilling -- anyway, I don't need to restate it.

EXECUTIVE DIRECTOR SCHWARTZ: Well, that's their question because they're saying if you're not -- if you're not going to do the work that Martha just specified with those elements, CMS is asking for tell us how you're going to do that.

CHAIR THOMPSON: Marsha?

VICE CHAIR GOLD: My comments were actually going to hopefully pick up on that in my memory of this. One is I think last year we reviewed the access requirements and did staff even go through and get some states to try and fill this out or do something?

MS. HEBERLEIN: So we did two things. One is we reviewed all of the state plans -- the access monitoring review plans not the SPA state plans -- to see sort of at the high-level -- did they include all the elements that were sort of laid out in the rule and sort of what types of data were they reporting? Did they have standards and benchmarks in there? Did they talk about their corrective action plan? And so we did that piece of work.

We also did a separate piece of work that was a 50-state survey, although we didn't get all responding, so

I think it was like 37 or 39, to talk about sort of what measures they were currently using, and the baseline was before the rule requirements were in place. So how were they measuring beneficiary utilization? How were they looking at -- were they looking at satisfaction? Were they looking at provider participation? So the chapter last March had sort of a review of those two on separate things to sort of give a picture of what monitoring access in fee-for-service looked like.

VICE CHAIR GOLD: Good.

MS. HEBERLEIN: In comparison to managed care.

VICE CHAIR GOLD: Yeah, so let me sort of lay out two takeaways I took from that. One is I think there were comments then about, you know, staff interest in making sure that fee-for-service had, you know, sort of -- that there was some level playing field on access requirements between managed care and fee-for-service, and I agree with what Toby -- no, Darin said. Sorry.

[Laughter.]

CHAIR THOMPSON: I'm not the only one.

COMMISSIONER GORDON: I'm flattered.

VICE CHAIR GOLD: Yeah, about that managed care

has quite a bit of oversight over their -- I don't know if that got into our comment letter, but I certainly would have no problem, even though it's not quite relevant to this, saying that in general we believe there should be level playing field and access is a concern and someone should look at these two systems and try and eventually get them together.

Second, I remember when we looked at the data that you came up with last year. Some of those measures, the way they interpreted them or who interpreted them -- and I'm not sure now -- there were a few cases where there were metrics for very small subgroups, and people that I thought, well, just do a focus group, or what is it, and there were some that I thought, well, God, if Arizona, for example, which has everyone in managed care, this would be an awful lot of work for them. So I'm not entirely surprised that there's something that says how do we ease it up.

Having said that, I agree with a lot of what Bill said and Sheldon said and I can't remember who else said, a number of people said that this is an important program that spends a lot of money, and it should be incumbent on

states, particularly given the legislative history, to show equal access. So I have a couple of thoughts on the managed care threshold. One is probably that 75 is too low, and the other part is that it needs to be stratified somehow. I mean, if their whole SSI population isn't in managed care, they should have to do fee-for-service requirements for managed care, and also any service where a substantial -- of the five that they list as the key ones, any substantial service that is not -- is still in fee-for-service.

So I don't know how we say that -- I agree that we don't necessarily have to give a number to them. I would like us to give -- and I disagree with you, Chuck. I hope we can come up with some language which says something, but avoids some of the specificity. It seems to me this is too low a threshold and it doesn't reflect the variation in the role of managed care across the different subgroups in Medicaid and across the services. And so the rule needs to be adjusted to give adequate protection to any subgroup that has a fair number still in fee-for-service and any service that's fee-for-service and whatever, people can play with things. And I don't have a

lot of thoughts on the rate change, but I had that same reaction that other people did that 4 to 6 percent is awfully high in some -- I mean, it can be a burden to people for a cut that high.

The other option -- you know, one option is if this is something that doesn't affect that many states, you could just have the state have an option to come in and complain or proposed an alternative, you know, to come in and say, "This doesn't make sense for me. Should I do it?" So some mixture of those might work.

So I understand where this issue is coming from historically. It may be a problem, but it seems like the solution's going to create -- that's listed here has more problems it creates than it solves.

CHAIR THOMPSON: Let's do Stacey and Toby, and then we can see where we are.

Oh, and Alan is going to jump back in. Good.

MS. LAMPKIN: So I'll try to be quick. One, I think this is too important of a rule for us not to have any kind of comment. I think we have to craft something that talks about some of the tensions that we've been talking about here.

Number two, I personally think -- and I think this is what Marsha was referring to with the stratification -- that any thresholds that exist should be sensitive to the nature -- should be at the service level, for sure, and it should be sensitive to the primary source of coverage for that service. So take into account that many that are receiving service, fee-for-service, may be dual eligible, and this is not necessarily a critical question. So the question should be not just managed care versus fee-for-service but who is the primary payer? Is fee-for-service the primary payer for the service?

And then I was going to talk about whether the key to this was that alternative data and analysis section of Martha's report, which is -- so if -- because when I was -- I was in Florida when all this was, I think, proposed originally, and there was a lot of concern about the administrative burdensomeness of the original rule in this context. And that's not to say nothing should happen, but what is the reasonable thing to happen in a situation like Florida or Tennessee or Arizona, that strikes a balance? So that was all I wanted to say.

CHAIR THOMPSON: Toby.

MR. DOUGLAS: Yeah, I just want to hit on the -- you know, from a state perspective, you know, regardless, I think, of whether this change in the rule is right or wrong, and we do need to view it through the lens of every beneficiary and their access, that being said, from a state perspective, and it's the accumulation of all the different requirements becomes a huge administrative burden with finite resources. And most states do not have amazing staff, like the MACPAC Commission does, to do these types of analysis, and it is a struggle.

And so there, you know, needs to be an acknowledgment of, you know, additional requirements, and this was a huge change in the requirements, but, you know, a big burden on big states to little states on being able to do this. And it's not just this one requirement but multiple different requirements that have come on over the years, that might be the right requirements but still, you know, without state legislatures and governors understanding the need for resources and the needs to think about state capacity and within the Medicaid program differently than other departments. And so that's all to say that I think we somehow need to weave in that comment.

It's bigger than this rule. It's about administrative capacity, both IT systems, staff, to be able to do these types of requirements, that also could, you know, back to the legal side of it, I do worry that this could go backwards on Armstrong or the previous Supreme Court ruling that I dealt with, that really was because of all the federal government and the states saying we have this coverage.

CHAIR THOMPSON: Alan.

MR. WEIL: I'm going to leave it to the Chair to figure out how to make sense of this, but in the intervening time I did find a Health Affairs blog written by our former Chair, Sara Rosenbaum, who notes that it is in the reg that they said it doesn't apply to managed care, but -- I'm reading a little between the lines -- I don't think she considers that a foregone legal conclusion, that that was a decision by CMS to say we're only going to apply this to fee-for-service, but I don't think she would take it as a given, based on my reading of this.

CHAIR THOMPSON: Oh.

MR. WEIL: But the statute doesn't --

MR. DOUGLAS: The Ninth Circuit believed the same

and kicked out and allowed managed care to continue with reductions but not fee-for-service. But that was the Ninth Circuit.

CHAIR THOMPSON: Well, all right. So I'm going to try something. Let's see if this will work. One is that I do think that we can -- and I'm going to try to not have this be pure platitude. I'm trying to think -- Chuck -- that we do need to express that we have, for a long time, been concerned about state administrative capacity. We've talked about that. We've published on that. We continue to talk about that. We are sensitive to that.

At the same time, I don't know that we have the information here to make a compelling case that this is a burden. If it is a burden, then perhaps there ought to be an attempt to simplify the burden across the board, not just for certain states that have a high penetration of managed care or have small payment reductions. If there are improvements in this monitoring approach maybe that should be what we're tackling, so that it makes sense and that it actually does what we hope it does, which is assure ourselves that we have payment rates set at a level that provide equal access.

That we don't see the evidence and are concerned about the lack of evidence for these particular standards. We, as a consequence, don't necessarily have another standard to substitute for it. And if we are engaged in a conversation about the places where we would pay attention and have concerns, it's with regard to understanding the place where we start, so payment rate reductions matter more if you started at lower rates versus higher rates. The populations and the numbers of people that you have in fee-for-service matter if you have certain populations in fee-for-service that are particularly vulnerable, and if they're sticking there for longer periods of time, we don't talk about that at all, because in some cases I think some of the states were concerned about the fact that they had people for very small numbers of time, and fee-for-service while they were awaiting a selection into a plan, and I think that's a different situation and deserves some separate consideration.

I think if we tried something along those lines, I don't know that that necessarily gives CMS a roadmap to a different, better proposal, but I think at least it puts us on the record with the kinds of issues that we've surfaced

in this discussion, that I think are worthy of sharing with the agency as it considers its finalization of the rule.

My suggestion, given the richness of the conversation, is that we make an attempt along those lines and maybe circulate that, and we can decide if we want to have a smaller group of commissioners take a look at that, or the whole group, given how much people were interested in the subject, and how central it is to the MACPAC mission, that perhaps everybody would want to take a look at that. And so I know that might cause you a little bit of pain, Martha, to get that amount of commentary, but I do think this is an important rule.

I understand perfectly well, and having been at CMS during part of the time that people struggled with, how to think about this. This is a toughie, and there are lot of things to kind of put together here. So I think, you know, it's no surprise that we didn't come up with some elegant solution that everybody can be happy with, but I do think we should try to drive some comments along the lines we've discussed.

Bill and then Chuck.

DR. SCANLON: I mean, I think this happens

naturally in a world in which there are not sufficient resources, I mean, to think about things as burdens. But I think that it's also important to really define what burden is, and burden would be either that the value of what you're getting is not worth the resources going into it, or that there's a better way to get that value -- get whatever you're aiming at, sort of a more efficient way, a less costly way to do it.

Those are the two things that maybe deserve the term "burden," which is somewhat pejorative, as opposed to any extra work is burdening. I mean, it doesn't work that way. It shouldn't be perceived that way. It should be the issue of value, sort of, and efficiency. I mean, I think those are the two things I think that we need to be careful about. And I just feel like having sort of been around D.C. a lot, that the limited resources are a real problem. And so a natural reaction is when you're asking for something it's like, "Oh, that's just too much." And we've to shift the focus to what the value is, and then we also have to sort of shift the focus to, let's get some more resources in here, because the task is worth it.

CHAIR THOMPSON: Chuck, do you want to have the

final word here?

MR. MILLIGAN: Yeah, I just want to say I really appreciate the robustness and thoughtfulness of the comments. I mean, I come here ready to be persuaded and moved, and I think it's a good outcome, and I just wanted to note my respect for the Commissioners' comments.

CHAIR THOMPSON: That's a perfect note to go out on then.

[Laughter.]

CHAIR THOMPSON: Let me just stop here and take some public comments, to see if anybody wants to complicate our lives further.

PUBLIC COMMENT

* MS. GREWAL: Hello. My name is Esme Grewal. I'm the Vice President of Government Relations for ANCOR, the American Network of Community Options and Resources. And we represent disability service providers across the country. We're their national trade association here in Washington, D.C.

And just on this rule, I know that this is not the point we're at with this latest NPRM. I think they're seeking to curtail a bit of what the 2015 rule was. But

something that was always troubling to us was that the original Armstrong case, the plaintiff was a disability service provider under the services that we represent, providing HCBS services, and those services were not included in that 2015 rule.

So that's not something that's being discussed in this latest NPRM, but I would urge the Commission to really look back at that, because in the 2015 rule, Armstrong is referenced heavily. This was really a reaction to the Supreme Court ruling, and HCBS services are not monitored, and that's really where this initial legal case derived out of, was the need to really look at those rates and at least, at the very least, create some sort of public access to what's going into the rate settings and how the workforce that we represent is being paid through those rates.

So thank you, and I hope that's something you can look back at as you consider your comments to CMS. Thank you.

CHAIR THOMPSON: Thank you. Any other public comments?

[No response.]

CHAIR THOMPSON: All right. We'll take a quick break and we'll be back in 10 minutes, 3:10, to pick up our final session.

* [Recess.]

CHAIR THOMPSON: All right. We will give the 20-second warning. It is getting shorter and shorter as the day goes on.

Okay. Kristal, we are going to end the day on a big up note, looking at a draft chapter for our June report on managed long-term services and supports.

REVIEW OF DRAFT CHAPTER FOR JUNE REPORT: MANAGED LONG-TERM SERVICES AND SUPPORTS PROGRAMS

* MS. VARDAMAN: Good afternoon, Commissioners. Today, I'm going to provide an overview of the draft chapter for the June report on MLTSS, managed long-term services and supports. The draft is primarily descriptive and serves to set a stage and a foundation for the Commission's future work in this area.

Just to set up some background, in fiscal year 2015, long-term services and supports, or LTSS, accounted for $158 billion of Medicaid benefit spending, which was approximately 18 percent of this was delivered through

managed care.

And currently, as of this year, about half of states are operating LTSS through MLTSS, at least one MLTSS program. That does not necessarily mean that states are including all populations or all services, but this is up from just eight states in 2004.

This map shows states that have at least one MLTSS program. Some states, like Arizona, have been doing this for quite awhile, whereas others are more recent in their implementation and adoption of MLTSS.

We start off the chapter with some description and setup of LTSS users, which of course are a diverse set of individuals with many different types of physical and cognitive disabilities, so we walk through some of the LTSS populations. We also note that state and federal policymakers have been seeking ways to manage LTSS spending while maintaining and improving beneficiaries' quality of care and quality of life, and MLTSS is one of those tools that they're using towards those goals.

We also wanted to start the chapter with some setup in terms of the ways in which managed LTSS is similar to delivering LTSS through fee for service, so some common

issues there. First, walking through some common principles in serving these populations, we wanted to highlight self-directed care options as being one of those principles, the importance of person-centered planning, and acknowledging the dignity of risk.

We also wanted to highlight that both fee for service and managed care face similar challenges in delivering LTSS. Those include state capacity to meet demand, which also includes workforce shortages being an issue of concern.

States pursue MLTSS for a variety of reasons, and so we highlight a few data points from some recent reports. One is a survey of 12 states that included a discussion of their motivations for pursuing MLTSS. Some of those reasons included rebalancing LTSS spending, improving beneficiaries' care experience, reducing or eliminating HCBS waiver waiting lists, and providing budget predictability and potentially containing costs.

Next, the chapter walks through some of the authorities that are used to implement MLTSS, which there are several. It also talks about the regulations that apply to MLTSS, which includes managed care regulations

broadly. In addition, CMS has codified certain guidance that is targeted towards MLTSS programs.

We then wanted to go on to discuss some of the key factors in MLTSS implementation and try to get to some of the success factors in terms of implementation process.

The mix of services and intense needs of LTSS users adds complexity to managed care, so we wanted to highlight that. And what we've heard through some of our discussions with stakeholders, the panels that you heard, some of the research we've conducted as around the initial implementation period of MLTSS, and later re-procurements are very critical periods. CMS has stressed the importance of transition planning and readiness review to minimize care disruptions. Of course, many beneficiaries, including LTSS, will need services on the day the program begins, someone who may have personal care hours each day, and so it's really critical that programs are ready to go from day one.

The chapter reviews some of the factors that have been described in the literature and through various interactions we've had with stakeholders in terms of success factors. First, states often include requirements

to promote continuity of care, which can include things like contracting with any willing provider for a certain period of time. We also heard from stakeholders that a successful rollout of MLTSS is carefully planned, deliberate, and incremental. An example of incremental can be phasing in by geographic region or by LTSS subpopulation.

In March, we talked about tailoring MLTSS programs to individuals with intellectual and developmental disabilities, and it was also noted that while an incremental approach had some positives, there's also some challenges in terms of managing two different delivery systems at the same time. So I wanted to note that as well.

It's also important to acknowledge that MLTSS represents a significant change in the delivery system for providers, many of which are either used to contracting primarily with the state, given that Medicaid is the nation's major payer for LTSS services. Some providers may be governmental or quasi-governmental entities, and so moving to managed care is a big shift that can require a great deal of training to get them ready for the change.

We've heard in a variety of forums whether related to our network advocacy work, tailoring programs for individuals with IDD and other areas, that stakeholder engagement, both at implementation and on an ongoing basis is a key factor in successful transitions and the success of the program going forward. Also, payment policy is important in determining the financial viability of MLTSS plans.

We next provide some discussion of capitation rates and how they are used to set program incentives. LTSS user needs can be difficult to predict, given the diversity in the population and their functional needs. Functional assessment data is used by several states to risk-adjust rates, but there's many factors that can contribute to differences in costs and needs.

Many state contracts are incentivizing rebalancing, so shifting the distribution of LTSS suspending from institutional care towards home and community services, and they're incentivizing it by paying a blended capitation rate that assumes a certain mix of HCBS and institutional care.

Next in this section as we go on to talk more

about how MLTSS works, we set up a discussion of care coordination, which is a key element of MLTSS programs. Care coordinators are often nurses or social workers and are used to help assess and plan services for a beneficiary, and it also helps to enforce principles that are important to delivering LTSS that we mentioned earlier. However, within a state requirements, plans do have flexibility to use a variety of approaches. There's been some work on different models that plans can use to implement care coordination, and we reviewed some of those model types.

In terms of MLTSS outcomes and oversight, there have been few rigorous research studies on MLTSS, partially due to lack of baseline data collected before implementation that can be used to compare. State reports show some evidence of successes, but given a lack of standardized outcome measures, which we'll talk a little bit more later, there's been a limitation in our ability to make comparisons across states.

And we also do want to highlight in the report that the measures that are of interest for LTSS populations need to address beneficiaries' experiences and some things

that may differ from other populations.

I also note here that in the draft report, we mention CMS's contractor's design plan for an evaluation of several states MLTSS programs. It's recently been posted, so we will update the draft reporting to highlight other preliminary findings.

Next, in terms of, again, thinking about the progress and the development of HCBS and MLTSS measures that can hopefully in the future add to our better understanding of how these programs work and their outcomes, I first wanted to highlight that as a part of the Testing Experiences and Functional Tools demonstration that CMS has under way, a number of states tested an Experience of Care Survey that has been now incorporated into the CAHPS as an HCBS survey, and so that is something that is available for states to use.

There's also the National Core Indicator surveys on beneficiary quality of life and outcomes. There's one for the IDD population and another for the aging population, and those can be used across delivery systems. And some states are incorporating those into their MLTSS programs as surveys of beneficiaries' experiences.

Next, the National Quality Forum has identified a number of domains for HCBS quality measure development in terms of identifying potential gaps that need to be filled in the future.

And then finally, I wanted to highlight that CMS has released some technical specifications for MLTSS quality measures. There are more in testing phase, and these measures are available for states' use. However, CMS has not indicated that they will require those measures to be used, but these measures have been tested and validated, and so that's a benefit for states to have that available to them.

The chapter then goes on to describe somewhat information on federal oversight of MLTSS. Again, given that nearly half of states now have at least one MLTSS program, there's increasing attention being paid to federal oversight. We highlight two GAO reports that have recently come out, one that found that five of six state programs' payment rates supported rebalancing, but that most states did not link payments directly to performance.

GAO also found another report that there were inconsistencies in CMS's reporting requirements for key

elements of MLTSS programs across states, again, limiting our ability to make some comparisons across states and their programs.

The next section of the chapter highlights several issues that are emerging or of growing importance within MLTSS. First, looking at tailoring LTSS for individuals with IDD, again, this is an area of increasing interest as more states have recently included IDD In their scope of services.

We did review at the March meeting some of the contractor research that was conducted for us by Health Management Associates that looked at some of the contracts and how they have been tailored to meet the needs of individuals with IDD. What was found was that the most frequent contract requirements related to the training of care coordinators, and also the stakeholder engagement was highlighted by interviewees and stressed the importance of having ongoing engagement activities beyond the implementation period.

The next section goes on to discuss integrated care models for dually eligible beneficiaries and how states are using MLTSS aligned with Medicare Advantage

dual-eligible special needs plans as an integrated care model. That's in addition to the Financial Alignment Initiative and other strategies that states are using. Alignment with D-SNPs, those dual-eligible special needs plans occurs on a continuum. There's a variety of approaches that states can take. For example, states can require that their MLTSS plans they contract with offer a companion D-SNP providing opportunity for beneficiaries to enroll in a plan with the same organization that they're enrolled in MLTSS.

D-SNP authority was recently made permanent, and so the removal of any uncertainty over the future of D-SNPs, which were scheduled to end might prompt more state interest.

And the chapter ends talking about some next steps, and so we highlighted some of the questions that we felt that the existing literature had some gaps and where there's more information that we're expecting to see some out in the future as some of these reporting efforts continue.

So just walk through some of these questions first, how are states aligning MLTSS with D-SNPs to

integrate care for dually eligible beneficiaries? Second, how do the federal government and states oversee MLTSS programs? Next, how do the costs and quality of MLTSS compare to LTSS delivered under fee for service? Next, how do different state design decisions influence outcomes? And finally, how to plans manage care and costs? These are some of the questions that we wanted to set up as areas that potentially the Commission may be interested in exploring in the future.

So I'd be interested in hearing your thoughts on the draft chapter and in particular some of these next steps in terms of the direction that you'd like to go going forward.

Thank you.

CHAIR THOMPSON: Great.

Well, first of all, Kristal, congratulations on putting together a chapter. In our last conversation on this subject, I think we were fairly dispersed in some of our commentary to you. You took it and did a great job with it, so much appreciation to you for that and to Bill, Brian, Chuck, and Toby who I think looked at an earlier draft of the chapter and helped give you some initial

feedback.

So let me open it up and see if Commissioners have any additional feedback or commentary.

Toby.

COMMISSIONER DOUGLAS: Just to say, again, a really good job. It's a great chapter, and thanks for taking all the different ideas and really distilling it down into a very good chapter.

CHAIR THOMPSON: Marsha, then Bill.

VICE CHAIR GOLD: Yeah. I agree. I think you put a lot in here, and it generally flows.

I thought there were some sort of big points, omitted things that as you finalize, it would help make some of it more incisive.

One is I think it's probably important to sort of note that you have to have realistic objectives for MLTSS because there's probably a lot of services that aren't given now. There are unmet needs. There is delivery systems that aren't created. So people going into this generally shouldn't be looking at short-term savings, though there could be some savings down the line as things get developed and particularly if acute care is hooked in,

which is one of the reasons there's so much concern for having Medicare and Medicaid more integrated.

It wasn't explicitly said, and there was one where it sort of said everyone is looking to save money, so we have to look at this. So I think it would be important to just make that.

Second, I thought there were probably some numbers that you could put in as tables from the existing work MACPAC has done, mainly to sort of create some table showing really which states are for which populations in managed care, and then also anything that we can get with the data constraints that show penetrations, what percent of the population that's potentially relevant is there, even if it's only -- there was another chart we saw through another presentation that just had the percent SSI in managed care. That could help, but just something to give it a little more stature.

I also thought we'd probably want to emphasize more when we talk about outcomes and oversight that there are some of the most vulnerable people. So we need to -- it's particularly important that we do that.

Finally, almost finally, when you talk about the

future of MLTSS, it's just the way it's written, I think. It makes it sound like the real issues are just IDD and the duals, but there are lots of issues with plenty of people who either are not in LTSS but states could move there, or there are parts of states that aren't in it, or there are subgroups that aren't in it, or there are states that will never be in it because it doesn't make sense in their delivery system to be there, but they still need good long-term care services. So I thought you might want to fix that.

My only sort of nitpicky point was when you talked of those three principles that you had up there, I didn't disagree with them, but they weren't really -- where they were put in the beginning didn't really give where they came from or why they were important. And I might either leave it out and keep it where you have it in the chapters, later on where it makes sense, or else it needs to be strengthened a little as to where those principles came from and why they're important.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: Yeah. I also think it was a really good chapter, and in part because I think it

really explained rather clearly sort of a very difficult subject, which there's no question in my mind. It actually brought back some painful memories for me, 25 years ago, with another person. We tried to do a similar kind of thing in describing the full long-term services and supports population, and it went through many iterations of do we divide them by age, do we divide them by disability, do we divide them by service system. And it was painful. So I say kudos to you for sort of having done it sort of well.

The other thing, I really feel like it's setting a foundation for future work, and I almost wonder if some of the things that you're suggesting, Marsha, are like kind of the basis for the book as opposed to the chapter because I feel like LTSS is not a well-understood sort of area.

There are many people that think that it's just a few words that were left out of the Medicare statute, and then it would have been fine if they were in, and everything would be solved. And I think it's not just another health care service. It's a fundamentally different sort of area, and we haven't really come to grips with what it entails. The discussion of how we measure

outcomes gets to that in part.

We're not talking about people that are all going to get better if they got the right care or even stay at the same level in terms of functioning. We are talking about, unfortunately, people which is natural occurrence that are going to sort of incur more disability and ultimately die, and so you have to think about what's good care for those individuals.

We haven't come to grips I think with this whole question of what's the public sector role. When we talk about rebalancing, we're talking about people not being in a nursing home where care is to be available, according to the rules, 24/7 to being at home, and we're not giving them 24/7 care when they're at home. The balance comes in by the fact that they have family members almost always to provide the care that hopefully meets needs. But what's the balance between families and this public sector investment? We don't have a sense of that.

And that plays a role here when we talk about network standards, when we talk about is the network sufficient to deliver the services that are prescribed. There's a question of whether the prescription was the

right prescription. Should it have been a different level of services that are being offered? I think ultimately, we have to think over time how to address these in a way that's helpful because I think we don't want to throw up our hands and say we know nothing, and therefore, we sort of need to maybe slow progress in some of these areas.

What we need to do is be very attentive to what's happening in all of these areas and look at them through the lens of what more do we need to know so that we can really protect sort of and appropriately, sort of assist sort of these -- the individuals that are involved.

In this interesting case, the family is a part of the entity that's involved. It's not just the care recipient. The services that the care recipient may be receiving may make a huge difference in that family's life. So that's another factor that needs to be taken into account.

CHAIR THOMPSON: Chuck and then Brian.

COMMISSIONER MILLIGAN: Nice job, Kristal. A couple of comments.

One is I think the D-SNP component going forward, we need to make sure we do a good foundational job here,

and to me it's -- your slides highlighted the permanent reauthorization. But I think just as important, Congress indicated in the reauthorization how much D-SNPs are expected to integrate with Medicaid and not just be kind of a stand-alone Medicare Advantage plan. And I think to me one of the observations in terms of next steps with all of this is that it seems to me that Congress has weighed in that this is the future of the duals demos, really is the D-SNP space, and the fact that you can't just do the Medicare Advantage side of the D-SNP without true efforts to integrate with Medicaid. So I think that I would like to see that elaborated a little bit.

And I just want to comment on Bill's comments. I agree with everything Bill said. I think it's important, however you integrate the comments from the session, to try to distinguish issues that are LTSS in general, which I think kind of informal caregiving I would characterize, as distinct from MLTSS, which are the unique attributes of managed LTSS, because I think that the informal caregiving, implications, all of that, are not just the managed part of it.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: I'd like to echo the positive review of others. I think this is a great foundational chapter and will be well read in the policy community around MLTSS.

As a foundational chapter, I do think one of its objectives -- and it meets many objectives, but one of them is kind of setting up our future work. I am in total agreement that the incorporation of persons with IDD into MLTSS and further alignment of Medicaid MLTSS programs with D-SNPs are two very important issues. But I do think that there are others. And maybe just too much emphasis on those two and not other alternatives for -- you know, for example, one area that I think really needs a lot more work is kind of more the business perspective around this. You know, what does the supply side look like? There are people around this table who this is their business. And there has been a huge shift in Medicaid funding from a fee-for-service construct to a managed care construct. And there are interesting things going on on the supply side in terms of who's actually -- who are the states contracting with? How many are homegrown plans, nonprofits, for-profit, et cetera? I just think that's another area that

we should look at. And there are other areas as well, so I would just advocate for putting in a few more, because I don't know where we're going to go, and I think we're going to talk about it at the retreat, and I think this chapter should set those options up.

CHAIR THOMPSON: Yeah, you know, I would also affirm all that's been said, Kristal. I think this last question which you drew our attention to, these next steps, is this kind of what we want to say, I think given the fact that we're still forming our thoughts about where we're going to focus attention and where we can develop research and evidence that's really helpful to understanding those places, I think let's just give ourselves some maneuvering room there. I do think looking at oversight matters. We've talked about MCO oversight in general, and I think here, you know, that applies as well, understanding what states are doing, what the federal government is doing.

I agree completely about the thinking that Chuck expressed about the D-SNP program, and I think that deserves our attention. The DD population, as you described it, which I think you've done a great job of identifying how there are some special considerations there

and maybe we want to take a particular look as we think about some of these larger issues about particularly vulnerable populations inside of MLTSS.

You know, I wonder if we want to go back and pick up some of the prior work that we've done on functional assessments. I shared with you some, you know, interesting developments that are happening in different states with the use of algorithms to do eligibility assessments and functional assessments and whether or not beneficiaries and their families have visibility into how those algorithms are making decisions and whether there's black box codes that are spitting out certain results and people don't understand necessarily why they're getting the results they're getting. I think that could be something that we want to revisit at some point.

So I think just in terms of that last section, maybe it's an element of listing some potential areas of interest that we will continue to develop around both research approaches and test Commissioner interest.

Kit, do you want to jump in?

COMMISSIONER GORTON: I just want to add program integrity to your list because there's a --

CHAIR THOMPSON: Oh, yes, thank you.

COMMISSIONER GORTON: -- whole new range of things that this opens up.

CHAIR THOMPSON: Yes, excellent.

Any final thoughts?

[No response.]

CHAIR THOMPSON: Thank you, Kristal. Wonderful job.

Let's see if the public has any comments to share before we close out, on this topic or any others that we discussed today.

PUBLIC COMMENT

* MS. GREWAL: Hi. I'm Esmé Grewal from ANCOR. I wanted to, on this topic, thank the MACPAC staff for engaging with ANCOR members and interviewing -- I think we've continued those interviews, but they very patiently thought that, you know, maybe three state associations would come on the phone line. I think over 20 did, and they managed that very well and connected after that process with them, specifically on managed care for intellectual and developmental disabilities.

I think that MACPAC can play in this June report

an extremely important role in specifically bringing attention to this issue for the greater public and also for Congress on managed care in the IDD sector. I think there's a lot of potential for managed care in IDD, but, unfortunately, we have two really terrible examples in Iowa and Kansas, and I think those examples need to be highlighted. Just last week, the Des Moines Register highlighted an example of a four-year-old with disabilities who was denied a walker, and so he crawled for over six months. And that's just one of the examples a lot of individuals that require 24-hour services have been reduced to 50 percent. And the blame really doesn't fall on the MCOs or the state or the service providers. It's really just a shared issue of not knowing how to address this population properly and diving in perhaps a little too quickly.

So I think MACPAC is the perfect agency to address this issue and also just brings some sunlight to these issues so that we don't see this happening in the future.

Thank you.

CHAIR THOMPSON: Thank you.

Okay. Terrific day. Thank you, staff, thank you, Commissioners. Thank you to the public. We are adjourned.

* [Whereupon, at 3:43 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, April 20, 2018.]

PUBLIC MEETING

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

Friday, April 20, 2018
9:00 a.m.

COMMISSIONERS PRESENT:

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

ANNE L. SCHWARTZ, PhD, Executive Director

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P R O C E E D I N G S

[9:00 a.m.]

CHAIR THOMPSON: Good morning. We'll go ahead and get started for our day two of our April meeting.

Very happy to be kicking off this morning's agenda with a discussion on Section 1115 waiver evaluations. Very pleased to have a couple of folks to talk with us about that who are quite knowledgeable, and, Kacey, you're going to kick us off and introduce our panels?

PANEL ON SECTION 1115 WAIVER EVALUATIONS

* MS. BUDERI: Thanks.

So today, we're picking back up the Commission's discussion of Section 1115 research and demonstration waiver evaluations, which is part of our broader topic of state flexibility versus program accountability.

And we've convened the U.S. Government Accountability Office to share the findings of a recently released report examining Section 1115 evaluations and the extent to which they have been used to inform policy, and the Centers for Medicare & Medicaid services to both respond to the report and describe steps it's taking to

improve the evaluation process.

And so the goal of this session is just to hear from our panelists about their work on this issue, and then we'll have time in the following session for further discussion.

So our panelists today include Susan Barnidge, an assistant director in GAO's Health Care Division, who can speak to the report's findings and recommendations for how to improve the evaluation process.

Over the last 10 years, she's led GAO reviews on a range of Medicaid issues, including federal oversight of Section 1115 demonstrations, the interaction between Medicaid and the exchanges, state and federal oversight of managed care, and financial oversight of the program.

In addition to her Medicaid work, she's also led work related to private health insurance, including the operation of the exchanges.

And then we also have Judith Cash, acting director of the State Demonstrations Group at CMS, and she's going to discuss some of the steps CMS has taken and plans to take regarding improvements to the evaluation process.

Ms. Cash leads the agency's work on Medicaid demonstrations authorized under Section 1115, and prior to assuming that role, she served as the deputy director for policy and before that led work on Medicaid eligibility and enrollment.

And so to start it off, I will turn it over to Susan.

* MS. BARNIDGE: Good morning, everyone. Thank you so much for having me here today to discuss GAO's recent report on evaluation of Section 1115 demonstrations, and I'm so glad Judith is here to give you the most up-to-date information on what CMS is doing in this space. So I'm going to try to keep my comments brief so you can get to the good stuff with Judith.

So I'm just moving right to Slide 3 here, which is a quick snapshot to kind of underscore the significance that demonstrations play in the Medicaid program at this point, but a third of federal spending in the program and over 35 states have demonstrations in place at this point.

So our work looked both at the state-led evaluations as well as the three federal evaluations that were under way at the time that we started our work, and

just a little bit of context on the state-led evaluations, historically CMS has required states to do evaluations, and those requirements include submitting a design plan for CMS's review and approval and final reports at the end of the demonstration. And if states seek to renew their demonstrations, they submit an interim report as part of that renewal package.

So what did we learn about the state-led evaluations? We looked at evaluation documentation in eight states, and we really found two things. First, there were some methodological limitations to the evaluations, and these were largely identified by CMS's contractors who were looking both at states' design plans as well as their evaluation reports. And they were finding things like insufficient control groups to isolate the effects of the evaluations as well as raising sufficiency issues around sample sizes for beneficiary surveys.

In addition to the methodological issues, we also found some gaps in the findings of the evaluations for pretty significant components of the demonstrations.

So this next slide highlights some of the examples that we highlighted in our report. So, in

Arizona, they were using managed care to deliver long-term services and supports, and the evaluation reports did not include some of the key information on access and quality.

In Arkansas, where they were testing using Medicaid funds to purchase coverage on the new marketplaces, one of the key hypotheses there was continuity of coverage that might be achieved through this approach, and the reports were not able to reach conclusions on those hypotheses.

And in Massachusetts, they were testing a DSRIP program, and the evaluation was to look at the impact of those payments to the seven hospitals in that program, including looking at the impact on quality of care and per capita costs, and the evaluation reports that we reviewed did not include conclusions or data on those two areas.

So one of the key things that was driving these gaps in the state-led evaluations was that when states went to renew their demonstrations, it sort of bumped out the final reporting due date. So CMS was sort of left with interim reports that were based on more limited data from early years of the demonstration cycle, and that was largely because CMS was tying the due date for final

reports to the expiration of the demonstration rather than the end of each demonstration cycle, so those are three- to five-year cycles. So they were never sort of getting a report that said this is what we found after this five-year cycle was completed.

As we note in our report, CMS had a number of improvements under way that they had really started implementing in 2014, and I'm sure Judith will speak more to those. But I just wanted to highlight two things here.

First, CMS had begun changing the reporting requirements for the demonstrations to tie the final report to the end of each cycle rather than expiration of the demonstrations. That was really a positive step forward.

We did have a recommendation in this space that that approach should be sort of institutionalized in their written procedures.

The other thing to highlight here is that they also started indicating to states that they could seek more limited evaluation of certain demonstrations, and CMS sort of highlighted examples of longstanding demonstrations as well as noncomplex demonstrations.

We also had a recommendation in this space that

they issue some written criteria, better laying out which demonstrations might be eligible for more limited evaluation.

So that's it for the state-led evaluations.

Moving on to the federal evaluations, just a reminder again here, we're talking about three evaluations, one of which was the large multistate evaluation that focused on four different policy areas, kind of really more like four evaluations in one, and then there are two single-state evaluations, one focused on Indiana's demonstration and the second on Montana's. And we found that in all three of these -- well, we found in the multistate evaluation and Indiana evaluation that CMS was experiencing some data challenges that were limiting the scope and delaying the process of the evaluation.

So this slide again highlights some of the issues that were coming up with the multistate evaluation and the implications those had for the scope of the four different pieces of the multistate evaluation, and there are really two issues. One was data sufficiency, and those issues resulted in the evaluators excluding states from a number of these different pieces. This was particularly the case

in the DSRIP evaluation and the MLTSS piece of the evaluation, where it started with 20 states and had to scope down to 2.

The other issue was obtaining data from the state directly, and that affected both-of the two middle categories, the premium assistance to purchase marketplace coverage and the evaluation of beneficiary engagement policies.

With the Indiana evaluation, there are two. There was a challenge in obtaining data from the state, and that focused largely around the state's concern that CMS's contractors didn't have sufficient controls in place to ensure the privacy of some of the beneficiary data that was being requested. So maybe Judith can speak more to that one.

We note in our report that despite these data challenges, the federal evaluation has potential to provide useful information to policymakers. The multistate evaluation, the contractor has produced 15 rapid cycle reports that included things like implementation decisions that states were making, design choices, challenges they were facing, things that would be useful to other states

who are considering taking up those policies. But CMS hadn't released those at the time that we issued our report. I was really happy to see this week that eight of those are now hosted online, so that's great, and the ones posted largely focused on the DSRIP evaluation and the MLTSS piece.

CMS had also received several draft interim reports from the contractor for the multistate evaluation. They were not planning to release those, but the final versions of those are due in September of 2018. And there wasn't a time frame for releasing those at the time that we did our work, and that's largely because CMS at that point did not have a policy for releasing findings from federal evaluations. So, again, that was another space where we made a recommendation that CMS establish a policy and that that policy includes standards for timely release of findings.

I think I have walked through our recommendations, but I just wanted to note here that CMS did concur with all three of them. And I'm sure Judith is going to speak to where they stand and responding to those. Included some links here to other GAO reports that we

thought might be useful for you.

Thanks again for inviting GAO to be here today and happy to answer any questions when we get to that part of the discussion.

* MS. CASH: Thank you very much. Good morning, everyone.

I'm Judith Cash, and I'm delighted to be here this morning. And let me say the first update between Kacey's slide and mine is that I'm no longer acting. This is now real life. Just last month, I was named the permanent director of the State Demonstrations Group. So her slide said acting; mine was able to take that off.

So I'm going to share with you today some information about the progress that we've made in the world of Section 1115 demonstration evaluation and where we know we still have work to do and a little bit about the evolution of that progress, and I think the underlying message, the main message here this morning is just that, that there has been -- progress has been made, and there is work to be done. So I'm delighted to be able to share with you some of what was happening before the GAO report was issued and some of the things that we have been doing in

response to the recommendations of the GAO.

So I would tell you that CMS noted and has been committed to improvements in the way we evaluate -- monitor and evaluate Section 1115 demonstrations for a number of years, and in fact, just a couple of years ago, as a result of some of that interest and attention and recognition, we actually did a bit of a reorganization within the Center for Medicaid and CHIP Services and made the demonstrations group a separate group with the additional resources that really were needed to focus on monitoring and evaluation as well as the preapproval process.

And so within the State Demonstrations Group, we have a division of monitoring and evaluation that really does focus on the need for both rigor on our side and on state side and on the resources that are required to get that there.

Among some of the general changes we've made include some improved technical assistance to states. That has taken and will continue to take a number of years to develop and really to get sophisticated in the way that we really recognize we want to be, but it really is in fact under way.

Certainly, before the GAO report came out, but certainly in recognition of the need to help states to improve their own evaluation designs and again to provide some support and assistance to do that and again to conduct some of the federal evaluations that the GAO report talked about.

So specifically, some of the things that we already had in process and have been working on over the last, about, two years or so include the awarding of contracts for the federal evaluations. These are in no way intended to replace the state evaluations that are required by the statute, but that allow us to really use some cross-state data to provide a national perspective and to really understand from a sort of 50,000-feet level what is happening across a number of the different demonstration types.

We've been working on focusing states not only on state-specific and state-driven metrics, which, of course, are important, given that each state is doing a demonstration of something that is state-specific, but also to integrate national quality metrics into the things that they are measuring. We're looking to drive some uniformity

across states in performance measurement, again, recognizing the need to be both data driven and outcomes based in the work that states are doing and the work that we are doing and helping states to get there.

We have created and are continuing to evolve and improve an IT system that allows us to have both internal controls on monitoring and evaluation and to produce reports that we know will inform us and all of our stakeholders about the 1115 demonstrations and what's happening.

And we continue to make investments in improving and leveraging TMSIS data. As I'm sure you're aware, lots of change has happened with the TMSIS over the years, over the last couple of years. It's continuing to happen, a lot of focus now that we have states in and reporting, a lot of focus now on the quality of those data. And for us really trying to be able to track 1115 demonstration-specific data through the TMSIS mechanism, and there's ongoing work to do that.

So in terms of the GAO report, I will tell you that for the most part, our general reaction to the GAO report was gratitude and acknowledgment, that there really

were not a lot of surprises in that report, and they really -- the recommendations aligned with the work that we already had under way. So it indeed validated the work that we knew we needed to do and had already begun and in fact provided support for the continuation of those improvements.

So we talked about some of the specific areas of improvement the GAO identified for us, but again, as a reminder, acknowledging that some of the state-led evaluations really didn't meet what we would consider standards for academic rigor, and those standards are critically important in the value of the evaluation.

That states were required to submit final evaluations when a demonstration expired, well, we know that many states renew their demonstration, and so the sort of concept of expiring was not one that was matched up with the need to get evaluation data.

And then, as noted, the evaluations that we did get were required when a state requested renewal, but again, those were interim evaluations that gave us some good information but not enough information, and so we acknowledged the need to change that.

Additional findings included the data challenges and limitations that were experienced by our federal contractors, so there were challenges on the state side as well as certainly challenges in our federal evaluations that we should, in fact, be releasing those federal evaluation reports that we had. And then one thumbs up that indeed there were some positive steps that we were taking and that was a work in progress.

You know, some of those steps I've already described to you generally. I want to talk now a little bit about some of the specific things that we're doing in response to the GAO findings and then give you a couple of specific examples.

So the first recommendation was that we should have written procedures around the policy for final evaluations at the end of a demonstration regardless of the renewal status. And so we have, in fact, done that. We have implemented that recommendation through the standard terms and conditions of the demonstration. So all demonstrations are driven by the special terms and conditions and standard terms and conditions, and those are really the policy agreements that we have between the

federal government and the states that lay out what the state is going to do, who is responsible for what, and how they're going to be accountable.

And so as part of those evaluation terms and conditions, there is now a requirement that the summative evaluation be submitted with every renewal and every demonstration approval. And so we have integrated this term into all demonstrations now, both new ones and renewing ones. And so we will begin to see those summative evaluations that come at the end of the demonstration period, not when, you know, the whole thing may end. And that will really help us to really understand better what some of the outcomes have been. So we'll begin to see some of those in the 2022-23 period since it was about a year ago that we started integrating those into the special terms and conditions.

The second recommendation was the criteria for limited demonstration or limited evaluation or evaluation of a portion of a demonstration, and this really came out of a recognition that we do have quite a few longstanding successful demonstration programs, certainly some of our managed care demonstrations, our family planning

demonstrations that are longstanding and at this point would be considered non-complex policy. And so we recognized that, you know, there needs to be some allowance for what we would be looking for in those demonstrations.

So we've identified some criteria to determine where we might do some of those limited demonstrations, and those include longstanding, what we consider non-complex policy and unchanged over a period of time.

The second one is a bit of a challenge, however, and I think that that's something that we will see going forward, but we're not going to see necessarily immediate, because one of the criteria that we've established is that the demonstration has been previously rigorously evaluated, so that we know we've got some good, solid, outcomes-driven, data-driven evaluation data -- evaluation results, includes small numbers of enrollees and have been operating smoothly without any administrative changes. So no kinds of operational changes that would also have an impact on the outcomes.

The third recommendation from the GAO was the policy around releasing of findings. So as noted, we have been doing federal evaluation, and we have had some draft

interim reports as well as the rapid cycle reports, which for us really are designed to help us understand what's happening as quickly as possible as it's happening, so really more understanding how the demonstrations are being implemented and are they being implemented as anticipated. Are there some early lessons that either we can learn and/or we can share with other states interested in demonstrating a similar thing that would be helpful as some of those early lessons learned?

So we have, in fact, developed a process for clearing those evaluation reports, and we're piloting that process with some of the reports that were mentioned in the GAO study. And as I'm sure you're aware, a few of those were just released and are available on Medicaid.gov.

We continue to have a way to go there. There are more reports to come, and as I said, we're piloting this clearance process, and part of that includes informing all of our federal partners about the evaluations, what we've learned from them, what we're doing with that information, et cetera. And so we look forward to having more dialogue about those as we begin to share them.

So just a couple of other points about some

specific evaluation improvements that we've made. You know, one of the things that was noted, of course, was the challenge in some of the state evaluation designs. And so we have really invested a significant amount of resources in providing technical assistance to states on evaluation design. As a requirement in those standard terms and conditions I referenced, states are required to submit to CMS for approval the evaluation design. That generally comes after the approval of the demonstration itself, as states often need that time then to work with their evaluation vendors and really develop a robust design that is based on what we ultimately approve. And we are providing states with some technical assistance on those designs. So, you know, the kinds of things that we'll be looking for in those designs around a variety of analytical methodologies, the evaluation questions and the hypotheses tied to what it is the state is demonstrating, the comparison groups -- that was another point that came out in the GAO study. We've done some work to provide states with some assistance in how to set up comparison groups in a rigorous way, data sources, anticipated limitations, and how the states will address them, et cetera. So we're

working on that technical assistance.

And then really trying to create much more of a learning environment among states around evaluation of demonstrations. We are talking about demonstrations, so we should be learning from the demonstrations and then sharing those learnings with states and using those learnings internally and externally. And so the culture of learning is something that we're really trying to diffuse across both CMS and our partners and really applying that knowledge across the broader Medicaid policy.

So then quickly just a couple of specific examples. As I'm sure you know, we have recently issued guidance on a slightly revised approach to substance use disorder demonstrations and, as part of that, have implemented some additional evaluation requirements -- monitoring and evaluation requirements, including standard metrics and measures, some of that specific evaluation design guidance considering sort of meta-analysis across those state evaluations, and some specific monitoring protocol.

We're taking a similar approach with the slightly newer new guidance that has come out from CMS around

community engagement demonstrations. That is allowing states to test work and community engagement as a condition of Medicaid eligibility. And it won't be surprising to you that there is a great deal of interest in those and, in particular, in the outcomes of those across the broad spectrum population who are impacted. And so we are working on developing standardized metrics and measures, ensuring that states are asking what will be data-driven and outcome-driven evaluation questions, and providing the same amount of technical assistance to states around those designs.

So that's it, and I'm happy to answer questions as well.

CHAIR THOMPSON: Thank you both very much. And, Judith, congratulations on your permanent appointment.

MS. CASH: Thank you.

CHAIR THOMPSON: We're delighted to see that.

So this has been an area that the Commission has had a number of sort of discussions about, so it's quite useful. As usual, what we'll do here is use the time that we have in this session to ask our panelists questions, and then we'll take a break, and we will, as Kacey mentioned,

come back and have an opportunity at that point for some cross-talk about the Commissioners about what we've heard.

So I'm going to ask Marsha to kick us off with questions.

VICE CHAIR GOLD: Thank you. This is a topic that is both central to our Commission's discussion often as we look to understand what we're learning from a demonstration, since that's the point of the demonstration, and also mine personally because I've been involved in a number of these evaluations and, you know, not the ones discussed here but earlier. And this is not an issue specific to any one administration, but it has been an issue, especially in an increasingly polarized environment the last several years. And as a taxpayer, I just get annoyed because, you know, there's a lot of good work out there, and it doesn't get shared.

So I had two questions, one focusing on the material you presented on the federal side and the other on the future. So the first area is I just wonder -- I mean, it's important to get the data out. I see you're committed to do that. I don't know -- I know there are lots of ways it could not come out or it could get delayed and lots of

reasons that can be provided there. I don't know if GAO came across anything that was relevant as to how you do it. I don't know if you just have transparency, you list all the reports that are coming on with when they're due and whether they get delivered and when they get out, or I don't know what. But I guess the question I have is it's an important issue and how do we make sure that the information gets out.

The second question that I wanted to get to was just if you -- I don't know, Judith, if you're the right one to answer this, but, you know, getting report information out depends on having there be studies. And I'm not sure what the current policy is on doing evaluation of state initiatives, which ones will be done. In our material we had an article from Modern Healthcare on scaling back plans for the Indiana demonstration, leaving out a survey which it seems is critical to getting things done. And so if you can clarify a little what the current policy is on evaluations, that would be great.

MS. CASH: Sure. Happy to do that. Thanks for the question. So to your first point about making sure the data get out, I will tell you that we agree with that goal,

and the administration is committed to getting the data out. So there are a number of reasons why the reports that the GAO mentioned and some of which were released yesterday have taken a long time, and mostly that is our just need to understand them and to ensure that everyone has the opportunity to review them.

These were independent evaluations, so they are not evaluations that CMS edited or changed, but, in fact, just needed to make sure that we understood and were able to fully share with all of our federal partners. And so that continues to be the case.

One of the things that you will see, I'm sure, if you haven't already, in those evaluation reports is that they are preliminary. They are an interim evaluation, and there are data limitations consistent with any significant health services research. And they are in the early phases of the programs that they were evaluating. And so, again, we wanted to make sure that we understood those limitations and really what we could and should be doing with that information.

That said, we take responsibility for the fact that we need to get them out more quickly, and so the

process that we've put in place we hope will do that. And I would tell you that the administration is committed to that as well.

In terms of the specific question, sort of where we're going with evaluation, and then I'll get to the Indiana question, I think that, as I think was noted somewhere along the way, there is, in fact, a commitment in this administration to more flexibility for states, and along with that more flexibility comes a requirement for accountability. And so we are interested in continuing to have states provide information to us and for us to then put that information out.

So the federal evaluation that we have been doing that actually began under the previous administration is continuing, and as I noted in my slides, we are looking to the future to be able to do additional federal evaluation, cost data evaluation. Those decisions have not yet been made, but we're still working through those. But, again, our expectation is not that federal evaluation would replace the state evaluation. States are still required to do an evaluation. And what we do not want is to put ourselves in a place where we have competing evaluations.

What we want is to learn from both of them. And so where we can learn across states in what we are doing with the work now and could do in the future is some meta-analysis of the state evaluation as well as looking at them from a variety of perspectives. So that is still very much a goal and one that we anticipate continuing to work through.

The Indiana one in particular, I can certainly tell you that we still feel like that is and will be a robust evaluation. That evaluation design is also posted on Medicaid.gov, and so you can see all of the different data sources that will be in that Indiana evaluation.

Not quite clear in the press article that came out last week, but the decision about the survey was not a new decision. That actually was a decision that was made over a year ago. And that really was a decision that we made, recognizing we wanted to make good use of our limited resources. And given that at that time we were not able to get the data that we needed from Indiana and there were other sources of data that we knew we would have, which I'll talk about in a minute, we decided to apply those resources to another state -- Montana, in fact -- evaluation and then to increase the number of focus groups

that we'd be using in Indiana to be able to get more information from those focus groups to have more of them.

But that is not the only thing that that Indiana evaluation is being informed by. We also are using or the contractors are using American Community Survey and Behavioral Risk Factor Surveillance System data, so there are a number of different data sources that we'll have to get what we think will still be a good picture and a robust evaluation of the Indiana demonstration.

CHAIR THOMPSON: Thank you. Very helpful.

We have Darin and then Fred.

COMMISSIONER GORDON: Thank you both for your presentation. I really appreciate it.

First, a comment. I was glad to hear from a CMS perspective that you are focusing the evaluations on things that are not the -- well, I'd say it this way. You said uncomplex or unchanged policy, you're setting those aside, and that's appreciated from a state perspective, I'm sure.

One thing that has come up in both of your comments and I'd like both your perspectives on this because they may be different, data limitations constantly comes us, and I'd just like a little bit more detail on

some of the things you saw in that respect. Is it inability to provide it, the data that was being sought after for an ideal evaluation just didn't exist? Is it a combination of those things? Is it the transferring of data, the quality of the data? Just every time I hear "data limitations," there's like a thousand things under it, and from our perspective I think it's helpful to understand what some of those issues are. And then as a follow-up -- and, Judith, this is more for you -- what is CMS doing to help states to try to address some of those things? Thank you.

MS. BARNIDGE: I appreciate the question. I think, you know, we raised some of the data limitations particularly that were affecting the federal evaluations, and those -- a big part of that was the switch to T-MSIS, and there was sort of a period of time where states were no longer required to submit data to the legacy system, but they weren't all submitting data to T-MSIS, so I think the evaluators had planned to be able to mine that to get this data, and it just wasn't there, so they were going to -- states were scaling back the evaluations to deal with that.

I think, you know, some of the methodological

limitations probably also related to data, and I know that Arizona, there were some delays in submitting final reports due to data limitations. I don't know all the details of that, but it does seem that what we saw was that CMS was more actively engaging states early in the evaluation process to try to anticipate those data challenges and think through how to design around them.

MS. CASH: Yeah, and I think -- thanks for the question, Darin. I think from CMS' perspective, we recognized that there are data limitations both on the state side and on the CMS side. And there are some similarities and differences to those limitations, but I think, you know, including the fact that state administrative data varies from state to state, I would venture to say that your data dictionary in Tennessee probably looked different from Toby's data dictionary in California, and across states there is some variability there. So yours was better than his, I'm sure.

[Laughter.]

MS. CASH: But I think that, you know, we learned that there are differences from state to state across the data.

You know, I think recognizing the issues related to T-MSIS data, we at CMS have spent a lot of time and energy with states over the last couple of years in helping them to get the data in, and that transition period was a really challenging one for both states and us. And now we really are realigning those resources to focus on that data quality, and I think our friends in the data systems group will be happy to talk with you some about how we're doing that. But there's a real focus on, again, getting some consistency across definitions and making sure that people are clearer that when, you know, we count this way, we mean it.

And, clearly, at the state level, that's a difficult thing to do, recognizing that the inputs for those data also come from, well, providers and certainly the eligibility systems and the multiple systems that feed into those data are in varying stages of development of interoperability. And so the chance to be able to really use those data I think continues to evolve.

CHAIR THOMPSON: Fred.

DR. CERISE: Thank you, and thank you for the presentation. Good information.

I have two questions and just a comment at the outset. So as we look at the issues that you're raising and describing, evaluation, design, comparison groups, lack of data, problems with protecting privacy, these sound pretty fundamental, right, and we've been doing the waivers for a long time and so we're talking about these things. So kind of going forward, my concern is as we go forward, how do we intend to have the rigor there around some of the important issues that we're talking about?

So yesterday we talked about social determinants. So my two questions. One, I want to understand what we're doing around social determinants, as you look at national quality metrics and how are you building those into evaluations, things like homelessness and serious mental illness, substance use, distressed neighborhoods, and those types of things. And then the second one is specifically around DSRIP. I know the agency is sort of moving away from DSRIP as a permanent part of waivers. As you look at DSRIP and look at the outcomes that are measured, many of those outcomes depend on ongoing activity, you know, reducing hospital-acquired infections, readmissions, managing chronic disease, immunizations, things like that.

And so as you look at the evaluation around DSRIP, or other programs, looking at the inputs, and are those issues, problems that are corrected and then you can move on or that require ongoing resources to maintain those outcomes? Maybe you can tell me the current thinking around DSRIP and particularly around those outcomes that will need ongoing support or effort to maintain.

MS. CASH: Sure. Okay. So to your first point, yes, we've been doing 1115 demonstrations for a long time, and identifying the kinds of limitations in our evaluation that we're identifying are, in fact, pretty foundational. And I think that that is why, at this point, we are really looking at the specific changes that need to be made in our approach to evaluation, and we've been doing that now for a couple of years. And I would say that the work that we started, probably two or so years ago, really is the first focused effort on improving evaluation that we've done in probably 15 years, in 1115 demonstrations.

And so I think, you know, it's not surprising, however, that what we're identifying is foundational, because they are the kinds of problems that we're seeing both in our own federal evaluations, in this early stage of

what we're doing, and in state evaluations, and it tells us that we need to provide the really focused technical assistance that we're providing to states.

And I will tell you that we've really seen some significant change already in how states are engaging in the evaluation process. They, too, are committed to improving the rigor of their evaluations. It benefits them to learn about their evaluations as much as it benefits us and the rest of our stakeholders. So we're actually seeing some change there. But I agree with you that these are foundational issues that we need to work on.

So relative to social determinants, we do have a number of existing demonstrations that are looking at social determinants of health and really beginning to address them, certainly in Washington, in California, in New York and a few other states. We've got states now that are continuing to express interest in that, and so the administration is looking at that overall policy approach and determining how and where Medicaid demonstrations really should play in that arena, recognizing that, you know, there are multiple determinants of an individual's health and Medicaid has a role in supporting those in order

to achieve positive health outcomes.

And so those are things that we are evaluating. As I said, we have existing demonstrations now. We have states that have expressed interest in them and the administration is looking at those and really developing its policy around those areas.

So in reference to comment about DSRIP and whether or not those are continuing, again, at this stage, we have a number of continuing DSRIPs that are working. The reports that were posted yesterday I think indicate some very preliminary data around DSRIP and we're looking forward to continuing to learn from those evaluations.

So, you know, we look at DSRIP as a one-time federal investment and we are working with states now, all of the states now that DSRIP is an investment that we are interested in making with them, and that we expect the states to also identify for us a plan for the state's sustainability of those efforts, once the federal investment is no longer there. And so some of the recent DSRIPs that we have approved include a phase-down of the DSRIP payments over time and a clearer plan for the states to sustain those programs, which will include continuing to

evaluate the sustainability of the change that is being made. So, you know, looking at what those inputs are now, what we're evaluating now, and how we expect states to continue to measure those changes, you know, at the -- sort of on the other side, if you will, of the DSRIP.

CHAIR THOMPSON: And, Fred, I took your question about social determinants to be, in part, at least, about reflecting the conversation that we had yesterday that as we look at our program interventions and determine what's working or not working, we should take social determinants into account.

DR. CERISE: In addition to those specific --

CHAIR THOMPSON: Right. So just think about that in terms of -- I think part of what we were discussing yesterday was the idea that social determinants may be complicating the success of different interventions --

MS. CASH: Oh, absolutely. For sure.

CHAIR THOMPSON: -- and, therefore, in the evaluation design maybe that's something that should deserve some specific attention, to see if that helps explain or account for --

MS. CASH: Right.

CHAIR THOMPSON: -- some of the results.

MS. CASH: So that may or may not be a variable --

CHAIR THOMPSON: Yeah.

MS. CASH: -- that we're actually evaluating as part of it, but it certainly may be a factor in -- our review of the findings. Absolutely.

CHAIR THOMPSON: Right. Okay.

So we have Brian, Alan, Kit, Toby, and then Chuck.

MR. BURWELL: I also very much want to thank you for taking the time to come and talk to us today.

One of the responsibilities of MACPAC is to make recommendations to Congress about Medicaid issues, and this is a topic that's of very large interest to us and we may end up making some recommendations at some point.

I have two questions in that regard. One is good, objective, robust evaluations cost money, and I just want to ask a general question. Do you feel that CMCS has the requisite resources to do the kinds of evaluations of 1115s that are going on, and there are a lot of them and there's a lot of experimentation going on, and there's a

lot of demand for information, like what are these changes all about and are they improvements to serving Medicaid beneficiaries?

The second has to do with kind of dissemination and ownership of the results. The dissemination strategy of CMS is often posted to Medicaid.gov. That is not exactly a broad dissemination strategy. There are limitations on your travel, in terms of attendance at conferences, et cetera. A lot of contractors who work on these have a desire to publish the results of these evaluations in referee journals. I guess this is also a question of Susan. Are there ways in which these results can get out into the academic community and to the broader community more generally than happens currently?

MS. CASH: So I'll take the resources question first and say that I would venture to say that resources are limited. We feel like we're making the best use of the resources that we have available, but, you know, I think that it would be -- it would not be an understatement to say that resources are limited and we do the best with what we have. Additional resources would help us across the board in our ability to do our work, and I think that's

something that we continue to look at, and we are looking at ways we can use the resources that we have in the way that it's most efficient. In fact, that was one of the things that informed our decision last year around the Indiana evaluation, was about how can we make the best use of the federal resources to get the best we can, the best evaluation we can, given the limitations. So, you know, that's sort of what we can say.

The dissemination and ownership, I would say we support broad dissemination. At this point, Medicaid.gov is the mechanism that we use, although I will tell you that we have, on occasion, some of the evaluators that work with us and have done some of these evaluations, have had the opportunity to share some of the information across a wider audience, and we would support that. I think that we recognize that, you know, the more light that is shed on any information you have, the better the information gets. And so we would support that broad dissemination of these -- of the results and would appreciate any sort of suggestions or recommendations you would have about how we would be able to do that better.

CHAIR THOMPSON: Alan.

I'm sorry. Susan, were you jumping in?

MS. BARNIDGE: Well, I wasn't actually going to add anything particularly useful other than to say we didn't sort of envision what dissemination might look like, but that sounds like a great space for MACPAC to consider whether there are best practices.

MR. WEIL: Thank you for these presentations and the work. This is a very important area.

I want to focus for a minute on sort of the meta-analysis or the multistate evaluation, as the term was used by GAO. This feels particularly important as we have potentially major policy changes or initiatives being considered and often adopted simultaneously by multiple states before there are any results from the early adopters.

From a GAO perspective, I'm trying to remember anything prior to the recent report that sort of talks about multistate. I can't remember but that doesn't mean I would, and would be interested. My sense, from your presentation and the report is that this is really sort of a data issue, but it seems to me there would be other relevant considerations in trying to understand the effects

of a policy adopted across states.

I guess what I'm trying to get at is I think the whole is more than the sum of the parts, and so if you look at sort of the individual state evaluations, that's not the whole way to understanding whether we can reach any conclusions about a policy across states. And I guess that's sort of my question for CMS. When you say a meta-analysis, and we talk about the duration of these evaluations, often our understanding of a policy change actually occurs long after, and it requires consistency in data elements and the like, and it requires some willingness to make judgments about the relative quality of each individual study. That's what a meta-analysis does.

So I'd just like to get a little more sense of where we might go in being able to draw more clear conclusions of initiatives that are adopted across states.

MS. CASH: Do you want to just talk about any previous multistate, if there were any?

MS. Barnidge: I mean, I think that -- I'm not remembering the details, but the last evaluations done by CMS, that I believe were multistate, were early 2000s. We didn't sort of look more broadly to see if the research

community had done more. So, yeah, not a whole lot.

MS. CASH: But, you know, to the point about the research community, I'd just have to say I do know that there are a number of, you know, really strong research folks out there who are doing a lot of good work in this space, and I think we continue to learn from them as well.

I have to say that I did a presentation a few months ago to a group that was convened by the Robert Wood Johnson Foundation, and I was looking out like this at the group of people, and I said, "So, you know, I'm a little nervous here because this is probably the first time I've been surrounded by people who know more about the work that I'm supposed to be overseeing than I do." But there's good work that's being done out there, and we have a responsibility to do our own good work as well.

So I think you're right, Alan, that, you know, there are some significant policy changes that are happening now that we care a lot about, and care a lot about understanding, and we take seriously the acknowledgment that, again, we are talking about 1115 demonstrations, and we really want to know what is it that the state is demonstrating and what are the outcomes of

those demonstrations, and the ability to learn not just from individual states about that state experience and experience of beneficiaries and other stakeholders in those states, but what we can learn across those patterns is critically important.

And part of our acknowledgment of the need to be able to do that, and the need for consistency across those analyses, is what drives us now to come up with some consistent metrics and measures that we are requiring all states that are implementing, for example, a community engagement demonstration. There is a specific set of metrics and measures that we are developing that all states that are doing community engagement demonstrations will be required to monitor and ultimately to evaluate. The purpose of those demonstrations is to determine whether requiring working community engagement as a condition of Medicaid eligibility leads to sustained employment and leads to improved health outcomes.

And so we really are looking to states to be able to really take that thread all the way through and to collect and report on data to answer those questions. And so we know that we have to really monitor those closely,

and I think that will contribute to the quality of any study, of any results that we might get in the future. But our attempt to do a meta-analysis, if we are to do that, and, as I said, that is still a work in progress, but it depends upon our ability to identify some of those consistent threads across demonstrations that we can then reasonably and rigorously compare one to another.

CHAIR THOMPSON: So we are coming to the end of the time, but we have three more folks with questions. So Kit, Toby, Chuck, and then we'll bring it to a close.

DR. GORTON: So I just want to join everybody in thanking you for taking time to come and talk with us. We understand that's a big commitment on your part, both the preparation and actually showing up.

Following up on Brian's question, for Judith, in your slides you talked about, you know, developing a learning diffusion plan, and I guess beyond just posting more stuff on Medicaid.gov, if you could give us a little more color about what that learning diffusion plan might look like, recognizing it's in its early days, it's developing so it doesn't exist yet, but just sort of what are the things you're thinking about.

The second piece of that question is, would you view MACPAC as a targeted consumer of the outputs of that plan and what do you think that might look like, other than just having Kacey click on Medicaid.gov once a week and see what's there.

And then the last piece is, in this context, once you come up with this and get it right, what's the goal of this? What does success look like? How will we know whether, you know, from a federal accountability point of view, how will we know whether the agency did this well or not? What is that target that you're shooting for, recognizing, again, that this is Version 1.0 and it's not going to be, you know, fully formed from the head of Zeus, you know, in any short period of time. But just a little more color and any detail you can provide about where that's going.

MS. CASH: Sure. So, yes, to start with your bookends, which is it is very much developing, a work in progress, and it will take time. You know, this is a significant -- it's very important and it's a huge amount of work, and it's going to take time to get from where we are now to where we ultimately can answer the question, how

will we know we've been successful, but some of the things we've been thinking about already, as we're in the developing stages.

So in terms of what the learning diffusion looks like and how we're doing that, besides just posting on Medicaid.gov, one of the things that we are doing is bringing together groups of states to have them have the opportunity to share their experiences, their learning with each other, to be able to ask questions of each other. You know, there are a number of opportunities for states to do that. We feel like we have a responsibility to be one of those opportunities, to give states a forum to be able to share the information that they're getting, as well as the information that we're getting, to do that.

Specific to the latest approach that some states are interested in taking with the community engagement demonstrations, we're actually creating what we're referring to as the Community Engagement Learning Collaborative, which is going to bring together some states that are interested in doing it and beginning to learn from each other, even right now in the planning and envisioning stages and then sort of carry that through over time.

We're doing the same thing with some of our DSRIP programs, to kind of bring those states together to have the opportunity to learn from each other and what they're experiencing.

So those are some of the ways that we hope to diffuse the learning across the states. And then, beyond that, I think, absolutely, MACPAC is an audience that we think is a really valuable one, and would be happy to continue a dialogue with you all as we learn from this process.

I think we'll know we've been successful when we actually have, you know, a similar approach that GAO took, to say here are the things that are happening in the 1115 evaluation space, and that some of the findings include states are using rigorous data-driven evaluation designs, and CMS is using the information and the findings from those rigorous evaluation designs to make decisions about 1115 demonstrations going forward.

CHAIR THOMPSON: Toby.

MR. DOUGLAS: Thank you both for your presentations, and congratulations, Judith, on your position.

A big area of concern is state administrative capacity, and you've talked a lot about TA and all the learning. But the question, you know, when I think of administrative capacity, it's both the breadth as well as the depth, and when we talk about a lot of these rigorous evaluations it takes, you know, very complex and a staff with a lot of different backgrounds. And the question is what are you seeing in terms of the change, the ability for states to react, to be able to take on these new requirements, and are there any recommendations in these areas that we should be looking or thinking about? You mentioned concerns at the federal level. Well, what about states?

MS. CASH: Yeah. Thanks for the question, Toby.

And I think what we're seeing is why variability, as you would imagine, from state to state in terms of both their current capacity and capability to do the kind of evaluation that we're requiring and that they want to do and in their ability to kind of come along with us on this journey.

And I think that we've got states that have existing relationships with evaluation contractors that

engage on their behalf in this work and are able to bring some of those resources to bear, and we have states that have state staff that are doing it as part of their other jobs and everything in between.

Recognizing that it is costly, we also -- that's part of why we're also trying to provide some of the tools that we're providing. So guidance in how to develop an evaluation design that is for us informed by experts in the field of evaluation that we can then share with states so that they can sort of understand, as I said, earlier the kinds of things we're looking for in terms of that rigor, evaluation and methodologies and data indicators and development of hypotheses and questions, all of those things that really states just in some cases need somebody to help them understand what it is that really makes up a rigorous evaluation design.

But it really is all over the map in states, and we are trying to states where they are with that evaluation approach and try to provide as many tools and as much technical assistance as we can provide to get them to that place because for the most part, as I said, states really are just as interested in a rigorous design of their

evaluation as we are and have varying levels of resources to bring to bear on that, and we're trying to provide some support to that.

CHAIR THOMPSON: Chuck, you can take us out.

COMMISSIONER MILLIGAN: Good morning, Judith.

I have a question for you with a couple of elements to it. I'm trying to learn a little bit about kind of the inner workings at CMS about how this is integrated with maybe some other groups or other parts of CMS.

MS. CASH: Okay.

COMMISSIONER MILLIGAN: So sort of two parts to the question. One is, to what extent, when states are pursuing advanced planning documents or other IT-related funding -- to what extend does the evaluation design for a waiver play into the funding decisions or feedback to states about their data management strategy, their data reporting strategy? So that's how you're working with kind of the system side.

MS. CASH: Mm-hmm.

COMMISSIONER MILLIGAN: I'm tempted to ask Penny this question too.

The second part of the question, though, is when new states -- and it's kind of following up on Alan's. When new states are pursuing an 1115 waiver, where there maybe isn't a whole lot of results yet from an early adopter of the same concept, to what extent do you all look internally are preliminary data, preliminary evaluations in how you inform the development of terms and conditions, questions that CMS and states go back and forth with about kind of the waiver approval process? So I'm interested in that element as well.

MS. CASH: Okay. So to your first question, this is also a work in progress, but we do work in fact pretty closely with our colleagues on the systems side of the house, if you will, to ensure that not only the evaluation requirements of the proposed 1115 demonstration, but all of the systems-related requirements for an 1115 demonstration are synced up with what's happening and what's described and what's funded in those -- via those against planning documents.

So where a state comes to us with a demonstration that includes a need to actually make changes to their eligibility system or their Medicaid Management Information

System as well as ultimately to then have systems capability to draw in data that will inform the evaluation, we work with a state, and we connect with our colleagues on the system side to ensure that those changes are identified, that they are costed out, and they are included in the budget that's laid out in the Advanced Planning Document.

So we've been doing that. We are continuing to do that, and we recognize that we've got work to do in that area in really syncing those things up, but it's very much part of the conversation.

The other thing -- you didn't ask this, but the other thing in terms of sort of inner workings is that we also know that 1115 demonstrations are connected sometimes to other things. So if there is a state plan amendment or a 1915 waiver, all of those things have to come together. So we work closely with our colleagues in all of those areas to make sure the states kind of got all the pieces of the mosaic together.

And then a state that's proposing a new demonstration that might be something another state is doing or has started doing, but it's still early and we

don't have data around, what we do, though, often is have at least some preliminary information about implementation and the kinds of road blocks or really lessons learned from that implementation.

And so we do share that information with states if we have them. We connect those states together to learn from each other.

The rapid cycle reports that Susan referenced and a few of which were posted yesterday also serve some of that purpose in that because they are rapid cycle, they're more implementation-specific than they are outcome-specific. They can tell us some of those early lessons that states are seeing, what are the things we need to know about eligibility or provider engagement or planning with the APD some of those things that come early that we can share with states. And we try to do that wherever we can.

CHAIR THOMPSON: I know we're a little bit past our time, but I wonder if you could indulge me to allow me to ask a final question. Just hearing this conversation, first of all, I think the GAO report is very useful, and I think the work that's going on at CMS is very promising. But I'm just wondering whether our paradigm about this is

itself fundamentally correct.

Judith, you mentioned that, for example, the discussion about the evaluation approach and design follows the approval of the waiver, and we're having a discussion as though in every case, which I think is more the exception than the rule, a state is genuinely unsure about what it's doing and why it's doing and what it's going to produce. In fact, most states who come forward asking for an 1115 have a point of view. They believe that what they are going to do is promoting the objectives of the program and is going to create certain kinds of outcomes that they're prioritizing.

So they're not exactly neutral in the proposition. They are advocates of the proposition, and so I just wonder if you can talk a little bit about the idea of should there be more up-front agreement within the STCs themselves about what constitutes success and what would generate a decision on the part of a state to abandon an approach or to refine an approach in order to affect the outcomes that they're trying to seek.

I think that we're in a world where the desire for rigor, which is understandable, the administrative

capacity issues, the data issues, et cetera, sometimes confound us and cause us to have a long period of time before we accumulate the knowledge and then the wisdom from the knowledge in order to make use of it, and so I'm trying to think about if there are ways in which we should be altering the approach differently so that we are focusing on specific measures, the data that we know exists in order to be able to inform whether we're accomplishing what we are accomplishing so that we have a better sense as decisions are made on an ongoing basis about whether or not we're achieving what we hope to achieve.

MS. CASH: Yes. So I would say that is in fact a lot of what we're thinking about.

Let me just make sure that I am clear. That while CMS generally approves the evaluation design after the approval of the demonstration itself for reasons I described earlier, that is not to imply by any means that we are not engaged in conversation, in negotiation, and that there are in fact terms and conditions in the demonstration about evaluation.

We do in fact require that states identify ahead of time before we approve what their hypotheses are, what

their evaluation questions are, and we begin to identify both some monitoring metrics and anticipated outcomes within the negotiation of the demonstration, and those are reflected in the terms and conditions.

Ultimately, the design is done after, but that foundational work happens during the negotiations.

And expect states to tell us what is it that they anticipate is going to be the outcome and how does it promote the effectiveness of Medicaid, and it is exactly, Penny, as you said that states most of the time are coming to us with a demonstration that they believe is going to work, and they believe it's going to achieve the state's desired outcomes. And I think it's incumbent upon us at CMS in part of our negotiation with them to ensure that not only are we looking with them at those outcomes but also what are other outcomes that may result from the demonstrations.

And so I think we do in fact have a responsibility and have been engaging with states on what some of those other outcomes might be besides the ones that you identified in your proposal, and that is part of the -- where we end with that is often very much a part of the

negotiation itself prior to approval.

And I think it's work that we continue -- that we have -- I think we have continued work to do, and we should continue to hold ourselves, have others hold us to those standards and expectations, that that's what we're looking for because we should be measuring not just what the state sort of thinks is going to be its outcome, but other outcomes that we care about that may or may not have been those that were part of the state's initial proposal.

CHAIR THOMPSON: Thank you very much.

Well, again, a terrific conversation and a subject of great and continuing interest from us, so we'll look forward to a continuing dialogue with you on this subject. Thank you both very much for coming and spending time with us this morning.

MS. CASH: Thank you.

CHAIR THOMPSON: We'll take a short break and father back together in 10 minutes. My watch says that will be 10:20 we will reconvene.

* [Recess.]

FURTHER DISCUSSION ON SECTION 1115 WAIVERS EVALUATIONS

* CHAIR THOMPSON: Okay. Why don't we try to reconvene here and pick back up on the conversation.

Okay. Let me open it up for Commissioners to reflect on what we heard and if there are some additional areas that we should be exploring in ongoing work with the staff.

I wanted to open up the conversation around the data limitations issue to kick us off maybe. You know, we've heard this before, and I think it was Brian, you made the point when we were talking about the money follows the person report about -- where we similarly had an issue where there were delays that I think were accounted for by T-MSIS that caused us to suggest that we actually needed some supplemental reporting as a consequence of not having data available. And so while I appreciate the idea that you might have federal evaluators who assumed that they would have T-MSIS data available, it's the states who are submitting some of this data to the federal government, and they certainly have MMIS data that they're processing and are available that would be transformed into T-MSIS data. And so certainly at least the states would have access to some of the data.

So I want to talk a little bit about whether or not we should be looking more about the extent to which federal data sets versus state data sets should be relied upon in some of these circumstances so that we don't find ourselves confounded by an expectation that we would have had certain data and now we don't have it. What do we do now that we don't? And the issue that came up with respect to Indiana not providing the data because they were concerned that a CMS contractor didn't have the proper protections in place seemed to me to be something that ought not to ever occur. That should be something that should be resolved by either the federal government making that assurance as opposed to a state simply deciding that it doesn't meet certain of their requirements.

So I'm wondering if we can talk a little bit about that and whether the Commissioners are interested in trying to think through some of those data issues which seemed to stymie us in a number of circumstances, both in terms of the availability and the timeliness of the data. Alan?

COMMISSIONER WEIL: Far be it for me to say no to a data conversation, but I'm going to say no to a data

conversation. I mean, I -- let me come at it from a different perspective. It's not where I would start in MACPAC's discussion about 1115s and what we're hearing and responding to. I think that's really my reaction, is that I think we -- there's a -- where do I go with this? I think there's a lot of desire to maximize the value of these. I think that if it were me, I would probably start more at the design level than at the data level. That's, I guess, what I'm...

CHAIR THOMPSON: And, Alan, can you say more about that then in terms of thinking about the design level in terms of establishing more consistent design parameters, more rigorous design parameters, more design parameters that produce insight earlier into the process?

COMMISSIONER WEIL: Yes, yes, and yes. And I just think that -- I mean, I'm trying to figure out where we have impact. It goes sort of to Brian's comment and a little bit to what Chuck said yesterday. You know, I don't want us to be just saying the generic, "We need to learn more," because that's not helpful to anyone. I guess I'm looking -- to me it's sort of middle, because I don't want to -- and, again, my view is only one view. I worry about

the data issue sort of being the endpoint of some of the examples you just gave. And if we could move up and fix -- or help guide on some of those, I think we'd be less likely to be doing sort of the cleanup on the back end. That's more where I was coming at it.

CHAIR THOMPSON: Brian?

COMMISSIONER BURWELL: I am thinking about recommendations and where we want to go with this. We all know that there is a very strong connection between 1115s and evaluations and political agendas, and it's not just true of this administration. It's been true of all administrations. So I'm wondering if we should think about some kind of more institutional independence from the administration around this type of research and advisory panels and designs, et cetera. If we could separate the evaluation and research part from the political agendas a little, you know, and get the control outside the administration a little more, we might see more responsiveness to the general health policy community about what these demonstrations are really doing in the -- I don't know. I'm just throwing out ideas.

CHAIR THOMPSON: Yeah.

COMMISSIONER BURWELL: I mean, part of the problem is that these things are owned by the people who want the results to show a certain result.

CHAIR THOMPSON: Bill and then Toby.

COMMISSIONER SCANLON: Brian, I guess we do have a problem. We only have three branches of government, so there's a question of kind of where it's going to go.

[Laughter.]

COMMISSIONER SCANLON: But I do think that, I mean, in part of this discussion that we need to be clear about what we're dealing with. And if we take the ordinary sort of reaction to the term "demonstration," we think of something where I'm testing a concept to see whether it should be adopted more widely or more permanently, and if we look at this, we're often using the word "demonstration" to mean I'm operating a Medicaid program that is contrary to current law on an ongoing basis, and it will be renewed periodically. And for the latter, I think there's a question of, we have for the regular Medicaid program, so to speak, put into place certain monitoring requirements to assure sort of that it's operating appropriately. And I think we have to ask sort of whether using an evaluation

framework accomplishes the same thing.

One of the things that struck me was that some of the changes that were referenced, we're going to first see them in 2022, 2023. This idea that if something -- if we discover in 2019 or '20 that there's a need for modification, do we have the flexibility to have that modification occur? So there's that aspect of it.

Then I think there is -- I'll go back to your data question, because I think that there is a need to identify what should be routine, and T-MSIS should be routine. It was an aberration that -- hopefully an aberration that we had sort of a discontinuity there and that it was not available. But in terms of ordinary administration, claims data and encounter data should be routine, and we should be able to, without sort of great sort of expenditures, be able to use them to monitor something. But we have to recognize the limits on those in terms of what we learn, and that's where evaluations may get complicated and expensive in terms of thinking about surveys, thinking about sort of other kinds of data that may be essential to a demonstration that's being tested, but they are going to represent a significant expenditure.

You wouldn't want to continue them forever if you renew this program, but you have to identify sort of what it is that is important and then make the commitment, I think, to get that essential information.

COMMISSIONER DOUGLAS: When I think through the lens of states, when they go forward with 1115s, both from the governor, legislature, and policymakers, they're really viewing the 1115 through the policy as well as, you know, in many cases around federal -- you know, as we talked about Medicaid-ization or any type of revenue maximization. Evaluation frankly from those people is not top of mind. It's not even in some cases on the agenda. And so this gets to the -- you know, as we think through this construct and these additional expectations, the question always comes back to me as how this is then driven back to a state level of built into the infrastructure as well as fabric of how they're going to do an 1115. And right now it's not there in most cases. I can't, obviously, say for all.

And so, you know, going to Alan's point, starting with the data to the left, I think we really need just the overall what are the levers to make sure states -- not just the federal government but states are actually able to

execute on very complex evaluations and that doing 1115 isn't just about policy and federal maximization of resources but about the expectation that there is going to be a rigorous evaluation.

CHAIR THOMPSON: I guess, you know, my suggesting talking about data in part is about trying to bring it home to a kind of practical level, to kind of say, sort of picking up on all of your points, that engaging in a significant change that affects potentially beneficiaries, providers, expenditures, all aspects of the program without an idea about how I'm going to know whether what my intention is being -- even if I get agreement, yes, this policy makes sense to try, this is why I'm trying it, this is what I hope to achieve, and to have some ability to provide evidence and data underneath of that, that helps you monitor -- maybe it's more -- maybe I'm saying I'm more interested in monitoring than evaluation. If evaluation is something that comes five or six years later, that's great, and we should care about that because we should care about accumulating knowledge and gaining insight as a whole community. But the idea of really understanding how is this demonstration performing is it performing as expected?

If it's not performing as expected, are there elements of the policy or the implementation that are associated with that result? Maybe I'm saying I'm more interested in that question in general.

Marsha?

VICE CHAIR GOLD: Yeah, I actually was going to suggest -- this isn't an either/or, but given how long it takes to show outcomes for some of these, I mean, I've done a lot of evaluations, and they always take longer, cost more, and don't get implemented in exactly the way people intended. And so I think formative feedback -- and that's where a lot of the contracts are going. That's what a lot of these reports are that are there -- is important, but not just to CMS. I mean, if you're approving others states and we've already learned from some existing states that it's really hard to implement a certain aspect of work requirements or whatever else, that's important information to get out there. And so I think figuring out how to -- you know, I think CMS probably does get that information now more, at least from the national studies, because you have to go and talk to the states to find out what's going on. The states probably don't tell you that themselves.

But how to make sure that's happening and make sure that gets disseminated in a way beyond just to CMS, but to the broader world in terms of what we're learning about implementation is important, I think.

Now, one of the things -- I don't know, you didn't mention it, Brian. I mean, it used to be an issue of what the contracts allow in the way of -- you know, you're a contractor at will or you end up -- they have total control over what you say and whether you're allowed to change anything, whether they even accept what you say, and looking at how those contract requirements are written now and what flexibility the -- maybe this is what you were getting at, Brian. The research community has to disseminate even if the results aren't as the people want is also important. But I certainly think we should be -- promote more -- you know, the continuation of national evaluations and the focus on the formative feedback and getting that out broadly, rapidly.

COMMISSIONER BURWELL: And the issue of control over the results is an important issue. I don't know if we can deal with it, but, you know, they own the results, they can bury reports, they can change reports. They can do

anything they want. And there are certain contractors, RAND being one of them, that will not sign an evaluation contract with CMS unless it has total independence over the control of results. And often they disqualify -- they're disqualified from bidding or they don't win because CMS won't budge on that, and neither will RAND. So, you know, it's an important issue.

CHAIR THOMPSON: Kit, then Chuck.

COMMISSIONER GORTON: So, I mean, the question I'm thinking about is we've been doing these demonstrations since the '80s. Has one ever failed? You know, when have we ever seen somebody -- and maybe I'm just ignorant and I don't know. But, you know, it just seems -- and one has to wonder, to Brian's point, whether the failures are simply not talked about, they get tweaked in a renewal cycle, somebody tried -- you know, sort of the demonstration ad infinitum without ever getting to evaluation.

You know, it might be useful for the Commission to look at the history of the 1115 program. You know, you would assume that if rigorous evaluations were being done of truly innovative program designs, at least once in a while you would have a massive fail, which we could all

learn from. And I don't know -- and, again, maybe it's just I'm uninformed and I don't read the right journals or click on Medicaid.gov often enough -- which is to say that I very rarely click on Medicaid.gov. But --

CHAIR THOMPSON: It's a really good website. You should go there.

[Laughter.]

COMMISSIONER GORTON: I'll think about that. Thank you.

But I just wonder if there's some perspective that -- and it gets to the question you were asking, Penny, about fundamentally what are we about here. And is this really about health policy research? My personal view being it is not now and has not ever been about health policy research. Or is it, in fact, a facile mechanism to allow states some flexibility to get around the basic SPA rules and the other accreted controls? And, you know, maybe it ought to be thought about in a different way, and that's to your point of let's stop putting all of our eggs in the final evaluation or the now interim evaluation at the end of each waiver cycle piece of it, and let's talk about ongoing monitoring of important things. Let's talk

about where we spent extra money, whether it's DSRIP or money follows the person or any of these other things, and did we get value from the additional federal share that got pulled down there?

You know, I just wonder if there's a role for MACPAC to say, look, here's the history of this tool, this 1115 tool, and here's how it's been used, and maybe that's good and maybe it's not, but at least here's what's happened, and to pose the question: Should we be fundamentally rethinking how this authority is shaped. Not to say that states shouldn't have some authority that lets them do exactly what they're doing, but maybe we oughtn't call it "demonstration authority" and be wrapping a flag of research around its shoulders when I think precious little research ever sees the light of day in terms of rigorous outcomes and results.

CHAIR THOMPSON: Chuck and then Darin.

COMMISSIONER MILLIGAN: As I'm listening to the conversation, where my thoughts take me is in terms of the waiver framework that we kind of brought this through and our role as advisory to Congress, and where that takes me is there's a lot of discussions in the waiver space around

streamlining 1115s for State B to adopt what State A already did, and what are the criteria for something to have been proven successful enough that it should be easier for the second state to do something that is successful? So that's -- one is kind of the waiver simplification for dissemination of an approach.

Second is for a state to have a simpler renewal process for something that's successful, which Judith touched on today.

Third is when should the Social Security Act itself be changed because something is successful enough that it shouldn't require a waiver anymore at all in ways, for example, like the PACE program became successful enough that it just became much more just of an option.

And so, to me, where that all takes me in terms of MACPAC's role is what would our criteria be to recommend to Congress that this is the evaluation rigor or the dissemination or the whatever that would lead to streamlining any of those three things, something becoming permanently part of the Social Security Act, something becoming easier for a second state to adopt after a first state has proven it to work, and third, for a state to have

a streamlined renewal path. And absent whatever criteria that might be, an 1115 would be contained, if you will, within a given state with no streamlining, no dissemination, no statutory permanence. So what helps me get oriented in this topic is how to inform Congress about 1115 as an authority.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: My comments somewhat dovetail with what Toby was talking about.

I don't think there has been a lot of priority in thinking about an 1115 waiver route, about the resources that would be necessary on the evaluation side, and quite frankly, in many cases, not thinking about the resources that would be necessary to actually implement the demonstration for what you're asking for authority.

And so to some degree -- and it's not because of lack of will or lack of knowledge and needing to do so. It's just because of some of the limitations that occur from state to state and time frames that legislatures sometimes put on the executive to keep something in a time frame that doesn't allow for a build-up and building on the capabilities.

But when we think about the evaluations, the one thing -- and this gets a little bit to Kit's comments about have things failed. Yeah, I've seen some of them fail, but then I've also seen them kind of regroup and recover as well. So do you abandon that path because it failed, or did you learn and did you iterate off of that? And that's one of these things through these programs that even through a waiver cycle, there is a lot of iteration that goes on throughout a waiver demonstration, and that doesn't always get captured.

But just trying to bring in those other elements when they do these evaluations -- I was asking to Judith to ask her where this comes into play. Where do you capture the fact that when you evaluate a particular situation that there were some dynamics that weren't part of the evaluation design that need to be considered to increase the odds of a different outcome and primarily about investments in human capital, investments in data infrastructure, regulatory oversight mechanisms that are needed?

The evaluation itself could be helpful. I think those other things, from a state learning perspective, are

critical from taking evaluation to transferring that into a learning that has the operational significance that's needed and know how that's needed before you go down a similar path.

CHAIR THOMPSON: I mean, as you say that, Darin, what occurs to me is that what you're describing is good program management, which is, however I'm managing my program, whether or not I'm operating under an 1115 program or I'm not, I should be understanding what I'm trying to achieve, and I should be collecting data and evidence. And I should be refining my approaches, and I should be acknowledging what isn't working and trying to solve those problems. So in that sense, is 1115 really a different animal in a significant way from just operating the general state plan authorities?

And sort of this gets to Kit's point too. In some cases, these longstanding 1115s have just evolved over time, and how much of this is really testing something really new, creating a level of risk to the program, to the beneficiary, to the providers that we're doing business with in the program and so forth.

What I did like -- there were many things I liked

about what Judith was talking about in terms of their progress -- this desire to distinguish -- and I think this is a little bit to your point too, Chuck, about what is the sort of ongoing, continual improvement. The program has been operating for a period of time doing what it's doing versus something really complex and different, and can we define those in some fashion and then establish a certain degree of scrutiny and rigor to the scrutiny over that second group of program approaches?

Alan.

COMMISSIONER WEIL: I can't help but note that I wrote about this 20 years ago, and I haven't worked for a state in 25 years. And when I worked for the chair of the National Governors Association, it was the policy of the NGA that when one state had a successful waiver, other states should be able to adopt it. It should be renewed with -- I mean, these are not new issues.

So to me, the question is how to move -- again, what's our role? I don't think we can resolve that.

Kit, I just have to say I -- my answer is it's both. I mean, it is clearly a political safety valve and an opportunity, but we have learned a huge amount of 1115

evaluation. And to suggest otherwise, I think it is overemphasizing the limitations relative to what we have learned.

I also think that even the word "evaluation" means something different now. People have this sort of retrospective view, and now there's formative evaluations that are more akin to the program management tool that you've described.

We kind of need to catch up, but what I was trying to do -- now I worry maybe I started us off the rails. I won't say I took us the whole way. When you started down here at data, I was trying to move us up. I do worry if we move too far up to the abstractions of what waivers are for and the like, that frankly it's all been said, and I'm not sure we need to say it again.

CHAIR THOMPSON: Marsha.

VICE CHAIR GOLD: Yeah. I think amidst the worrying about the waivers that have been there forever and what to do about them, I'm more concerned with making sure that the new stuff -- I don't want to lose sight of -- there's new stuff being tested that is very controversial that may have big effects on people, that may be hard to

implement.

In any case, the kind of things I was talking about I think, Darin, were just the ones that the formative evaluation does in these rapid feedback cycles.

I mean, you have to, if you're going to do some of these, and I've worked with people doing demonstrations, lay in a logic model of what you're trying to do and what has to happen to implement it, and you have to have metrics that tell you where you've gotten with those. Those are not easy to get ahead of time. They're not easy to create. You have to think it through.

When evaluators do it, they have to spend a fair amount of money going out and talking to people. Your existing management systems may provide some of that, but I think it's vital that on some of these new demonstrations that are controversial as to how they fit Medicaid even at all, that we have that rigorous formative evaluation as well as the outcomes evaluation eventually. And so I'd hate for us to get on track of these are all just a waste of time and burden on states. There are things we need to figure out about those ongoing whatever, but I do think a priority needs to be holding people's feet to the fire to

look at the current stuff.

COMMISSIONER GORDON: Yeah. I wasn't implying that you think about them as just needless burdens on states, my point being when you go down a path and the legislature says you have to get this implemented by July 1 and you just finished up April 15th, and that your mindset typically isn't going to -- how do I build out and how am I going to support a rigorous evaluation design and/or thinking about what are the things I need, the components I need to actually lead to a successful implementation, and how will I measure a successful implementation.

It's a little bit back to Toby's point. These are things that I think would be helpful that as they're going through that process that there is given some time and attention and thought and support and doing that because in the absence of it, it's going to be -- they're running as fast as they can to get the things implemented. So it wasn't saying that they don't add value as much as how do you recognize the reality that you're also implementing typically very complex programs in a very quick period of time.

And in some of these cases -- I mean, we saw

this. We had some third-party evaluators that we ended up having to take people that were responsible for implementing programs, and they had to educate some of these third-party evaluators about some basic things about the program and what we were trying to accomplish.

So I know we all like to think of the perfect scenario in how these things work, but when you're tasked with actually running the programs and doing this, I just think there's got to be that space on the front end when you're helping states and CMS to think through how they're going to do that, how they're going to support that, and ask those questions there because in the absence of that conversation, it isn't going to get the attention that I think people are expecting to end up with a good evaluation and good end product.

COMMISSIONER DOUGLAS: And even if a state or official were to raise it, the response in most cases, the government is going to figure it out with existing resources. You know, there isn't a desire when you look at 1115s to build large administrative infrastructures, but rather how you're effectuating policy. And so we just need to think through what are the carrots, what are the

approaches.

And this gets again to our discussion yesterday. This isn't the only thing that's coming down. We have access monitoring requirements, multiple layers, and it is -- you're right, Penny, about overall program management and structure and gets to what is MACPAC's role in terms of thinking through the evolution of Medicaid and the expectations on overall program management and outcomes and continuous quality improvement on a state agency that may not have the resources or has not kept pace with the evolution of the change in the program.

CHAIR THOMPSON: Okay. Brian.

COMMISSIONER BURWELL: What I find difficult to get my head around is this idea of 1115s as a demo or testing something new, whereas it's -- I mean, the way it's evolved in many states, it's just another program design mechanism, like a state plan amendment almost. So there are various states that have used 1115s to just design their Medicaid program and the way they want, whether it be Tennessee, Arizona, Vermont, Rhode Island. So I have difficulty conceptualizing what's the role of evaluation in this kind of -- the reality of how 1115s operate in the

Medicaid program, and why should we be evaluating 1115s any more than just regular SPA, regular changes in Medicaid or other program design tools.

CHAIR THOMPSON: So I don't know exactly where to take this conversation. You guys are very challenging in this meeting, trying to pull it together.

COMMISSIONER WEIL: Maybe we need a thorough-some subcommittee.

[Laughter.]

CHAIR THOMPSON: Go ahead.

EXECUTIVE DIRECTOR SCHWARTZ: I think we need -- I would like to sort of regroup with the staff and think about sort of what our capabilities are.

I get a little nervous hearing about some of these threads because I think our discussion of them could not be helpful from either a federal or a state policy perspective. So I think we should think a little bit more about what our role might be.

I know we have staff here who read the special terms and the conditions of these new waivers and know them really, really well, and so we learn some things in our implementation work over the last series of expansion

waivers about things that change, things that didn't happen that I would like to think about in terms of like what we might go next with and then maybe come back to you all with some ideas about some work that we could do.

CHAIR THOMPSON: All right. I will take advantage of that offer.

[Laughter.]

CHAIR THOMPSON: But obviously an important subject and one that we'll continue to grapple with. So I'm glad, Kacey, that you arranged for us to have this conversation this morning. Thank you.

Okay. So, Anne, you're up next with a quick update on general MACPAC activities before we go into our final session on upper payment limit supplemental payments.

UPDATE ON MACPAC ACTIVITIES

* EXECUTIVE DIRECTOR SCHWARTZ: It would be ironic if I did not actually print out what I was going to say, but it actually seems to be extremely possible because I remember doing it on my computer at home.

I think the points that I wanted to make, I can make fairly quickly. One is just to make sure the public understands where we are with our June report. The June

report comes out on June 15th, as per the statute. The report has four chapters in it.

The first two were the ones that we talked about at our March meeting, both of which include recommendations. Those are -- the one on changes to the drug rebate program, and the other on clarifying the 42 CFR Part 2 regulations that affect privacy for folks with substance use disorder.

The other two chapters of the report were the ones we talked about yesterday on the review of managed long-term services and supports and our assessment of access to substance use disorder treatment, and neither of those have recommendations. And those will be out in June.

We have been doing a ton of publishing, and so if you are not aware of the various issue briefs and fact sheets we've been doing, I would direct you to our website. We have had issue briefs come out on DSRIP, on work and community engagement requirements, on Medicaid and schools. We've updated all our fact sheets on the duals demos. So every single state fact sheet is up to date. We've updated our brief on the 1115s expanding to the new adult group and have updated the state fact sheets to reflect the new

waiver approvals for Arkansas, Kentucky, and Indiana, so all of those are up to date.

We have updated the background information on our website to reflect changes in the Balanced Budget Act. All of our CHIP pages have been updated and our CHIP fact sheet.

I also want to call your attention to MACStats because even though we published the book in December -- and I'm very old school. I like a book, and as someone pointed out to me, if you look at the book online, you have to tilt your head. It's much easier to tilt your book than to tilt your screen. But MACStats, we update continually as the data are available, and I think in the past week to 10 days, we've updated about 10 data tables. And those are all up. We announced all of those on Twitter. We don't tweet a lot, but if you ever want to look at our Twitter feed, that will give you the latest in terms of what's up to date.

We had another issue brief on Medicaid and public health emergencies.

We have a new compendium on state policies, on appeals policies that will be up on Tuesday. It's a

massive spreadsheet, not easy to print out, but behind that, we have a summary spreadsheet and also a spreadsheet for all of the 51, I think, state policies, so the 50 states and the District of Columbia, and that will be up to add.

We are about ready to update our compendium on state policies for paying for inpatient hospital services and have a schedule for updating our other state compendia.

So I think that's the main thing that I want to report on. Our next public meeting will be in September, and I also just want to let folks know in the public know that staff of MACPAC meet at the request of various associations and others. If you have something that you would like to discuss with us, we have an open-door policy. My only request would be that you have something specific that you want to come talk about, and we are available to do that. We will be doing planning over the summer, although some of the work that we've been doing over the course of this session, it's obvious we've already signaled where we'll be doing more work on hospital payment, and we assume on around opioids and around prescription drug spending and the like.

So that's my update about what's been going on.

CHAIR THOMPSON: Thank you.

All right. Rob.

USES AND OVERSIGHT OF UPPER PAYMENT LIMIT (UPL) SUPPLEMENTAL PAYMENTS TO HOSPITALS

* MR. NELB: Thanks. All right. So last but not least I will be talking about the uses and oversight of upper payment limit supplemental payments, also known as UPL payments.

I'll begin this presentation with some brief background about UPL payments and about how they fit into our larger hospital payment work plan. Then I'll review findings about how states are currently using UPL payments, based on our review of Medicaid state plans. And, finally, I'll spend most of our time talking about CMS's process for overseeing UPL payments. Specifically, I'll describe CMS's new annual UPL review process, and I'll share findings from our review of the first round of data that states submitted.

This new review process was intended to address some of the transparency and accountability concerns that were previously raised by MACPAC, GAO, and OIG. However,

as I'll discuss, we find that many of these prior recommendations have not yet been fully implemented.

The information today will hopefully jump-start some conversation around several policy questions, including questions about specific improvements to UPL policy, by itself, as well as larger questions about how this work fits into our work on hospital payment, more broadly.

So as you recall, at our January meeting we outlined a long-term work plan that aims to broadly consider all types of Medicaid payments to hospitals, and at our last public meeting in March we began our work in this area by discussing the different types of base and supplemental payments that states make. We found that although the majority of Medicaid enrollees are in managed care, the majority of Medicaid payments to hospitals are still in fee-for-service.

Second, we found that about half of fee-for-service payments were supplemental payments in 2016. There are a variety of different types of supplemental payments that states make. As you know, we've spent a lot of time talking about disproportionate share hospital payments, or

DSH payments. But UPL payments are also a large source of supplemental payments, the second largest, and the rules for UPL payments are a lot different from DSH, so we'll be diving into UPL today.

As we move forward, this summer we're going to plan to kind of round out our analysis of payment methods by interviewing states and other stakeholders about how they develop their hospital payment methods, and also talking about how some of the fee-for-service payment policies affect managed care payments to hospitals. And then, in the fall, with this better understanding of payment methods, we'll continue to examine some of the other questions in our work plan around payment amounts and outcomes related to payments.

Okay. So UPL payments, as you know, are lump sum payments to providers that are intended to offset low fee-for-service based payment rates. The UPL stands for Upper Payment Limit, which is the limit established in regulation that applies to all fee-for-service payments, including base and supplemental payments. And, in short, if base payments to hospitals are below the UPL in the aggregate, then states can make UPL supplemental payments to make up

the difference.

States are also allowed to make UPL payments to a variety of other types of providers, including nursing facilities and physicians, but in today's presentation I'm just going to focus on UPL payments to hospitals, which we see the majority of UPL payments.

So, of course, like most things in Medicaid, the specifics of the UPL requirements are a little more complicated than they sound, at first. Here are just some important details that I think are useful to be aware of for the conversation today.

So the regulations that establish the UPL state that, in the aggregate for a class of providers, fee-for-service based payments and UPL payments cannot exceed a reasonable estimate of what providers would have been paid according to Medicaid payment principles. There are a couple of important things to unpack there. First of all, classes of providers are defined based on ownership, so there's different UPL limits for public and private providers.

And second, the fact that the UPL is an estimate means that states do not use actual Medicare payment rates

when calculating the UPL. Instead, they have the flexibility to choose from a variety of different methods for estimating what Medicare would have paid, according to Medicare payment principles. And finally, since UPLs are established in the aggregate, some hospitals may receive payments that are higher than what Medicare would have paid, as long as total payments for the class of providers is below the UPL in the aggregate.

States have been allowed to make UPL payments since 1981, when Medicaid payments were delinked from Medicare. However, when we look at the historical data, we see that the use of UPL payments started to grow, really, in the 2000s. It's hard to say exactly why but in the '90s Congress enacted several limits on DSH payments, and so we see DSH payments going down while UPL payments were going up.

In 2000, OIG reported that 15 states were making $4.5 billion in UPL payments to hospitals, and in 2016, we found that 36 states were making $16.4 billion in UPL payments to hospitals, so there's been a big increase.

In recent years, some large states, such as Texas, have transitioned their UPL programs to Section 1115

waivers in order to preserve these payments when they've expanded managed care. However, we continue to find that a number of states still use UPL payments, and these are a large source of payments to hospitals.

Based on our review of Medicaid state plans, we find that states often target UPL payments to specific provider types, including some of the ones listed here. These are often the same types of providers that states target for DSH payments: government-owned hospitals, safety-net hospitals, rural hospitals, and specialty hospitals, such as children's hospitals.

We've also found, in our review, that most states allocate UPL payments among providers in ways that are not really tied to particular services. So, for example, a lot of states allocate UPL payments based on the relative number of Medicaid days at a hospital, or as an equal share of a fixed amount. In our review, we found very few examples of states that use UPL payments to incentivize delivery system reform or in other ways tie the UPL payments to achievement of any quality metrics.

So in addition to looking at how states use UPL, let's look at how they're overseen by CMS. In 2013, CMS

issued new guidance establishing a process for states to demonstrate compliance with the UPL annually. Previously, states only had to demonstrate compliance with the UPL when they made changes to their hospital payment rates. As part of this new review process, CMS has required states to submit hospital-specific data in a standard format, including data on Medicaid payments and on the estimates of what would have been paid according to Medicare payment principles.

In general, states are supposed to include all hospitals in the state. However, in practice, states do tend to exclude some hospitals that are paid on a cost basis, typically the critical access hospitals.

To date, we have obtained state-level data from CMS for state fiscal years 2014, 2015, and 2016, and this will be the basis of our presentation today. Actually, good news. We are hoping to work with CMS to get some of that hospital-level data, hopefully this summer, and so as we continue work in this area we may be able to share some findings at the hospital level as well.

When a state submits these what are called UPL demonstrations, which are different from 1115

demonstrations -- this is the term that they use, anyway -- the first piece is they indicate what method that they're using to estimate what Medicare would have paid, and CMS guidelines have outlined four methods that states can use for hospitals. First is a cost-based method, which is an estimate of facility costs based on services provided to Medicaid patients. It's important to note -- so Medicare no longer pays on a cost basis for most hospitals, but this option is still permitted because costs are calculated according to Medicare payment principles, so that's the key term there.

Second, states can choose a payment-based method. Generally, this is based on a facility's aggregate Medicare payments relative to its charges, and then that payment-to-charge ratio is multiplied by a total Medicaid charges to establish the UPL estimate. And then for inpatient services, states can use a price-based method, based on what Medicare actually pays for specific DRGs. But even in this method there are adjustments to account for the different acuity between a Medicaid and a Medicare patient, different use of services that they have. And finally, for inpatient services, states can also establish the UPL on a

per diem basis, based on average Medicare payments per hospital day.

Based on our review states' 2014 submissions, we found that about half the states use cost-based methods for inpatient hospital services and about half used one of the payment-based methods listed here. For outpatient hospital services, most states used a cost-based method.

When states pick that overall UPL method they then apply a variety of adjustments to the baseline data used in the UPL calculation, for example, if they adjust older data for inflation and may make adjustments for changes in the volume of services provided. It's important to note that states that use the cost-based method can add in the cost of provider taxes that are used to finance UPL payments. However, states are not allowed to add the cost of other types of provider contributions to the non-federal share, such as IGT payments from public hospitals.

This adjusted Medicare estimate is ultimately compared to Medicaid spending in order to demonstrate compliance with the UPL, and states have the option to report Medicaid spending in one of two ways. They can project Medicaid spending for the future year or they can

report on actual Medicaid spending. Unfortunately, we don't know how many states use which method. In our conversations with CMS staff, however, we understand that what states submit in the UPL demonstrations is ultimately not reconciled with what they submit on their CMS-64 expenditure reports. There are some technical reasons to this about the timing and sort of definitions about how data is reported in both sources.

So as part of our review we looked at the state-submitted data in the aggregate for 2015, which was the latest year for which we had complete data. We found that most states reported compliance with the UPL requirements in their state-submitted data. And so, specifically, total Medicaid payments that states reported were below the UPL by about $12.4 billion, meaning that states, based on the data they provided, it looked like they could have made $12.4 billion more in UPL payments in 2015.

However, when we compared the state-submitted data to actual expenditures reported on the CMS-64, we found some big discrepancies, and we particularly found that most states appeared to underreport UPL payments in their submissions to CMS. Specifically, we found that UPL

spending reported on the expenditure reports was actually about $11 billion higher than what states reported in their UPL demos. Some of these discrepancies may be due to data lag or some of the technical issues I mentioned earlier. It's important to note that some states would still have been in compliance with UPL even if their spending was higher.

However, we did find that if UPL spending was actually as high as what was reported on expenditure reports, it appeared that about 15 states may have had fee-for-service hospital payments that exceeded the UPL in 2015, and in the aggregate, these payments may have exceeded the UPL by a large amount, several billion dollars.

In addition to finding discrepancies in the Medicaid spending side, we also found examples of large adjustments on the Medicare side of the calculation, which may result in UPLs that are larger than what Medicare may have paid and may also have implications for whether or not states are in compliance with UPL requirements.

So just for example, we found an example of a state that was out of compliance with the UPL one year but

then was in compliance with the UPL in the later year, after they increased the adjustment factor that they applied to the Medicare baseline. So the state applied an 8 percent increase in one year and then a 54 percent increase in a future year. And so with a higher adjustment factor, the state was then in compliance with the UPL, even though it was actually making more UPL payments.

Okay. So just linking this back to some of the prior recommendations, as you know, MACPAC and other stakeholders have made a variety of recommendations to CMS to improve its oversight of UPL payments. This table summarizes some of the major recommendations that have been made since 2001. First, as you know, MACPAC has recommended that CMS collect and report hospital-specific data on Medicaid payments, including data on the sources of non-federal share. GAO has made a similar recommendation, but MACPAC is actually unique in sort of recommending that this data be publicly available.

The second to address concerns about the accuracy of the underlying data, both GAO and OIG have recommended that UPL data be audited. And finally, UPL has -- OIG has recommended that UPL limits be established at a facility-

specific level rather than the aggregate, since, as I mentioned, some hospitals may receive fee-for-service payments that are above what Medicare would have paid.

So CMS has taken some actions to address some of these recommendations and more changes may be forthcoming. But, as I noted at the outset, many of these recommendations still remain unimplemented. For example, CMS is now collecting hospital-level data but these data are not publicly available and, in some cases, appear to be incomplete. Second, although CMS has issued more guidance to states about how to calculate UPLs, the UPL calculations are not audited and are not reconciled with other sources of data, such as expenditure reports.

CMS has indicated that it is currently planning to release a supplemental payment regulation this fall to codify some of its prior guidance, but at this point we don't yet know the exact content of the rule or even the timing, to be frank.

And finally, it's just worth nothing that the President's budget includes a legislative proposal to limit Medicaid payments to public providers to provider-specific costs. This proposal would, in some ways, be a step

towards establishing that hospital-specific UPL limit that OIG has commented on, but it's hard to say since this legislation has not yet been introduced and there's a variety of important details still need to be worked out.

So that concludes my presentation for today. I look forward to your feedback and discussion, again, both about what this means for looking at UPL payments individually but also how it can help inform our larger hospital payment work plan. Thank you.

CHAIR THOMPSON: Okay. Let's see. We have Stacey, Brian, Bill, Sheldon. Let me start off for a second here.

I find this extremely concerning. You know, if we go back to the slide where we talk about the various recommendations that have been made by MACPAC, GAO, and OIG, and appreciating that CMS may be considering additional action in the realm of supplementals, all of these recommendations make certain assumptions that collecting the data, making it available, and auditing it, and establishing limits, that the data is actually used. None of this matters if the actual expenditures that are claimed are unrelated to any limits or the demonstration of

compliance with any limits.

And I want to distinguish between consideration and reconciliation. I can totally understand that it isn't always possible to reconcile, if we think of reconciliation as being a financial term in which there are two ledgers and they match. But the differences ought to be understandable and accounted for.

And when we're talking about a demonstration being supplied, about how we're ensuring that we're under the limit, and then when the expenditures are claimed no one is even looking at those demonstrations, no one is asking questions about why what we're seeing in the claim for the expenditures diverges from the information or the expectation established in the UPL demonstration, then that, to me, is a significant issue and a significant concern as a matter of procedure and process.

The fact that we are identifying potentially billions of dollars in discrepancies between those two data sources elevates our concern beyond the simple, you know, this is bad hygiene, into this is a real significant vulnerability that we ought to be understanding and addressing. You know, it's something I think we ought to

be highlighting to the Congress and highlighting to CMS as needing some immediate action.

I think there are various other issues that you've identified here about methodologies that others might want to jump in on, but I will just say that, you know, there's, as you mentioned, a tremendous amount of flexibility in how states can use methodologies and create these demonstrations, but you've also identified that there are very large adjustments. Even with all those flexibilities there are very large adjustments that are being used by states, and I don't think that we understand what those adjustments represent.

And so we have the UPL demonstrations. They, themselves, may have issues associated with these adjustments or some of these other methodological issues, and then we have a huge discrepancy between what those would suggest would be the appropriate level of expenditures and what's actually being claimed.

And so I think before we can even get into a conversation about more reporting or more availability of the reporting or more applications of additional limits, we have to make sure that we're using the data that we

currently have and applying the limits that are currently in place as a basic condition of ensuring the integrity of the program.

CHAIR THOMPSON: Stacey.

COMMISSIONER LAMPKIN: Thank you. I just have a few, I suppose, technical questions to help --

VICE CHAIR GOLD: Stacey, could you pull the mic closer?

COMMISSIONER LAMPKIN: Sorry. A few technical questions just to make sure that we have the right context for some of this interpretation.

Can you tell us just a little -- a few more basics around the demonstrations themselves? For example, are they retrospective? Are they looking at expenditures on a paid basis or an incurred basis? How much later after the close of the reporting period are those calculations made? Just some basics about that. And then when you compare them to the 64s, you're comparing what the demonstration says are actual supplemental payments for that time period? Or are you looking at the gap? Just kind of walk us through that in a little bit more detail.

And then the second piece of my question is: So

this is a very complicated demonstration to prepare, clearly. Do we know whether states are doing this in-house versus using consultants or which states are doing that?

Those are my questions.

MR. NELB: Sure. So, actually, I can't answer much of the second question about who at the state is kind of compiling the data. I would imagine there would be some different consultants, and as we interview some states this summer, we can sort of talk more about how they actually operationalize it. But to get at your point and some context for understanding this large discrepancy we see between what states report on the UPL demonstration versus what's in the 64, the points that you make about time periods -- are important to keep in mind.

So the UPL demos, again, they have sort of two options to report the Medicaid spending. So some states do report it prospectively, so, you know, where state fiscal year '19 might start in July, and so they're going to submit a demonstration, you know, in June to say this is how much I'm going to spend on UPL the next year. Some states submit the UPL demonstrations sort of retrospectively using their own internal state data. And,

again, we don't exactly know the timing of that and, you know, so let's imagine a state fiscal year ends in June of 2018 or something, they might sort of report the UPL spending as of that date, but then it is possible, you know, you have a two-year claiming period in Medicaid, so a state could potentially make future UPL payments that apply to that year but they make them sort of after that year has actually passed. So there are some different timing issues.

The CMS 64 data that we report is sort of the same that we have in MACStats and things. They're net expenditures as of that period, and so there could be some cases where there are sort of prior period adjustments and sort of the claiming for prior years where the timing could get off by a little bit. But the other challenge, though, is -- in the 64, we have the date that they sort of submitted the claim, but we don't have the date that the claim was actually for. This is unlike a DSH payment. When a state puts in a DSH payment, they apply it against an allotment for a particular year, we can see what year it applies to. With UPL, we just know that the amount was spent. We don't know whether it was spent for '16 or '17

or '18, and so that's another reason why there might be some of these gaps.

That being said, you know, we have seen this discrepancy between the 64 and the UPL demos in all three years that we looked at. So there does seem to be something going on that's beyond just the time period. But, yeah, to make those apples-to-apples comparisons, understanding the differences between the sources is an important context.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: So I have to say I am starting to feel left out. I think we should seek redesignation as the MACPAC demonstration.

[Laughter.]

COMMISSIONER BURWELL: More in the spirit of what's going on.

Secondly, I also enjoy very much watching Darin's facial expressions when Rob was talking about the discrepancies in these demonstrations.

I do have a technical question around the impact of managed care on supplemental payments, and the story that -- this is not my area, but I remember hearing that

Texas wanted to expand the Texas STAR+PLUS program into the Dallas area, but there was great resistance to doing that from a number of hospitals in the Dallas area because they would lose their UPL payments as a result of the shift to managed care. I think it was eventually worked out. So I wonder if Stacey and Fred can shed more light on that. Is that an ongoing issue, or is that only resolved through an 1115? Or how are those two things interrelated?

COMMISSIONER LAMPKIN: I'm sorry. I'm going to confess I was sidebarring with Toby, and I missed kind of the --

[Laughter.]

COMMISSIONER BURWELL: Is there a risk to hospitals of losing their supplemental payments if states shift from fee-for-service to managed care?

COMMISSIONER LAMPKIN: So, yes, definitely so. If the state doesn't go out of its way to try to do something to restore those dollars through various mechanisms -- and there are now some regulatory allowed mechanisms that are relatively recent that states can employ. But there is a risk there.

COMMISSIONER BURWELL: Regulatory mechanisms

other than other authorities like 1115s or -- I mean --

COMMISSIONER LAMPKIN: Right, so the new managed care -- relatively new managed care regulation actually explicitly gave states some options of ways that they could direct payments that would allow them to deal with former supplemental payments in a particular way. Now, the authorities that are specific to those -- and I may be getting out over my skis and need some help here, but states have to submit in advance of making those directed payments plans to CMS and get approval for that before they can actually deploy them and actuaries can build them into capitation rates or whatever the mechanism is. BP is one of the ways, and there are some pass-through options that are time-limited that states can use.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: I think this is very useful information, and the questions you're going to be pursuing are very important. I want to share Penny's concern. I might raise the level to alarm over sort of what you found to date. And I think part of that, to sort of reinforce this, would be to in some respects change the context and stop -- and not think about UPL payments as

filling in a shortfall, but actually thinking of them as something that was created as a limit to try and avoid excessive payments.

As you mentioned, they began sort of after some limits were put on DSH, and those limits on DSH were put there for a reason, because money wasn't necessarily going for care. We know that quite graphically, when the DSH limits first went into place, it was so dramatic that when one state had to live with their DSH limit, Medicaid spending nationwide went down one percentage point. Okay? So there was considerable money that was what I used to characterize as "making round trips," arriving at a provider and then sort of going out. And with upper payment limits, we had the same kind of situation. And part of it goes to the question of that we're making the test sort of in the aggregate, not necessarily sort of by individual hospital. And the proposal in the budget maybe sort of will deal with that by putting a limit on the basis of cost. But that wasn't historically the case.

Now, I don't know what has happened to deal with intergovernmental transfers because that was the mechanism that was causing most of the abuse. And I could be dated

in terms of that we have sort of mechanisms now that handle that well enough and so that some of when we investigate this will disappear, and I'm perfectly open to sort of learning that, because that would be very sort of welcome information to know that we have stopped some of that.

But I think at the same time, you know, we shouldn't think about this as we're making up a shortfall, because what was keeping the base rates from being the appropriate rate to begin with? Why are we doing this in sort of two buckets as opposed to sort of one which would be tied to the care that's being delivered and sort of an appropriate amount of payment?

CHAIR THOMPSON: And that is somewhat not a UPL issue but a supplemental payment issue, which are somewhat related by different, you know, in terms of how payments are being made and why we've seen this increase, which we've talked about in the Commission before, the increase in the level of supplemental payments and the amount of the total payments accounted for by supplementals which has occurred over time.

I have Sheldon and then Fred and then Toby.

COMMISSIONER RETCHIN: Well, let's see. How do I

provide any commentary here without seeming to be an outcast or an outlier in terms of my own feeling about what I'll call the "ecology of safety net payment and care."

We've raised this issue about supplemental payments numerous times, and I think we always come up with a discrepancy in terms of the identification of how the payments are made and perhaps the abuses of the system that we believe are present, and particularly having mentioned the whole issue of the provider tax and the threshold for provider tax as a percent of total revenues.

That said, it seems to me here, Rob, that the discrepancy is so large that -- I mean, I don't know if you want to hypothesize -- it can't be timing. So let me just be sure I understand. In both of these, the provider tax is embedded as a cost. There's no discrepancy there on how 64s are filed or the UPL demonstrations. Provider taxes are used as a cost on both. Is that right?

MR. NELB: Not quite. So the UPL -- provider taxes are a cost when calculating the Medicare side of the equation for the UPL, but what I was presenting is the discrepancies on the Medicaid side of the equation. And, theoretically, that is supposed to be total computable

cost, so the federal and state, and is -- you know, even if, as we've -- even if the provider receives lower payments after making the provider tax or an IGT contribution, they're theoretically supposed to be reporting the full payment that they receive that's matched by the federal government.

COMMISSIONER RETCHIN: So could that explain -- or not?

MR. NELB: I'd be cautious to make any predictions now without taking a closer look, and maybe once we get this hospital level data, we can help. But, obviously, as we've talked about just in general the difference between the gross payment that the hospital receives and the net payment, after you subtract out the taxes and the IGTs, it's a lot less. So there is some difference there.

COMMISSIONER RETCHIN: So that difference could be large, 32 percent I think you estimated in terms of the provider tax. Is that right?

MR. NELB: So I think it's something like, yeah, 30 percent of the non-federal share for UPL payments is provided by provider taxes. Another larger portion is

provided by IGTs.

CHAIR THOMPSON: But that would not account for the difference that you're reporting here between the 64 and the UPL demonstration.

MR. NELB: Right, correct. Well, first of all, they're supposed to be reporting it the same in both ways, so there -- so yeah, that's -- we can take a look into it and explore more, but we'll -- yeah, they're supposed to be reporting total Medicaid spending and in both sources.

COMMISSIONER RETCHIN: So the provider tax would have been on both sides undoubtedly.

MR. NELB: Right, so the provider tax is a cost; it's not part of the spending.

COMMISSIONER RETCHIN: I'm confused, but I started my question and comments confused, so I feel that I'm pretty balanced on that.

[Laughter.]

COMMISSIONER RETCHIN: Let me just make a qualitative judgment on this. Listen, I know that there is a lot of concern on how supplemental payments are made, and there are some that are quite pejorative about it. My only cautionary note is before a rush to judgment and trying to

determine why there is such a discrepancy is appropriate, that the ecology of safety net payment and care and the delivery of care is fragile. And that said, my only lament about supplemental payments is that we have not used those to leverage delivery system reform. That's where I would go with this, and also to understand the fragility on the side -- and I've mentioned this many times -- about physician payments. While hospital payments are on average at a cost of about, I think, 60 percent of Medicare, 70 percent, and the supplemental payments make up some of the shortfall, even though they're not designed for that for the UPL, on the physician side it's not true. On the physician side, they are on average something like 60 percent of Medicare, and while there is a thin veneer of UPL, there is no DSH, obviously. The "H" stands for hospital. So I continue to come back to that and wish that we would focus on the delivery system reform that we could be able to leverage these for.

CHAIR THOMPSON: Fred and then Toby.

COMMISSIONER CERISE: Thanks, and these guys have made much of my comments, but I'll say a couple of things.

One, Brian, the Texas thing, exactly what

happened is they shifted those UPL payments to waiver payments, and that's why it's worked out. So now those are coming through UC payments and DSH payments. So, anyhow.

You know, Bill, you said the rates -- I mean, there's a way to deal with this, and it's rates. You can get to the UPL through rates, and generally, you know, states use the supplemental payment programs to sort of get closer to rates, but without putting up state share, and it's easier because you can use other sources of -- you know, it's easier to use IGTs and provider taxes and things like that. And so I think then states become less lax about how broadly to make the payments, because the state's share is coming free to the state, and so you can see how these things will grow.

And so, you know, I would, Sheldon, take issue with one way you described it, because I agree with your point, but these I don't believe are safety net payments. I mean, they become very broad payments. And if you looked at who's getting UPL payments, it's gone way beyond somebody that may have a 30 percent Medicaid utilization and 30 percent uninsured population. But it's kind of the general -- it's gotten to be a much broader general

population. And so I do think, you know, you could address rates through rates and not through supplemental payments, and then use supplemental payments to drive delivery system reform, to drive some policies that you want to look at. And there's a lot of opportunity -- there's a lot of opportunity to do that. You could start with looking at the source of the state share and what's allowed to go into that. And then when you make these supplemental payments, tie them to explicit delivery system reforms that you want to see.

CHAIR THOMPSON: Yeah, and I would just say regardless of how you mix and match the rates and supplementals, all of it has to live under the UPL. So you can have a debate about how much should be in the rate and how much should be in the supplemental and what the supplemental are for, but all of it is still subject to the upper payment limit. So I think that's the distinction that I would drive between that conversation and the conversation of whether or not you're enforcing the limits and whether or not we have an issue in which people may be exceeding the limits by a significant amount above the level that they have demonstrated in these demonstrations

to the federal government that they're living within.

So that's just the distinction that I would want to make sure that we keep in mind as we have the conversation.

COMMISSIONER RETCHIN: Can I ask for one clarification? Fred, at your hospital are you able -- you must make payments to -- well, I already know you make payments to physician groups. Are you able to put that on your 64?

COMMISSIONER CERISE: I don't know. For --

CHAIR THOMPSON: Well, a hospital doesn't have a 64. We're talking about the states.

COMMISSIONER RETCHIN: Oh, I'm sorry. For hospital --

COMMISSIONER CERISE: But I think what you're asking is do I -- those are not costs I can claim for DSH, unless they're for admin or things like that. But they would be covered in my UC, uncompensated care, you know, eligible for match to other -- through UPL or through UC.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: Well, first I just want to -- one thing that Fred said, you know, they are permissible

-- they are state share, IGT provider taxes, so I want to make sure we're on record and clear, those are all permissible state share, and it's just another source of the other. I mean, that brings up bigger issues of financing.

The question I have for you, Rob, before we raise alarms, I'm still questioning if there's more work that needs to be done on making sure the reporting is -- you know, there are issues at the state level or at CMS on the reporting, because these discrepancies and just looking at the data on a state-by-state -- just truly I'm concerned we're raising alarms before we dig a little bit deeper. And if there's more -- and a question to you is: Is there more we can be doing before we take that step?

MR. NELB: Sure. So we will continue to take a closer look at state level. We've been talking with CMS staff about some of our preliminary findings, but yeah, the hope is as we get more of the hospital-level data this summer, we can take a closer look. And then the states that we're interviewing, we can learn more. We can also just even reach out to some other states that we're not doing the full interview but just to better understand some

of these really big discrepancies.

So we'll continue to look into it and agree it's important. This is just a preliminary analysis, seeing some of these big disconnects, and so now as we continue our work, we're going to really want to dive in and understand it more so we can help inform ways to improve the process.

CHAIR THOMPSON: Yeah. And, Toby, I mean, I guess it is possible that there is an explanation and we can account for it. My concern is that we don't have a process under way to account for that. We don't have the information that supports accounting for it. So we don't know what it represents, and that's concerning, the fact that we don't know the answer to that. And I think we've tried to see if there is any process that's under way to account for it.

So I'm not expressing serious concern because I absolutely know that we have a bunch of states that really exceeded the UPL. I'm concerned that we have information that isn't being used and that we don't have explanations for, which could mean a variety of things.

COMMISSIONER DOUGLAS: I'm not up on that, and

I'm concerned about that too.

CHAIR THOMPSON: Right.

COMMISSIONER DOUGLAS: I just don't want us to jump to the next --

CHAIR THOMPSON: Yes, that's right.

COMMISSIONER DOUGLAS: To the next step.

EXECUTIVE DIRECTOR SCHWARTZ: And it is not for lack of asking. I think there's also a question about sort of the disconnect between folks who are tasked with the mechanical exercise of compliance versus the meaning that's found, to that compliance for a broader policy consideration.

CHAIR THOMPSON: And just in terms of our own continuing work, because I don't think that we actually started to dive into this because we were interested in looking at compliance with UPL. That wasn't kind of what our focus was initially. We just kind of have identified this.

But in terms of being able to put these pieces together in the way that we want to put together, we're trying to complete an entire picture, the theory of everything, of how all these payments are lining up and if

the data is causing us concern in terms of do we have a data problem, do we have a reporting problem, do we have a compliance problem. We need to understand that just as a matter of program management, but we also need to understand that in order to make use of some of this information, especially at the hospital level. Are we going to encounter some of the similar kinds of questions or concerns about that as we try to put it together?

So I would like to suggest that we try to put this information together and send this off to CMS and ask them for some additional information or explanation -- I know that we've done that informally -- and then as well make the Congress aware of this ongoing inquiry.

All right. Any other final comments or questions?

[No response.]

CHAIR THOMPSON: Okay. Can we open it up for public comment on this or any other issues that we've been discussing this morning?

PUBLIC COMMENT

* MR. BADARACCO: Hi. My name is Andrew Badaracco. I'm a technical director in the Financial Management Group

at CMS that actually works on UPLs. Rob has been working with a lot of my colleagues over the last several months -- I dare say years on this.

One of the areas that the templates are -- the adjustment factor, first of all, one of the areas that the templates is intended to figure out is -- and kind of streamline is kind of remove the ability of states to make those adjustments. It's just a straight presentation of data.

In the first few years, we're trying to figure out what do we have, where does it belong and all that stuff. I think we're finally getting to a place where the next couple years should be result in better data.

I would say as far as the gap is concerned, one of the things that states do and don't do in terms of their state plan as it relates to the UPLs is they put methodologies in the plan that say, "We pay up to whatever the gap is in the UPL," so that delta between what they have paid and what the UPL represents, they just pay it out.

In many cases, they don't report that on the UPL. They probably should, but they just say this is how we pay,

and this is where the top line will be, whatever the UPL results in.

So, in large part, you have a lot of states that have UPL gaps on the demonstration itself, but as far as the actual payments are concerned, they're paying up to that gap. So that might help explain that delta. I mean, we'd have to look back and see. Maybe that's a reporting mechanism through the UPL demonstrations, but I think that in terms of listening to the discussion today, in actual practice, there is some of that that's going on, and that might help explain the large gap.

But, anyway, thank you, guys, for the discussion today.

CHAIR THOMPSON: Thank you, Andrew.

Okay. We are adjourned. Thank you very much.

* [Whereupon, at 11:47 a.m., the meeting was adjourned.]