



PUBLIC MEETING

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

Thursday, September 13, 2018
9:30 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
MELANIE BELLA, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
PETER SZILAGYI, MD, MPH
ALAN WEIL, JD, MPP
KATHERINE WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA

PAGE

Session 1: Multistate Collaboration: Panel on State

Perspectives

Moira Forbes, Policy Director.....4

Panelists:

Elena Nicollela, Executive Director, New England

States Consortium Systems Organization.....6

Rhonda Anderson, Director of Pharmacy/Director of the

Drug Effectiveness Review Project (DERP), Oregon

Health and Science University.....14

Public Comment/Recess.....57

Session 2: Further Discussion on Multistate Collaboration

Moira Forbes, Policy Director.....57

Session 3: Changes to MACPAC Conflict of Interest Policy

Anne Schwartz, Executive Director.....94

Public Comment/Lunch.....98

Session 4: Themes from Interviews on the Development

Of Hospital Payment Policies

Robert Nelb, Principal Analyst.....99

Session 5: Disproportionate Share Hospital (DSH)

Payments: Policy Changes and Policy Options

Robert Nelb, Principal Analyst.....129

Public Comment.....164

Recess.....166

Session 6: Operational Considerations for Work and

Community Engagement Requirements

Kacey Buderer, Senior Analyst.....166

Public Comment.....206

Session 7: Medicaid Coverage of New and High-Cost Drugs

Rick Van Buren, Senior Analyst.....218

Chris Park, Principal Analyst.....225

Public Comment/Adjourn Day 1.....249

P R O C E E D I N G S1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

[9:30 a.m.]

CHAIR THOMPSON: Okay. Why don't we go ahead and get started. First of all, welcome, everyone, to the 2018-19 report cycle for MACPAC. We are very happy to kick off our meeting today with the folks that are going to be presenting on this topic.

First I want to also acknowledge and welcome two new Commissioners -- this is their first public meeting -- Melanie Bella and Kathy Weno. Welcome. And also congratulate Stacey Lampkin on being appointed by the Comptroller General as the Vice Chair of MACPAC. We are delighted with Stacey's appointment as well.

So we are kicking off today with a discussion on multistate collaboration. This continues MACPAC's work focused on how to think about and help states in terms of their administrative capacity and their approach to common challenges across state lines. So it's a subject that we are very much interested in.

As we have been doing in the past, we're going to have some expert conversation, led by Moira, to discuss some successful efforts and also some ongoing challenges in

1 this area. I'm going to encourage the Commissioners, if
2 there are subjects that the panel touches on that you want
3 more exploration of or clarification around, you should
4 jump into the flow of the conversation at those moments.
5 Don't feel like you need to hold back your questions for
6 the end of the presentation.

7 There will be time, at the end, to go around and
8 see if people have particular questions or issues that
9 they'd like to ask of Elena and Rhonda, and then we will
10 have, then, time for Commissioner-only conversation and
11 discussion about where we want to next take this topic.

12 So, Moira, let me go ahead and hand it off to you
13 for introductions.

14 **#### MULTISTATE COLLABORATION: PANEL ON STATE**
15 **PERSPECTIVES**

16 * MS. FORBES: All right. Thanks, Penny, and
17 welcome back, everyone. This session is a follow-up to
18 prior Commission discussions on state administrative
19 capacity, including a session last fall where I presented
20 findings from a literature view on multistate action. You
21 had asked for more information, particularly about the
22 differences between state efforts to collaborate around

1 information-sharing issues and those focused on ongoing
2 operational initiatives, and you had also asked us to
3 provide more of a typology of state partnerships.

4 Commissioners also asked us to find out more about how
5 changes in federal policy, particularly in federal
6 financial participation, could be used to incentivize
7 states to work together more.

8 So over the last year we've done a lot of
9 research, including interviews with a number of state
10 Medicaid agencies, staff from multistate organizations, and
11 interviews with some state staff from non-Medicaid agencies
12 that partner with other states. In your materials is a
13 background paper that provides a more detailed typology and
14 a summary of the findings from our interviews and
15 additional research.

16 We also thought it would be helpful for you to
17 hear directly from some of the experts in this area who we
18 interviewed in the course of this research. We have invited
19 two speakers today who have experience on both the state
20 side as well as current positions leading multistate
21 collaboratives.

22 Rhonda Anderson is the Director of Pharmacy and

1 Director of the Drug Effectiveness Review Project, or DERP,
2 at the Oregon Health & Science University. DERP is a
3 collaborative of 15 state Medicaid and public pharmacy
4 programs that develop concise, comparative, evidence-based
5 research projects to assist policymakers and other
6 decision-makers.

7 Elena Nicollela is the Executive Director of the
8 New England States Consortium Systems Organization, or
9 NESCSO. NESCSO is a private, nonprofit organization that
10 supports state health and human services agencies through
11 operational and technical assistance projects. Their full
12 bios are available in Tab 2 of your materials.

13 So as Penny said, I'll ask each speaker to give a
14 brief overview of her organization, and then I will ask
15 them each to respond to a series of questions that we've
16 prepared ahead of time. We will leave the last 30 minutes
17 of the session for Commissioner questions, and then we've
18 set aside another 30 minutes after the panel ends for
19 discussion among Commissioners.

20 And I think Elena is going to begin.

21 * MS. NICOLLELA: Good morning. Thank you very
22 much for the opportunity to talk to you about the

1 organization I work for, New England States Consortium
2 Systems Organization. We're thinking about a name change
3 but not yet. I have been with the organization for a
4 little bit over two years, and I wanted to give you some
5 history and then talk about some of our current projects.

6 The organization started in 1999. It was the
7 brainchild of the then CMS Region 1 Administrator, Ron
8 Preston, the Medicaid directors of New England at the time,
9 and then Tom Manning, who was the Chancellor at UMass
10 Medical School.

11 The idea of bringing together the New England
12 states was really about systems and the concept that there
13 could be some cost savings and other benefits from
14 purchasing one Medicaid management information system.
15 That never happened, but the organization was formed.

16 The organization, as was mentioned, is a private,
17 not-for-profit organization. The board is made up of the
18 commissioners and secretaries of the New England health and
19 human service agencies. Often they will delegate their
20 board responsibilities to their Medicaid directors, but
21 this year Jeff Meyers, who is the commissioner in New
22 Hampshire, he is the chair of the board, and Al Gobeille,

1 in Vermont, serves on it, and then we have some of the
2 Medicaid directors in New England.

3 The state of Maine had been a member of the
4 organization up until about, I think, three years ago, and
5 I think decided to leave the organization as part of a
6 decision to leave several other partnership organizations.
7 We still continue to include Maine, though, in our project,
8 and I'll talk a little bit about those projects.

9 So I think it's important to talk about the
10 financing of the organization, and then I'll talk about the
11 mission, because it's the financing that I think has been
12 extremely helpful and is a bit unique.

13 We derive our revenue from the annual dues that
14 the member states pay. They each pay \$28,500 a year.
15 Excuse me. I should mention, the University of
16 Massachusetts Medical School is also a member of the board
17 and a NESCSO partner.

18 So the \$28,500 that each state pays, when they
19 pay it to the organization they do not seek any federal
20 financial match for that payment, so it is straight general
21 revenue funding. What happens then is we accept that money
22 and then we spend it on initiatives that support the member

1 states, and at that time, because of our relationship to
2 UMass Medical School, we are able to access some federal
3 financial participation. And I can go into the details of
4 that later, if you have questions, but suffice it to say
5 that is one advantage, unique, again, advantage of the
6 organization, its board membership, its mission, and also
7 its linkage to UMass Medical School, a public entity that
8 enables it to access federal financial match.

9 So our mission. We are not a consulting
10 organization. We do not sell any services to state
11 organizations. That is not part of our revenue model. Our
12 mission is to support the health and human Services
13 agencies. The revenue, as I said, is the annual dues, and
14 we also host a conference every year, the Medicaid
15 Enterprise Systems Conference, and that enables us to gain
16 a little revenue through that conference.

17 Our overall mission, as dictated by the board, is
18 to promote person-centered, effective delivery of health
19 and human services. So we have a focus on Medicaid, but
20 it's really Medicaid as a tool to finance HHS services and
21 Medicaid as a policy lever to, again, bring about person-
22 centered health and human service delivery.

1 So just to clarify, what I mean by that, because
2 I know those terms are thrown around quite a bit, as an
3 example, if a family is receiving services from a child
4 welfare entity and a behavioral health entity in the state,
5 as well as receiving Medicaid-funded health care services,
6 our goal is that within the state there is collaboration
7 across those agencies.

8 So we pursue that goal in four areas. The first
9 is to strengthen administrative capacity within the state
10 agency, and I'll talk about some of the specific projects
11 we have under that. The second goal is around information
12 systems. We really believe that technology is one way to
13 link those disparate agencies, and data is a third area.
14 And then the fourth is multistate procurements.

15 So in the area of strengthening administrative
16 capacity -- oh, and I forgot to put my timer on, so I'll
17 look to you for my time limit -- we have invested quite a
18 large amount of resources in what we're calling Health and
19 Human Service Academies, and we've partnered with the
20 Center for Health Care Strategies, in each member state.
21 We've put together a curriculum that is Medicaid focused,
22 but we have about 35 to 40 individuals in each state come

1 together for six to eight sessions around using Medicaid as
2 a financing tool and as a policy lever. So, training child
3 welfare mid-level managers, usually, is a group that we
4 want to attract, training them on what is a state plan and
5 then what is an 1115 waiver, what are the basics of
6 Medicaid and how can that help you. One of the aspects of
7 those HHS Academies that's very important to us is that
8 people within the state get to know each other and develop
9 relationships across the agencies.

10 We also have peer-to-peer learning communities
11 around topics and subject areas that are of greatest
12 interest to the state. So we have pharmacy. The pharmacy
13 directors in each state come together once a month for
14 calls. And what we do is just provide the forum and the
15 administrative support for those calls. We have a group on
16 Medicaid quality. We have a group on long-term services
17 and supports, and we have a systems group. Often some of
18 the other initiatives that we are pursuing in those three
19 other focus areas are a result of these peer-to-peer
20 learning communities.

21 Lastly, in that area of strengthening state
22 administrative capacity, we have a very close relationship

1 with the CMS regional office. So, for example, next month
2 we will be partnering with them to host a training on how
3 to do state plan amendments. And what we bring to the
4 table is we will provide travel reimbursement for the state
5 employees to attend that training, and we'll provide lunch,
6 which is something the federal government can't do, so it's
7 very important.

8 In the area of systems, in addition to hosting
9 the Medicaid Enterprise Systems Conference, we also provide
10 administrative support to a CMS effort called the Systems
11 Technical Advisory Group. It's really a state-CMS
12 partnership. What NESCSO does is provide the scheduling
13 information, we send the information out, we help to
14 support the agenda development. The services we provide
15 are what, I think, in your prep materials, are that
16 investment of time that states don't often have to pursue
17 these multistate efforts. They just need somebody to do
18 kind of the background work, and that's what we provide.

19 I'll talk about multistate purchasing, because I
20 think that that's where your interest is. We have had
21 several efforts in the area of multistate purchasing. The
22 one that we are currently heavily involved in is around

1 electronic asset verification services. This was a
2 requirement that CMS placed on states. It was a law that
3 each state, as part of a Medicaid eligibility process for
4 certain populations, each state needs to verify the assets
5 of applicants at banks.

6 So it was a very straightforward process, not
7 really requiring that much customization, and the board
8 member states came to NESCSO. One state in particular
9 said, "We are not going to have time to do a full
10 procurement in order to meet the time frame that CMS has
11 imposed on us, so we'd like you to try to pursue some way
12 to facilitate access to the service for us."

13 So in partnership with that state, we developed a
14 request for proposals and we were able to contract with a
15 vendor to provide the service and then offer it to other
16 states. So we currently have five states using this
17 process to access electronic asset verification. It didn't
18 require the states to change their processes. What we did
19 was really facilitate access to the service, but each state
20 can, because the service is a software as a service, it
21 doesn't require that they - that there's a lot of
22 governance or there's just one option -- you could just

1 keep it customized to the extent you need to.

2 And then, lastly, I'll just talk about data is
3 one area where we think there's a lot of potential and
4 benefit from multistate collaboration, but it's been the
5 most difficult. We've, over the years, have had several
6 efforts that have failed, just because it's been difficult
7 to have common data definitions and accessing the data from
8 states has been very difficult. So we have one now where
9 we've worked with UMass Medical School. We're doing a
10 study on hepatitis C medication adherence, and we have four
11 states in the region who are interested in partnering with
12 us on that. So we're hopeful and would like to grow that.

13 I'm going to stop but I'm happy to answer any
14 questions you have. Thank you.

15 * MS. ANDERSON: Good morning. Thank you so much
16 for the invite. Thanks, Elena, for your background. I'm
17 Rhonda Anderson and I have been with the Center for
18 Evidence-Based Policy about two and a half years. Prior to
19 that I was the Deputy Director for Missouri Medicaid, so
20 I'm fresh out of the hot seat and enjoying my tenure thus
21 far, being able to extend the bench for states through
22 collaboration and evidence.

1 So the Center for Evidence-Based Policy was
2 established in 2003. We have about 35 employees, right,
3 and I'm the only pharmacist. We have masters- and PhD-
4 level researchers and physicians that comprise the
5 institution called the Center for Evidence-Based Policy.
6 We're based at Oregon Health & Science University, but
7 we're not your traditional funding model or your
8 traditional research model for a university-based
9 organization.

10 So our work is fully focused on states. We use
11 the Oregon Health & Science University intergovernmental
12 agreements to contract with states, and that allows states
13 the opportunity to draw down federal match on their
14 contracts with us, but we don't do investigational
15 research. All of our work is fully focused and
16 commissioned by the states that we partner with.

17 We work with about half the country in some
18 capacity, about 25 states that are either a part of the
19 bucketed work, that I'll talk about here in a couple of
20 minutes, or members in our collaborations, of which we run
21 three collaboratives. We're not funded by industry, we do
22 not lobby, we are nonpartisan, and we are completely

1 conflict-free. So again, our financial model is built
2 around our collaboration with states.

3 We have one foundational grant from the Laura and
4 John Arnold Foundation. It's pretty recent, actually,
5 since I've been with the organization. We partnered with
6 the Arnold Foundation to do the SMART-D program, which some
7 of you might have heard of, the State Medicaid Alternative
8 Reimbursement and Purchasing Test for High-Cost Drugs. I
9 did that off the top of my head. Thank you. So the SMART-
10 D collaboration is looking to kind of dream up new
11 reimbursement models for some high-cost drugs and then
12 pilot-test those in some interested states. That's our
13 third collaboration.

14 Moira, in my background information, talked about
15 the DERP program, the Drug Effectiveness Review Project,
16 and we also run the MED collaborative, Medicaid Evidence-
17 based Decision-making. So those are the three
18 collaboratives that are the lion's share of the work that
19 the Center does.

20 The Center's mission is addressing policy
21 challenges with evidence and collaboration, which is a
22 pretty simple mission, and we strive every day to help our

1 states address these difficult policy questions by using
2 evidence and extending their bench to do so.

3 I talked about our work of the Center, and we can
4 kind of bucket it in four different categories, if you will
5 -- the multistate collaboratives that we run; single-state
6 evidence assistance and data, so think of that more like
7 offering direct evidence for single states that run
8 generally health care commissions or have some sort of
9 state requirement for evidence in their pooled purchasing.

10 I've got three state examples of that -- New
11 York, which is very Medicaid focused. Their Medicaid
12 purchasing outside of drugs has to go through an evidence
13 look, and we are, or were, the contracted evidence vendor
14 for New York. Then Oregon and Washington. It's a little
15 bit broader than just Medicaid. It looks at all of their
16 state purchasing, all combined. Both of those states have
17 health care authorities, and we are, again, the contracted
18 evidence vendor for those. So single-state evidence, we're
19 able to provide as well, again, because we're non-
20 conflicted whatsoever.

21 We also have helped states with health processing
22 engineering, so think "DSRIP-y", right. Some states that

1 we worked helping them re-engineer some larger health
2 systems would be New Hampshire, Texas, and, again, most
3 recently the Washington State Accountable Communities of
4 Health, the ACHs that were just rolled out over the last 12
5 months. We were the contracted evidence vendor for those
6 ACH programs.

7 And then we have the all-glorious, all-other
8 bucket, where we do things like the Colorado Multipayer
9 Collaborative, which brought to the table all the payers,
10 both public and private payers, in Colorado, and have been
11 trying to find ways to kind of re-engineer payment systems
12 in the state of Colorado. And we also provide evidence-
13 informed health policy workshops for states. We help
14 states and their legislative bodies, as well as the
15 executive branches, to kind of figure out what you can do
16 with evidence. Evidence is generally one piece of the
17 policymaking funnel, but it's not the end-all, be-all to
18 making good policy. So we try to help states figure out
19 how evidence fits into their decision-making practice.

20 So I'm going to stop there, and would be happy to
21 entertain questions.

22 MS. FORBES: All right. Thank you. I think

1 those are very helpful introductions and set-up for the
2 questions we have.

3 The first I'll ask is, you each talked about sort
4 of some of the specific assistance the states get from
5 participation. They get evidence reports from you, or they
6 get procurement support on the electronic verification.
7 What are some of the maybe sort of intangible benefits that
8 states get from participation in a collaboration like this?
9 They pay dues to get sort of direct support, but what other
10 benefits do they get?

11 MS. ANDERSON: I'll go first on that one.

12 So, again, I'm coming from the perspective of
13 having been a participant in two of these collaboratives.
14 While I was in Missouri, I was the point of contact for
15 DERP and MED. So, as a participant, I can tell you that
16 one of the things that we got out of -- and what we receive
17 today out of these collaborations is a safe space and the
18 ability to interact with their colleagues, again,
19 completely conflict-free. So there are meetings all over
20 the country for Medicaid directors and pharmacy directors
21 and clinicians for Medicaid, but very few of those meetings
22 are without conflict or without industry being present.

1 And we offer two conferences a year for our
2 members and monthly meetings that allow these states to get
3 together and learn from each other and share experiences in
4 a completely safe space.

5 You add that to the evidence that we are able to
6 provide, and our states really look forward to the
7 opportunity to learn from each other and try to move their
8 programs forward. And, again, you've seen one Medicaid
9 program, you've seen one Medicaid program, so the ability
10 for them to share and interact with each other is very
11 precious.

12 MS. NICOLLELA: I'll just second that the benefit
13 from being able to sit down with your peers and learn from
14 them about how they're addressing a similar challenge, I
15 think is really helpful.

16 It's not so much an intangible benefit, but these
17 system-related multi-state collaboratives that we've done,
18 some of the discussions around business process have really
19 caused states to think about how they're doing, for
20 example, eligibility and the policies that they've set up.
21 And maybe there are more efficient and effective ways to do
22 them, so that's been very helpful.

1 MS. FORBES: Thanks.

2 You each talked a little bit about governance,
3 but can you talk a little bit more about -- this is an
4 additional activity for the states. I mean, you talked a
5 little bit about your boards and how states sit on that or
6 how you decide to take on new projects or new areas of
7 focus, but can you just elaborate on that a little bit
8 more? Especially when you have a lot of states
9 participating and they may have different needs or
10 interests and you have a limited budget, how do they
11 collectively decide when they're peers, how they will spend
12 their joint resources?

13 MS. ANDERSON: That's a very good question.

14 So the governance process is as diplomatic as it
15 sounds. Usually, once or twice a year, states get the
16 ability to nominate topics for research. Those topics are
17 then brought to the entire group and ranked in a ranking
18 exercise, and we match the available funds for the budget
19 projection with the number of topics and the potential size
20 of these reports after a pretty robust scoping exercise,
21 which involves kind of shaping the topics of interest.
22 Figuring out you can't ever know everything about

1 everything, so you kind of do a hierarchy of scoping to
2 figure out what are the key questions that are most of
3 interest to the participating states.

4 So we put all that together. It's a match of the
5 strength of evidence with the questions that are being
6 asked along with the budget, and after the ranking
7 exercise, it goes to a vote of the participating states.
8 And they vote to commission the work or move a topic
9 forward, and that's true in both MED and DERP.

10 MS. NICOLLELA: Sure. I think I will answer the
11 question from two perspectives.

12 One is from the services that we offer, the
13 initiatives that we pursue. We really try to, again,
14 facilitate access to services and decrease that need for
15 states to, say, compromise their own requirements or their
16 initiatives, and that's just because we are looking for
17 sort of quick wins. So we try to decrease the need for
18 governance as much as possible.

19 It comes into play when I talk about the
20 organization as a whole and how the board members
21 themselves decide how to use the resources of NESCSO, and
22 one of the things that we find is because it's New England

1 and we have a lot of commonalities across the states, but
2 we still have some states who have many more resources than
3 others. And so we find that the services that NESCSO
4 provides will usually go to the states that don't have as
5 many resources. So even though everybody is a member, some
6 of the larger states just don't take advantage of what
7 we're offering because they can either access them through
8 internal resources or other arrangements.

9 CHAIR THOMPSON: Moira, we have Kit wanting to
10 jump in on this question.

11 COMMISSIONER GORTON: Just a follow-up question
12 when you're talking about governance. So on the flip side,
13 it's clearly a consensus-based governance model. Are there
14 sort of guardrails or third rails or places that you just
15 don't go, and how do those get defined? Do states have
16 sort of a veto or some way to say, "No, we don't want you
17 going anywhere near that one"?

18 MS. ANDERSON: So not really, right? It's a
19 consensus model to move forward, but I'm going to answer
20 that in the reverse.

21 So states actually in both of those
22 collaboratives have the ability to commission

1 individualized work for questions or topics that are not
2 chosen to move forward by the entire governance group. So
3 there's a silo of funds or points that are commissionable
4 by the state. It's like individualized research requests.
5 So it's less the third rail of "Oh my god, don't touch
6 this." So your vote of no would be the way that you
7 attempt to kill a topic, question mark? I think that's
8 what you're asking for.

9 But that hasn't really been the issue as much as
10 a topic that's being presented or asked about not moving
11 forward and what happens -- because inevitably there's more
12 topics than resources -- is how do we try to figure out how
13 to get the most evidence produced within a particular work
14 plan?

15 COMMISSIONER GORTON: Thank you.

16 CHAIR THOMPSON: Let me ask a couple of
17 questions. Moira, is this the right time to ask
18 governance-related questions, which I think are really
19 important here?

20 So it feels to me like both of these
21 organizations, you're basically membership models. People
22 join. They participate in leading the organization in

1 terms of deciding where its focus is, they call on you.
2 There is some process for resolving questions about what
3 are we going to spend time on, et cetera.

4 Did you experience other models in your
5 histories? Elena, you mentioned initially NESCSO was
6 thinking that it was going to operate a single MMIS, and it
7 sort of -- I don't want to say devolved to this, but it
8 evolved to a different kind of focus of attention.

9 So just asking a little bit about the roads not
10 taken and what some of those experiences were in terms of
11 how you thought about that?

12 MS. NICOLLELA: Sure. So I'll give an example of
13 a project that we completed about a year ago, and that was
14 around every state agency is required to do a state self-
15 assessment of their technology. It's called the MITA SSA,
16 and it's a pretty prescriptive process that the states have
17 to go through. And we worked with three states to -- we
18 had a lead state, and they procured the services. We wrote
19 the procurement all together, and then this one lead state
20 went ahead and actually conducted the procurement. We all
21 selected the vendor together, and then it was time to
22 implement. Again, NESCSO's resources that we brought were

1 the organization and administrative support.

2 It was a challenge because there were some staff
3 changes at the lead state that caused the project to be
4 delayed by about 10 months. So that experience -- it all
5 worked out in the end. Every state was able to get their
6 resources, but we probably would not pursue a lead state
7 model again, just because of the risk that the non-lead
8 state models pursued. But we had to give it a try.

9 I think what we might do in the future is -- I
10 think this is in some of your prep materials. The State of
11 Montana has been working with NASPO ValuePoint, the
12 procurement official association, and they're a lead state.
13 But it's a model where they do a procurement. Several
14 vendors are able to win the contract, and then states can
15 individually choose the vendor. So it's a way to
16 facilitate procurement but, again, not require states to be
17 held hostage to the process.

18 MS. ANDERSON: I'm going to answer your question
19 in that our model has been about the same for the last 15
20 years. What has evolved is I think that we've gotten
21 better as an organization at helping states tease out the
22 research questions and the methods that we use to collect

1 data and evidence, and we've gotten much better at that.

2 We used to have this standard set of research
3 questions that would apply. Especially in the drug world,
4 you can think back to the early 2000s when the blockbuster
5 drugs were on the market. So we were having questions
6 about purple pills and which one is better than the other.
7 That's not really as appropriate in today's new drug
8 landscape.

9 So as Medicaid pharmacy and as Medicaid clinical
10 worlds have continued to evolve, the questions that are
11 being asked in helping states develop those research
12 questions have gotten better, but the core kind of
13 fundamental way that we collaborate has not changed.

14 CHAIR THOMPSON: And just to follow up on those
15 point, Elena, your organization is geographically based.
16 So there's not an opportunity for other states outside of
17 NESCSO to join in; is that right?

18 MS. NICOLLELA: The governance of the
19 organization itself is limited to New England.

20 CHAIR THOMPSON: Right. Yes, thank you.

21 MS. NICOLLELA: But the services we provide, for
22 example, this asset verification project --

1 CHAIR THOMPSON: It could be more available.

2 MS. NICOLLELA: -- includes states across the
3 country.

4 CHAIR THOMPSON: Broadly.

5 MS. NICOLLELA: Yes.

6 CHAIR THOMPSON: Okay. And, Rhonda, you said
7 that you have how many states that are --

8 MS. ANDERSON: About 25.

9 MS. NICOLLELA: Yeah. There's 20 in MED, and
10 there's 15 in DERP, and then we do some of that other work
11 too.

12 CHAIR THOMPSON: Okay. And so for the states
13 that -- maybe this is more for you, Rhonda. For the states
14 that don't join, why don't they join? Are they getting
15 that information elsewhere? Do they feel like they have
16 all the state-level resources they need to investigate
17 those questions that some states are looking to you to
18 investigate?

19 MS. ANDERSON: So we are in a constant
20 recruitment process. I'll put it that way. States are
21 forever asking questions about how to, A, be a part of the
22 group or, B, get access to the research that we produce.

1 DERP was nonproprietary for the first 10 years.
2 So from 2003 to 2012, the DERP reports were accessible on
3 an online website, and once we went proprietary in 2012 --
4 and I'll explain why and how that happened. We've spent the
5 last five years or so fielding requests for these reports
6 from everyone, from commercial insurers to the military.
7 So the evidence was being used by a large variety of public
8 and nonpublic pharmacy programs to help establish coverage
9 criteria.

10 States have -- the reason that I hear, most of
11 all, that they can't or won't join tends to be budget-
12 related. You know how it's a public process to get
13 consensus within a state to allocate funds to join, but
14 once you are able to be a part of the group, you get so
15 much more for your money minus the federal match or
16 whatever, however states pull that down.

17 So in MED, they produce roughly 75 to 85 reports
18 a year. They tend to be all about -- so DERP is drugs and
19 pharmaceutical-focused, and MED is kind of everything else.
20 So it can be anything from non-emergency transportation to
21 managed care to some sort of home and community-based
22 services model in MED.

1 DERP tends to focus on drugs. They are much more
2 densely written reports that follow kind of the AHRQ EPC,
3 Evidence-based Practice Center methodology for generations.
4 So DERP does an average of 15 to 20 reports a year, but
5 they are a lot more dense and meaty and check all the boxes
6 of the AHRQ EPC kind of processes. So there are two
7 different kinds of methods that follow behind these
8 programs, but the states are able to get a vast amount of
9 research. I haven't seen a state Medicaid program that has
10 that internal horsepower.

11 CHAIR THOMPSON: Darin, you want to jump in?

12 COMMISSIONER GORDON: Yea. I mean, one thing for
13 us, because it took us a while before we actually
14 connected, it was lack of an understanding and appreciation
15 on what was available. That was a big deal.

16 But I will say, after using it for some time,
17 then we got called in front of our legislature at times, it
18 was like, "Why can't you use" -- these a misunderstanding
19 of really what the service was and "Why can't you use an
20 internal state resource for this? Why can't you leverage
21 some of the university capacity that we have here?" We
22 tried to explain the bulk benefit and the focus, and

1 eventually, we were able to get it to continue. So that's
2 just a little --

3 CHAIR THOMPSON: So you experienced a little bit
4 of pushback inside of your state --

5 COMMISSIONER GORDON: Yeah.

6 CHAIR THOMPSON: -- around using resources
7 outside of the state to do some of this work?

8 COMMISSIONER GORDON: Yeah. Because they felt
9 that it was an accessible resource inside the state, which
10 wasn't completely informed. So we had to do a better job
11 of helping them understand really what the service was and
12 the benefit of doing it with multiple other states.

13 I look at these, the two very different
14 approaches. I mean, a little bit to Kit's issue, what we
15 did with -- we're going to say health sciences -- was
16 really more about the evidence. The evidence wasn't really
17 -- I didn't see us as states arguing, "Don't look at this
18 evidence, or don't look" -- it was really helping raise the
19 collective intelligence of the group. So there was less
20 state friction of don't do this or don't do that.

21 Now, on a different situation, because it's
22 really around standing up solutions in which you start

1 getting into some of the dynamics of states' capabilities,
2 states' preferences, prioritization, and I know New England
3 has had a good history of that level of collaboration.

4 So I want to direct a question more to you. What
5 are some of the things that you see that make -- even with
6 that history, but also interacting with other states --
7 that make that level of multi-state collaboration
8 difficult?

9 MS. NICOLLELA: Sure. Rhonda and I were just
10 talking about in the hall.

11 I think that the biggest challenge is we haven't
12 yet been able to institutionalize this concept of
13 collaboration. So because of the changing senior
14 leadership at state agencies that is sometimes every two to
15 four years, we have to do a reeducation process, every time
16 there is, say, a new Medicaid director or a new Secretary
17 or commissioner.

18 So one of the things that we've started to do in
19 the last two years is to think about our primary audience
20 as the person that we think of as a career civil servant,
21 the person who is going to be there throughout the changes
22 in administration, which is often the person that doesn't

1 get to go to the conferences and maybe is not aware of who
2 the person is in the neighboring state who's doing exactly
3 the same job as they are, so that's been our strategy with
4 those Health and Human Service academies, is to try to
5 address that, that challenge.

6 MS. ANDERSON: And I'll add onto that. Again, we
7 were talking about this a few minutes ago in the hallway,
8 but the evidence-informed health policy workshops that
9 we've started and in partnership with the Milbank Memorial
10 Fund or strategic partners with them, we are able to go
11 across the country and touch more than just the Medicaid
12 agency staff.

13 Darin, you had a really great point about not
14 being informed. It's hard. We try to help our state
15 partners extend their bench, not only from evidence, but
16 also for the process of having to reeducate constant
17 leadership changes not only from the executive branch, but
18 also the legislative branch. So we've gotten better in the
19 last 10 years of bringing the tools necessary to assist our
20 Medicaid agency partners in, again, spreading the word
21 about what truly this little budget item is that says
22 Portland, Oregon. It's pennies on the dollar for real if

1 you look at it compared to the Medicaid budget, but it's a
2 random Oregon contract that nobody really understands.

3 So we've started to invest with our state
4 partners to help them have the tools necessary to better
5 inform decision-makers at the upper end of leadership, that
6 they understand what this contract does, what our services
7 are, and how much we impact these state organizations.

8 CHAIR THOMPSON: We have Chuck and then Melanie.

9 COMMISSIONER MILLIGAN: Good morning, and
10 welcome. It's good to see you again, Elena.

11 What I'm trying to work through, there's lots of
12 forms of collaboration. Associations are a form of
13 collaboration. In some ways, the fact that a lot of states
14 hire the same vendor and the vendor can scale and
15 presumably make something more affordable than for every
16 state buying itself is a form of collaboration. It's minus
17 the governance, minus maybe the conflict-free that you were
18 talking about, Rhonda.

19 What I wanted to get at -- I have two questions,
20 ultimately. One is, from your perspectives, what are the
21 essential dependencies for your models to work? And one of
22 the things I'm hearing, I think, is that there's a public

1 university underneath that can both provide a kind of a
2 forum, kind of a sense of independence from any particular
3 administration of any particular state, but it's also a way
4 of drawing federal funds and maybe simplifying some
5 procurement stuff because public universities can sometimes
6 be contracted with by other states without having to go
7 through a procurement in the home state, so to speak. So
8 one seems to be a public university as a key dependency.

9 One seems to be a kind of, as you said, conflict-
10 free or more of a consensus-based or collaborative approach
11 from a governance perspective.

12 And one seems to be -- I want to ask the
13 question. One seems to be that there is an absence of a
14 profit motive, sort of a cost-based kind of model
15 underneath.

16 So my first question is, I'm curious what you
17 perceive to be the critical dependencies for your models to
18 work in their current forms.

19 MS. NICOLLELA: Okay. So I think those are all
20 true, and I would agree with those.

21 I would add that explicit federal support is very
22 helpful. So from the organization's perspective, we have

1 had, as you might imagine -- some of you had experience
2 here -- this concept of the ability -- It's not NESCSO
3 drawing down the federal match. It's the University of
4 Massachusetts Medical School who draws down the federal
5 match, but that arrangement has been audited several times
6 at the state and federal level. So I feel very comfortable
7 talking about it.

8 So on an organizational perspective, that's
9 helpful, and we also enjoy, as I said, the support and
10 partnership with the CMS regional office.

11 On some of the initiatives that we've pursued --
12 so, for example, this asset verification project -- we did
13 have the support of CMS, and they reflected that in a
14 letter that they sent to state Medicaid agencies saying,
15 "You really need to comply with these asset verification
16 time frames. Here's one option for you. It's through
17 NESCSO." So that was just a little thing, but it was
18 extremely helpful for the states to get that.

19 The other item that I would say has been really
20 helpful and beneficial is that it needs to be easy for the
21 states to participate and relatively cheap. I had a
22 conversation with one of our state members the other day,

1 and he represents a pretty resource-rich state. And I
2 said, "I struggle with how NESCSO can help you."

3 And one of the things that we provide member
4 states is reimbursement to conferences, so, for example,
5 reimbursement to the National Association of Medicaid
6 Directors conference. And he said that by itself is
7 extremely helpful, just the ease of saying, "Sure. We can
8 send two people there because NESCSO is picking up the tab
9 for travel." And you would think that that's not that big
10 of a deal, but he said, "Sometimes when state budgets are
11 constrained, the only way we're going to get people to get
12 to conferences is through reimbursement."

13 CHAIR THOMPSON: Melanie, did you want to --

14 COMMISSIONER MILLIGAN: I have one more, and I
15 think Rhonda has a --

16 MS. ANDERSON: I was going to comment that you
17 pretty much nailed all of our essential dependencies, but I
18 will add -- so you called out the university situation.
19 You called out the ability to contract quickly and fairly
20 easily with all of the states as important, and I'm going
21 to say the only thing I'm going to add to this is the
22 economies of scale for evidence, for both of these

1 collaboratives, it's just priceless to the states. And you
2 can think about that really simply in the drug world as
3 these new drugs are launched.

4 It generally applies -- think about the hepatitis
5 C phenomenon. These questions and topics that are
6 generally brought up in one state apply to all 25 states
7 that we're in contract and collaboration with. So it's an
8 economies-of-scale opportunity for the states as opposed to
9 trying to go and independently either do this research or
10 contract with directly with another consultant or an
11 opportunity to bring that evidence in-house. You have an n
12 of 1 versus your money being economized with questions that
13 apply to your organization as well.

14 COMMISSIONER MILLIGAN: And when we get to the
15 next agenda item and there's more of an open discussion, I
16 want to come back to that. Thank you.

17 I have one other question, which is, Elena, it
18 sounded like you were 1999-formed; and, Rhonda, 2003. Have
19 you seen other models come back since 2003, and if not,
20 other forms of collaboration, not your organizations? And
21 if not, why do you suppose there hasn't been more take-up
22 in general of this kind of model?

1 MS. NICOLLELA: We do see collaborations come
2 about sometimes that are specific to an issue. I think one
3 of the challenges is you need that administrative support
4 to keep it going. So, say, the champion of X collaboration
5 leaves for another job, then that partnership kind of goes
6 away. So I think that's one of the things we've seen with
7 other collaborations.

8 MS. ANDERSON: I would agree with that. Our
9 model is fairly unique, and the conflict-free part is --
10 I've mentioned it several times because I don't know of
11 another organization quite like the Center. And I don't
12 know if I can answer other than -- so a piece of
13 information about the Center. So the DERP program actually
14 preceded the Center. The Center was built around DERP,
15 which started in '99, actually, as three states, much like
16 the New England group.

17 The Pacific Northwest of Oregon, Washington, and
18 Idaho, under the then Governor Kitzhaber's administration,
19 had this brainchild of trying to, again, answer the high-
20 cost drug phenomenon back in the day with evidence. And
21 those three states pulled together in the late '90s, early
22 2000s. And then, in 2003, when the Center was formed, the

1 invite went out for states across the union, and there were
2 12 original states that were onboarded as part of this
3 collaboration model, and it's just kind of grown from
4 there. But it takes inertia, it takes administrative
5 capacity, and the conflict-free thing is a major barrier
6 for many, I believe.

7 COMMISSIONER BELLA: I'm a big fan of DERP and
8 MED, so thanks for being here. My question, actually,
9 Elena, I have a couple for you. I understand the
10 procurement aspect. I want to understand a little bit more
11 about the policy sort of programmatic aspect, as the states
12 work together.

13 So, one, with all the Medicaid reform debate,
14 does NESCSO play a role in that with the states, so like
15 those types of discussions? And then the second is, your
16 states are -- thinking about complex populations, whether
17 it's complex duals or behavioral health or any other social
18 factors, your states have very different delivery systems.
19 As they are challenged to figure out how to have capacity
20 within their state to do delivery system reform around
21 those things, how are you able to help them do that and how
22 do you bridge or overcome the variation in the delivery

1 systems, as they're all trying to come up with solutions to
2 these challenging populations?

3 MS. NICOLLELA: Sure. Thank you for the
4 question. So one of our foundational values is that we do
5 not want to replicate what is already out there. We
6 recognize that many state Medicaid agencies and other HHS
7 agencies suffer, quote/unquote, from just a lot of
8 technical assistance opportunities, so we didn't want to be
9 yet another. And there are some excellent technical
10 assistance opportunities, so we didn't want to be
11 redundant.

12 So our approach has always been to provide the
13 forum, really, and we don't make policy statements. We
14 don't take stances on anything. We don't try to push a
15 view. What we really try to do is facilitate the
16 communication across the agencies.

17 So in regards to, say, long-term services and
18 supports where there are very, very different approaches to
19 delivery of those services, just last month we hosted, we
20 called it an LTSS Academy, and there was representation
21 from all six New England states. And what we did was we
22 really tried to focus on issues that were -- that all the

1 states were experiencing, and then to talk about the
2 different ways that they've addressed them.

3 So, for example, workforce capacity. That was a
4 big topic. But we stayed away from whether or not you
5 would use a managed care delivery system, because most of
6 the states had already made their decisions and it didn't -
7 - would not be fruitful, say, to try to convince one or the
8 other of a better way. But we talked assessments at the
9 point of eligibility application and whether or not you
10 could use a universal assessment. So we tried to find
11 areas where they can all learn from each other, and then we
12 brought in some subject matter experts from the outside.

13 And just really quickly, we're doing something
14 similar around market consolidation. We're partnering with
15 Milbank and the National Association of State Health
16 Policy. The concept is if the market, the commercial
17 market -- providers, hospitals -- are not viewing -- don't
18 define markets as states, but are really looking across the
19 country or across the region, how can we, as a region,
20 start to work together so that we change our responses? So
21 we have -- and again, every state is different, but we've
22 got a group around certificate of need coming together, and

1 how can certificate of need rules be changed? Is there
2 something that we can do as a region to address certificate
3 of need? So it is work to find those areas of common --
4 where there's benefit in having the discussion.

5 CHAIR THOMPSON: Peter, do you want to jump in,
6 and then I know Toby, and Moira, I'm conscious of you had a
7 line of questions that we've hijacked from you. But if
8 there are things that we haven't touched on that were in
9 your list, you should jump back in as well. So Peter and
10 Toby.

11 COMMISSIONER SZILAGYI: Sure. Thank you for
12 excellent presentations. Could you give a sense for the
13 evidence of the benefits in terms of costs? So for both
14 DERP and NESCSO, and I'm thinking of pharmaceutical costs
15 to the states. So what level of evidence is there of the
16 degree of cost savings from joining the collaborative, and
17 can you kind of describe how you do this? I know it's an
18 imperfect world in terms of measuring the impact of a
19 program like this.

20 MS. ANDERSON: It really is, and this is an area
21 that we are striving to improve on, right? As we moved out
22 of the first decade of the 2000s and into the second, and

1 budgets really tightened, we had to figure out an ROI
2 model, and we're still kind of working on that because it's
3 different in every state.

4 So I don't have a really good answer for you, and
5 I don't know if my states have the time, really, honestly,
6 to really figure out how the evidence is -- it's a little
7 bit easier in a preferred drug list kind of capacity, where
8 they're able to establish supplemental rebates and leverage
9 drugs within a therapy to class against each other, and you
10 can kind of tag that a lot easier than you can an LTSS or a
11 non-emergency medical transportation report. So it's a
12 little nebulous to try to get our arms around, but we are
13 trying to figure out a better model, to help our states do
14 that.

15 MS. NICOLLELA: It's a little bit easier for
16 NESCSO. We look at the member states, and their
17 contribution, as I said, is \$28,500 a year, and it's pretty
18 easy for us to quantify that they receive more than that in
19 either travel reimbursement or, for example, these Health
20 and Human Service Academies that we're doing are at much
21 greater cost than \$28,500.

22 So it's easy for us. We can only do that because

1 we've been around since 1999 and we've been able to build
2 up some reserves that we can spend. So if there were to be
3 a similar model set up, say, in the Pacific Northwest or in
4 the Southeast, they probably would not be able to, in the
5 first few years, provide as much benefit to their member
6 states.

7 CHAIR THOMPSON: Darin, are you trying --

8 COMMISSIONER GORDON: I was going to say, one way
9 we were looking at even -- because how states apply the
10 evidence, I mean, it's going to vary by state because
11 you're not really required to apply it the same way. By
12 the way, we looked at it as what we were putting into the
13 contract with them versus us building out that capacity.
14 That alone was a cost savings to us. So it was very basic.
15 There's a lot more beyond that, but that was the cost
16 benefit that we looked at.

17 CHAIR THOMPSON: That's almost a purchasing
18 equation. I can purchase it here or purchase it there.
19 All right. So Toby.

20 COMMISSIONER DOUGLAS: Thank you both for
21 presenting. Good to see you, Elena. A question for you,
22 Elena, on managed care procurements, and if there's been

1 discussions on that front around, given the complexity of
2 both developing the design, the criteria, as well as just
3 the evaluation, if any of the states have thought about
4 working together around that.

5 MS. NICOLLELA: No, they haven't, and I think the
6 conversation starts, but with several initiatives, we
7 talked about the need for the staffing and the
8 administrative capacity to support these collaborations.
9 One of the other aspects that gets in the way is timing,
10 even if you have a great concept that would really benefit
11 from multiple states participating. And I'll give a current
12 example.

13 State Medicaid agencies are required to implement
14 electronic visit verification, so they need to verify that,
15 say, a home health worker is actually in the home, and
16 that's verified electronically. There is a whole
17 regulation around it and there's policy, but the different
18 ways that states have chosen to implement this program, you
19 know, it's kind of amazing how differently they're doing
20 it.

21 So you take what on paper seems like a pretty no-
22 brainer for multistate partnership, but not just in the way

1 that it's being envisioned in each state but also the
2 timing is on very different schedules, and that's driven by
3 sometimes the legislative calendar and other priorities.

4 So when you talk about an idea like multiple
5 state purchasing around managed care, I think most of the
6 states just say "there's no way we can do that." What we
7 have tried to generate discussion around are things like
8 program evaluation. I think people are much more
9 interested in a comparison. How do we do in terms of our
10 implementation? On the systems side, testing and quality
11 control. Those sort of after-implementation functions,
12 people are much more open to discussing.

13 COMMISSIONER DOUGLAS: Not even procurement
14 evaluation? I get the front end, but even just a lot of
15 these states don't even have the capacity to evaluate.

16 MS. NICOLLELA: Right. So that is something that
17 we haven't done but there seems to be much more interest in
18 that, yes.

19 COMMISSIONER DOUGLAS: Okay.

20 CHAIR THOMPSON: Can I just clarify size? So,
21 Elena, how many people are working at NESCSO, and the total
22 budget, and same for you, Rhonda?

1 MS. NICOLLELA: We have two full-time
2 equivalents. One of them is me. And then we do hire
3 consultants on a project basis. They are usually paid by
4 the hour. But it's a pretty lean organization. We have an
5 operating budget of \$2 million.

6 CHAIR THOMPSON: And so you're generally, then,
7 creating kind of, on an ad hoc basis, around particular
8 initiatives or efforts. This is what we need, rather than
9 just having that sort of stood up as an ongoing or routine
10 business, where you have full-time employees associated
11 with that?

12 MS. NICOLLELA: The organization has gone through
13 some different models, so we've had greater capacity in the
14 past. But it feels, for us, right now, that that
15 consultant project model works well.

16 MS. ANDERSON: And so for the Center there are
17 about 35 employees, total. The lion's share of that staff
18 are researchers. Like we are an in-house research shop.
19 We have six of us that are more leadership team-ish, right,
20 the executive branch, if you will, and I kind of straddle
21 the fence, being the only pharmacist, and pharmacy, of
22 course, is all over everywhere, in the medical benefits and

1 in the pharmacy benefits. So I kind of have my fingers in
2 a bunch of pies, and I do some research as the DERP
3 director, as well.

4 The Center's budget is somewhere around \$10
5 million or so, in total, and we operate in some capacity in
6 about 25 states. So I mentioned earlier that DERP has 15
7 states, MED has 20, and think of them like concentric
8 circles. So we're deep in some states, like Washington and
9 Oregon, and then we have a lighter touch in some other
10 states like maybe Idaho or -- I was trying to think of
11 another state that's not in more than one of our
12 initiatives, but that one pops to mind. Oh, Alaska is
13 another one.

14 MS. NICOLLELA: And can I just add one thing? To
15 Chuck's point about the role of the public university, I
16 think I'm understating the importance that, for us, UMass
17 Medical --

18 CHAIR THOMPSON: But they're part of your
19 resource, effectively.

20 MS. NICOLLELA: They are. So they provide us
21 with payroll services and HR services. And also, because
22 of our relationship to UMass Medical School, that does help

1 with that continuity. So it's not just, say, the executive
2 director of NESCSO, if that person leaves, NESCSO falls
3 apart. It's that there is this other entity ensuring that
4 it continues.

5 CHAIR THOMPSON: And then, can you both talk
6 about, on the state side, so you're pulling together, doing
7 work, bringing insight, doing the work that you're doing.
8 But in order for that to be successful you have to have the
9 right people on the state side who can ingest what you're
10 doing, who can participate in this.

11 So can you talk a little bit about your
12 observations about, you know, if this Commission were to
13 come out with a series of recommendations to try to
14 strengthen the opportunity, or even beyond that, for
15 structuring more, enabling services and activities around
16 multiple state action, what do we need to be thinking about
17 needs to be on the individual state side of this in order
18 for those connections, communications, and ingestions to
19 work correctly?

20 MS. ANDERSON: I'll go first. It's a little bit
21 easier, I think, in my world, because we are so heavy
22 clinical and clinician focused. So we port into the

1 states, generally speaking, in the pharmacy programs for
2 DERP, and on the medical side with the medical directors as
3 the point of contact in MED. And that's a broad
4 generalization because there are some states that don't
5 have a pharmacy program or don't have -- you know, they
6 contract out with whomever, for certain services within
7 their state.

8 But, in general, we are so heavy clinically focused that in
9 order for a state to maximize that opportunity, which
10 includes -- because our collaboratives are run and totally
11 focused on the states -- to get your money's worth, if you
12 will, you need to send people to be really active in not
13 only the creation of a question, like a topic, but also in
14 how that topic is framed, so that you can get the answers
15 to the questions you need to help for the development of
16 policy as the end game.

17 So I say that to say, sending your financial
18 person to a DERP conference doesn't make a lot of sense,
19 because they are going to come from a different place. And
20 we don't run these topics. We, the administrative team
21 that supports the collaboratives. We are there to
22 facilitate and to really administer, make sure that the

1 architecture is built to sustain the programs, and do the
2 mundane things like listserv generations, so states can
3 interact with each other seamlessly or help with the
4 contracting and make sure that the clearing house where the
5 reports are housed is working.

6 So we administer these programs but we don't --
7 we're not the content drivers. It's the states sitting
8 around a table, just like this. They meet monthly or
9 multiple times a month, and there are often workgroups that
10 are spun out of each of these collaboratives to help move
11 issues forward and to dig deeper on areas of interest.

12 So it takes the right manpower around the table
13 to make sure that the issues are addressed appropriately
14 and categorized such that the states get the most out of
15 this research.

16 MS. NICOLLELA: I would add that what has been
17 necessary for us has been this explicit sense of ownership,
18 to having the state secretaries and commissioners, or the
19 Medicaid directors be on the board has been challenging,
20 because these folks have pretty challenging jobs. But to
21 ask them to be on a call once a quarter and to be engaged
22 and involved in decisions around the resources that we're

1 offering to their states and states across the country is
2 very important. We have to show our value to those board
3 members all the time.

4 And the second piece that has been very helpful
5 to us, again, is our relationship to the CMS regional
6 office. I talk to the person in charge of that office all
7 the time, and I say, "Think of us as an extension of your
8 staff. If there is training that you want to put on,
9 anything that you want to do, we can facilitate that," and
10 that provides legitimacy for us in the eyes of the states,
11 and then also helps further CMS's objectives.

12 CHAIR THOMPSON: Moira, what was on your list
13 that we haven't found a way to?

14 MS. FORBES: I think everything has been covered.
15 I think the only sort of final question is, given that this
16 Commission's primary job is to recommend potential changes
17 to the Congress, are there areas where you think that there
18 are things that -- where there are changes in federal
19 policy, or things that CMS can do? I know Elena mentioned
20 one, submitting a letter. Are there any federal roadblocks
21 or are there incentives or things like that that you think
22 could make it easier for states to partner, or make it

1 easier -- is there something that you wanted to do and
2 couldn't because of a federal issue, that you can think of,
3 that is something that this Commission could take back?

4 MS. NICOLLELA: So I do think the role of the
5 federal government is very important. Some of the
6 challenges that we've found in deploying our initiatives is
7 that the state laws on procurement can -- they are
8 extremely different, and then can really stop a project.
9 So when there is explicit federal approval or facilitation,
10 that helps.

11 I've often wondered why, for example, this
12 project that we've done with asset verification, or the
13 project that the state of Montana is pursuing with the
14 National Association of State Purchasing Officials, is
15 there a way that the federal government itself could give
16 states a list of preapproved vendors and services? I know
17 in your prep materials there was information about pre-
18 certified modules. So along those same lines, just to,
19 again, facilitate access to services for states, I think
20 that would be extremely helpful.

21 And then also I think this model that NESCSO
22 pursues, I have heard often from states across the country

1 that they would like a forum to be able to come together,
2 and they'd like an agency. Again, it's pretty
3 straightforward stuff. It's sending out the agendas,
4 making sure the conference line is available. It's not all
5 that exciting but if there isn't someone at the state
6 agency who is going to take that on, then these discussions
7 don't happen. So I think it's a pretty low-cost model that
8 if there were federal government support for that, that
9 would be very helpful.

10 MS. ANDERSON: And from the Center's perspective,
11 we -- I can't even imagine what recommendation we would
12 need. We've gotten a lot of support from not only the
13 states that we are in partnership with but also from the
14 federal government. Like the areas where we've been tapped
15 -- SMART-D is a great example. We did a lot of research
16 work. Those papers are available on the SMART-D website,
17 and we kind of -- it was important to call out in SMART-D
18 that we were interested in piloting alternative
19 reimbursement in today's regulatory architecture.

20 We were not trying to go lobby Congress to change
21 pharmacy laws for Medicaid. That's not what the objective
22 of SMART-D was. It was really to look at today's

1 regulatory framework and see if there were opportunities to
2 potentially, either within the confines of the Medicaid
3 drug rebate program or outside of the MDRP, is there the
4 ability to think about purchasing drugs different? And
5 we've found eight or nine pathways, legally solid pathways,
6 where we think that that work could happen, and we've spent
7 the last two years kind of pilot-testing some of that.

8 And you guys are probably familiar with Oklahoma,
9 which is one of our SMART-D states we assisted in the
10 development of that health outcomes-based supplemental
11 rebate contract that was ultimately approved by CMS in
12 June. So we've gotten a lot of support across the
13 country, not only at the state level but also at the
14 federal government level, for the work that we do. And not
15 to beat a dead horse, but I believe us being conflict-free
16 helps to perpetuate this work, and also allows the states
17 to lean on us to extend their bench from a clinical
18 perspective.

19 CHAIR THOMPSON: Thank you. This has been
20 extremely helpful. Elena and Rhonda, before we let you go
21 I just want to open up for any public comments on this part
22 of our conversation, so that we can take those into account

1 as we enter into our Commissioner-led conversation after
2 the break.

3 Are there any public comments on this topic?

4 **#### PUBLIC COMMENT**

5 * [No response.]

6 CHAIR THOMPSON: Okay. Hearing none, Elena,
7 Rhonda, thank you so much. This has been an extremely
8 useful conversation. Moira, much appreciation for the
9 materials and for the organization, and we'll look forward
10 to talking about this more after the break. Thank you.

11 [Applause.]

12 * [Recess.]

13 **#### FURTHER DISCUSSION ON MULTISTATE COLLABORATION**

14 * CHAIR THOMPSON: Okay. Why don't we go ahead and
15 pick back up on multistate action or collaboration.

16 So I'll start off and then ask other
17 Commissioners to jump into this. I just want to step back
18 for a second and remind us that because of this
19 longstanding concern that we've had about administrative
20 capacity, we really wanted to explore this topic and think
21 about different kinds of models or authorities or financing
22 that could really be successful in promoting multistate

1 action as a way to address some of these concerns that we
2 have about state administrative capacity.

3 I was very glad for Toby's question about managed
4 care as an example of a place where we may, through other
5 activities and conversations in this Commission, decide
6 that we want to promote more attention to those areas, and
7 rather than simply think about ways in which we call on
8 states to take action, given some of our understanding
9 about their administrative resources, we might want to
10 think about the ways in which multistate action may be able
11 to be responsive to some of those calls.

12 I would just make the observation that -- and,
13 Chuck, I think you touched on this a little bit when you
14 were talking about NESCSO starting in 1999 and the other in
15 2003.

16 There is a lot of activity. There is a lot of
17 technical assistance. There are a lot of -- I mean, we
18 need to recognize that there's a lot of forums and a lot of
19 platforms that states use to gather together and learn from
20 each other, and that's always been a point of emphasis for
21 a number of states. And so I think we should be cognizant
22 of that.

1 At the same time, I think that we recognize that
2 some of the things that, Moira, you played out in your
3 paper around where are the financing incentives and how
4 difficult it is to initiate something if it's not already
5 existing to join, if you have an idea for working with
6 other states, what some of the downsides are for states in
7 joining something not only in terms of expends some
8 resources on their part to make use of it -- and I think we
9 should be conscious of that and think about that aspect of
10 this too if we want to be successful -- but also that they
11 may -- especially if we're talking about purchasing or if
12 we're talking about contracting or operation, have to give
13 up some amount of flexibility.

14 And I was interested in, Darin, your comments
15 about some concerns in the state about are we maximizing
16 the use of our in-house resources and our state resources
17 before we go to some kind of regional or national forum.

18 So I still feel like we need to continue to play
19 out what we would consider to be success because I think
20 some of these different models, whether we're talking about
21 developing reusable practices or tools and then
22 disseminating them to the states versus trying to bring

1 states together to do something collectively as a piece of
2 collective action and whether or not we're talking about
3 what level of operational risk, what level of operational
4 demand exists for what we're suggesting happen.

5 So I think we still need to figure out our aim in
6 terms of some of those different models up against some of
7 the barriers that we've discussed and then play out the
8 idea of are there recommendations or structures that we
9 should be thinking about where maybe it's financed
10 differently, maybe it's established with different kinds of
11 purposes in mind, and play out some of those different
12 scenarios.

13 So let me ask other Commissioners to jump in.
14 Kit and then Alan and then Chuck and then Brian.

15 COMMISSIONER GORTON: So I would add another
16 question to that, which is -- so I was a Medicaid chief
17 medical officer back in the '90s, and I participated in the
18 first-ever convening of Medicaid medical directors, which
19 happened in 1996. I think it was a NASHP grant-funded
20 opportunity, and there were 13 full-time medical directors
21 serving the Medicaid programs across the country, and 11 of
22 them were able to come because of the NASHP grant.

1 And it was the Wild West. We had zero of this,
2 and everybody was making it up as they went along. One of
3 the challenges many of us were confronting was in the
4 commercial world and certainly very highly developed
5 Medicare world, there are technology assessment processes
6 for evaluating emerging technology and when it should be
7 added to coverage and under what circumstances it should be
8 paid for, for beneficiaries.

9 And in Medicaid, there was no resource to do
10 that. So several of us were in the process of building
11 shops to do that, and I think getting to Darin's point in
12 terms of the ROI, I think there may be a very simple
13 descriptive piece that MACPAC could do in terms of --
14 certainly in terms of clinical evidence. If you want to do
15 it yourself, what does it take to do it?

16 And I was struck by Rhonda's response about how
17 many people they have that are doing that because that was
18 the answer that we came up with in the '90s in
19 Pennsylvania, is "Okay. You want me to do this myself and
20 do it right. I need a staff of about 20 people," and
21 that's a very expensive resource. And if you multiply it
22 times 54 or 56 Medicaid programs, then you're spending a

1 lot of money when you could do it once and do it right and
2 accomplish probably more.

3 And so this whole question of build or buy, I do
4 think that the Commission is in a position to say, "Okay.
5 You can build it." I now live in Boston, the medical
6 capital of the universe, and we certainly have no shortage
7 of smart people who can ask and answer questions.

8 The issue is, is it cost effective for
9 Massachusetts to do that all by itself? And I will tell
10 you that I know, because my wife is the chief medical
11 officer of MassHealth today, that it's not. They do not
12 have the administrative resources.

13 And so I think this question that we've posed
14 about administrative capacity gives us a very focused lens
15 into clinical evidence, but also IT procurement and some of
16 the other things that many of us have had experience with.
17 States don't do well because they simply don't have the
18 firepower to attack the problem, and so by setting this up
19 as being penny wise and pound foolish in terms of don't
20 send your smartest person to a meeting where they can
21 powwow with their fellow wizards and learn stuff because
22 you don't want to pay for \$500 worth of airfare and a few

1 hundred dollars' worth of hotel.

2 But if NASHP or NESCSO or somebody else will
3 cough up the money, then, okay, we'll take advantage of
4 that resource.

5 I do think we can say something about that
6 without violating what the Committee staff don't want us to
7 do in terms of saying spend more money. This would
8 effectively spend substantially less money if there were
9 are more organized way about it.

10 CHAIR THOMPSON: Well, and if we get to that
11 point, there is a place where we can look at some models
12 and think about how to price them, how to understand the
13 economics associated with them.

14 Alan.

15 COMMISSIONER WEIL: Having run NASHP for 10
16 years, I spent a lot of time looking at these two models
17 and others -- and there are others, and I'm a big fan of
18 them.

19 Just a couple of observations and maybe something
20 that is helpful for us in thinking about where to go. I
21 don't think the timing of the creation is a mystery. The
22 U.S. Office of Technology Assessment closed in 1995. That

1 used to be a federal function. I'm not saying it's
2 identical to this, but the whole concept of having a
3 federal infrastructure, doing assessment, was something we
4 did for 20 years, and then we stopped. And people said
5 there were a lot of people thinking what falls in its wake.
6 DERP is only one of the examples.

7 What I'm struck by -- and I think it comes
8 through pretty clearly in the presentations we heard -- is
9 that these are not policy consortia. These are practical,
10 operational consortia that you just -- you know, in a world
11 where there are 55 separate policymakers around Medicaid
12 policy, the opportunities for alignment, they're hard to
13 find.

14 One example not mentioned here is the opportunity
15 in the Affordable Care Act for states to have multistate
16 insurance exchanges, another missed opportunity, given the
17 infrastructure requirement, but why not? Because all of
18 the individual state insurance regulations and policies,
19 even the ones that were made national by the ACA.

20 Even when there's policy alignment, the other
21 thing we heard is that there are two sides of the puzzle.
22 So when you think about like electronic verification, you

1 may have a single federal policy, but you have very
2 different state operational interfaces required. So you
3 can say, well, it's all the same, but it's not because it's
4 a two-piece puzzle. And the second piece of the puzzle is
5 different in every state.

6 So I'm always impressed by the organizations that
7 have been able to build this kind of infrastructure, but I
8 just don't think we should have any illusions. It's in
9 fairly narrow places, and drugs, of all things, assessment
10 of the functioning of a medication on a body is about as
11 uniform across the country as you're going to find. You
12 start talking about managed care purchasing or value-based
13 this or coordination of care, and there is no national
14 platform on which to build.

15 So with those thoughts in mind, I think if we're
16 serious about the efficiency opportunities here, I think we
17 have to be serious about one of two things, and I'll just
18 put them on the table. One is if we're serious about
19 administrative savings, we are going to have to recommend
20 places of policy alignment, or else there aren't going to
21 be administrative savings. And that's not something we
22 would take on lightly, but there are places where we might

1 say it shouldn't be up to the states. And it's got to be a
2 single national policy, and once there's a national policy,
3 we can get some uniformity. And then we can get some
4 administrative savings. If we're not willing to say the
5 policies need to be the same, I think we're kidding
6 ourselves if we think we're going to generate
7 administrative savings.

8 The other place, I think is on more straight-on
9 administrative work -- joint procurement, particularly --
10 and the example, of course, of the origins of NESCO on the
11 MMIS, similarly again with some of the improvements around
12 the exchanges. I mean, I think those are opportunities,
13 but they are going to be fairly narrow.

14 So I'm a big fan, but I just think we have to be
15 realistic about why there isn't more of this.

16 CHAIR THOMPSON: So let me ask you, Alan, in
17 thinking about that. So that suggests that in order for
18 something to be multistate, it has to be national, and
19 that's a question that I have, which is -- so let's suppose
20 there are five different ways of doing something. There's
21 not one single policy alignment, but there may be types and
22 taxonomies and models and lanes that most states are in,

1 and maybe there's some states that aren't in any lane.
2 They've created their own little pathway.

3 So the place that I might part company slightly
4 with what you're saying is I think there can be
5 opportunities to continue to support where states are
6 heading in the same direction, and is there a way to think
7 about structures and process that allows those states by
8 choice and by self-identification of the path that they're
9 taking to come together in a more easy way with more
10 incentives to focus on finding those opportunities rather
11 than staying in their own world.

12 COMMISSIONER WEIL: If I could just respond, I
13 think that's terrific, and I wasn't sitting here saying
14 everything should be national policy.

15 We actually have this on our agenda. It's called
16 hospital rate setting, and we have states moving from per
17 diems to DRGs. You have different models of payment. I'm
18 not talking about the supplemental. I'm talking about the
19 base payment. Yes, definitely opportunity for cross-state
20 alignment and efficiently learning from each other.

21 If you're going to stick with per diems, God
22 bless you, and we'll help you, maybe, because we sure know

1 you need it.

2 But if you're trying to make the transition, here
3 is an opportunity. I think your comment is very well
4 taken.

5 CHAIR THOMPSON: Thank you.

6 Chuck and then Brian.

7 COMMISSIONER MILLIGAN: So I'm actually
8 struggling a little bit with what problem it is we're
9 trying to solve, and I think in the absence of a problem
10 statement, I have a struggle with recommendations that
11 might emerge down the road.

12 So let me articulate why I'm struggling with
13 that. I think we have lots of forums of multistate
14 collaboration, and I want to just sort of tick off a few.
15 There are associations. NGA has a Center of Best
16 Practices. There is Medicaid directors. There's lots of
17 variations on other themes that are, I think, conflict-
18 free, information sharing, dissemination. So there's that
19 forum in various ways.

20 There are I think -- and I kind of alluded to it
21 earlier. I think there's an informal or non-structured
22 multi-state collaboration. When states hire national

1 vendors -- and United Healthcare, where I work, is one such
2 place. We're in 28 states, more than Oregon. Mercer is
3 another example, where there's scale. They're for-profit,
4 publicly traded, that kind of thing, which I'll come back
5 to.

6 But states could leverage capacity, and within
7 the United States by way of example, there are more lives
8 in United's PBM than, I mean, in terms of evidence-based,
9 but that isn't what we would perceive to be a multistate
10 collaboration, although every state that's buying that is
11 buying that research capacity.

12 There are other forms of multi-state which is
13 through philanthropy, when RWJ or others convene or through
14 TA, et cetera.

15 So what is the unique problem we're trying to
16 solve that the guests we invited today will help us? Is it
17 that there are some small states that just will never have
18 the resources to scale, and so getting those states, the
19 New Hampshires and Vermonts and Rhode Islands, to get
20 together helps them leverage scale? Is it that we perceive
21 there's an inefficiency in terms of use of public funds?

22 And that the for-profit, the United for-profit is

1 an inefficient use that having multistate collaboration and
2 scale can help every state and the federal government avoid
3 waste.

4 And, Penny, you and I have had this conversation
5 before about MMIS. I think the way that 90/10 money is
6 used encourages states to all buy the same thing over and
7 over again, which is not an efficient use of funds. So is
8 there a way, in terms of the matching rates, to incent
9 states and technology companies to keep procuring over and
10 over again individually the same thing? And that that's
11 inefficient, or every state trying to solve their drug
12 research is inefficient. So is that the problems we're
13 trying to solve, is the efficiency and use of public funds?

14 I worked for seven years at the University of
15 Maryland, Baltimore County. We had a similar model to
16 UMass and Oregon that you've heard about. One of the
17 things that Elena touched on in terms of federal policy
18 changes in response to Moira's questions is procurement.
19 UMBC, because we are a public entity, other states could
20 hire us to do work, and we did multi-state collaboration.
21 We did work for Rhode Island and New Mexico and Connecticut
22 and lots of states because they could procure us without a

1 competitive -- because they were allowed under their state
2 laws to hire a public entity someplace else,
3 noncompetitively.

4 So is it we're trying to simplify that
5 administrative cost? I don't know what problem it is we're
6 trying to solve, and until we can articulate that, I don't
7 know what our role is. So let me just kind of maybe leave
8 it there for now and I'm interested in kind of coming back
9 to when we get to the point of do we need to make
10 recommendations, should we -- what would help me a lot is
11 to try to understand better what problem it is we're trying
12 to solve.

13 CHAIR THOMPSON: Yeah. And I think that's a
14 little bit of what I'm getting at when I say what does
15 success look like because I think that that allows us.
16 We've talked about a lot of things. We certainly tethered
17 a lot of this conversation to the concerns that this
18 Commission has expressed previously about state
19 administrative capacity, and the idea that perhaps multi-
20 state action provides a way to address some of those
21 concerns, and I think we have to fill in the dots to that
22 issue as well as some of the other things that you've

1 raised here in terms of saying how far do we want to go
2 because I think some of those things that you've mentioned
3 are easier lifts than other things.

4 COMMISSIONER MILLIGAN: But, Penny, just to maybe
5 push back a little bit, the way you frame it presupposes to
6 me that there is a problem that needs to be solved and what
7 does success then look like, and I haven't gotten past that
8 first stage, which is, Is there a problem that needs to be
9 solved through a multistate --

10 CHAIR THOMPSON: Well, we agree there's a problem
11 with state administrative capacity, right? Or no? Do you
12 want to dispute that?

13 COMMISSIONER MILLIGAN: Well, I don't want to
14 dispute that, but I guess I want to challenge whether
15 there's a problem we need to solve through federal policy
16 around multistate collaboration or not. I think for me,
17 that's --

18 CHAIR THOMPSON: Sure, okay. Yeah.

19 COMMISSIONER MILLIGAN: Because one of the things
20 that I thought was interesting in the way Elena commented
21 is that there's almost like a re-distributional element
22 underneath NESCSO where the smaller states maybe get more

1 value than some of the more wealthier, bigger states that
2 can kind of go without needing NESCSO.

3 So maybe the problem we're trying to solve is to
4 help smaller states that are under-resourced, and the
5 under-resourcing is the basis for their state
6 administrative capacity.

7 I don't think anybody would dispute that
8 Massachusetts Medicaid has sufficient capacity to run a
9 pretty complex program, but that that is quite mal-
10 distributed around the states.

11 CHAIR THOMPSON: Right, right. Absolutely.

12 Brian.

13 COMMISSIONER BURWELL: So I'm interested in the
14 area of procurement more than information sharing or
15 whatever, and there seems to be very significant barriers
16 to join procurements for specific projects, like Toby's
17 managed care question. But I'm interested in the model of
18 -- it was mentioned a couple of times -- of some
19 organization, kind of a two-step procurement process, where
20 a smaller group of vendors are pre-certified to do certain
21 work.

22 I work in an environment where CMS uses that

1 model all the time. You get on a short list. You pre-
2 certified yourself around data governance, around
3 protection of PHI, all kinds of things. So then CMS has a
4 pretty short procurement process every year in terms of
5 outside research, et cetera. So that helps CMS a lot in
6 turning things around. I thought it's the most efficient
7 operation.

8 So I'd like us to explore opportunities for that,
9 kind of creating short lists of vendors in specific areas,
10 and I can think of a lot of potential application in the
11 LTSS area where there's a lot of now conversion from -- you
12 still pay for base processes to automated systems around
13 care planning and assessment, et cetera.

14 And I think it's not only necessary opportunities
15 where it puts you on the front end in terms of shortening
16 the procurement process, but on the back end around
17 protests because a lot of procurements end up being delayed
18 or programs get being delayed because of protests from
19 losers and vendors. And if you're on the short list and
20 you're pre-certified, I think that might address some of
21 the protest issues that come up.

22 CHAIR THOMPSON: One thing I'll say about that is

1 states have those authorities within statewide procurement
2 authorities to establish the equivalent of IDIQs, the
3 equivalent of short lists of preferred vendors for one
4 activity or another

5 So there's one issue, which is Medicaid in terms
6 of the entire state, and to what extent can a state
7 Medicaid agency take advantage of what's available
8 statewide.

9 The other is there's federal authorities for
10 states to actually use federal procurement vehicles as
11 well. Some of the GSA vehicles can be used by states. So
12 there's, I think, a variety of different kind of
13 combinations of things that might be considered there.

14 And I thought it was very interesting, Moira,
15 what you were talking about in terms of the state
16 procurement officer is trying to kind of think about this
17 issue and how they can come together on it.

18 You're making a face. Okay, okay. I'm just
19 making sure that you're --

20 COMMISSIONER MILLIGAN: Yes.

21 CHAIR THOMPSON: Okay. Toby.

22 COMMISSIONER DOUGLAS: So I'm going to push back

1 on Chuck a little on this point. I definitely agree -- and
2 Alan's point -- on the policy and anything around program
3 design flexibility, I just don't think there is going to be
4 a national approach or a way to consolidate.

5 But when it comes to the problem, I think we've
6 heard loud and clear on the admin capacity that there's a
7 problem from states in terms of administrative capacity and
8 a way to leverage resources.

9 And then there's a problem as you point out in
10 terms of the 90/10, just in terms of how that does, and I
11 thought the paper that Moira -- of ideas that probably came
12 from you around thinking of shared savings and ways of the
13 overall costs of the project rather than focusing in on
14 changing the matching rate when 10 percent for a lot of
15 states, paying that is not enough of an incentive to do
16 joint projects.

17 So I do think there can be solutions on the
18 administrative capacity and especially as the evolution.
19 When you think back on managed care, there are some
20 problems around the complexities of these procurements. I
21 think you know firsthand as well as the different
22 approaches to evaluation, to coming up with designs, if

1 there was ways to incent some more standardization to deal
2 with it, and then there's the capacity to be monitoring and
3 oversight, and are there ways around that to incentivize
4 better as we're going to go later through all the
5 requirements, since states and capacity, are there ways to
6 incent, encourage that.

7 And then coming up with approaches to solve this,
8 I think we have the problem that Medicaid directors, the
9 administration, are turning over, as Elena said, more and
10 more should be able to actually have a consistent group to
11 actually formalize these structures is very difficult. So
12 is there a way to incent from federal policy, these types
13 of either pointing out where these best practices are or
14 actually creating venues that from a federal standpoint
15 that states can then leverage and not have to worry about
16 trying to create it in a state consortium when there's so
17 much turnover in the leadership there that you never get it
18 off the ground?

19 CHAIR THOMPSON: Yeah, and I think just building
20 on this theme, I mean, I think there's a -- to me, part of
21 the conversation is by looking at what I would call a use
22 case or the business proposition, we can kind of back into

1 a question of what kind of model supports that end result
2 that we're aiming for. And I don't know that it's the
3 same, based on different use cases, or it's the same for
4 every state. So small states versus large states, or
5 states that have certain kinds of histories or experiences
6 versus others.

7 So I think we ought to be open to the idea that
8 what we're trying to construct, if we decide that there is
9 a problem that we want to solve, and we have a suggestion
10 about how to solve it, doesn't necessarily need to be one
11 thing, and there can be ways in which -- I mean, I'm struck
12 by both of our panelists this morning, that both of those
13 initiatives were started by states identifying that they
14 had a problem and trying to come together to address that
15 problem. And I think it's important to continue to promote
16 the idea of, with the right kinds of structure available
17 and the right kinds of incentives, for states to make
18 choices that this is the way that we think we can address
19 some of these challenges and issues that we have.

20 So we have Darin and then Kit and then Sheldon
21 and then Stacey, and then we'll have to bring it to a
22 close.

1 COMMISSIONER GORDON: So I don't disagree with
2 Toby's articulation or your articulation about the
3 administrative capacity issue. I think we've beaten that
4 to death. I do agree with Chuck, though. As I think about
5 these things, and every time I'd be getting in
6 conversations about these types of things, you can't really
7 force that collaboration. It has to be a state-led
8 interest in collaborating with others for some perceived
9 benefit.

10 And so when I try to think about it, what we
11 would be asking someone to do to kind of promote that, I
12 mean, I like Toby's thought process. Maybe there are some
13 incentives for doing that. Because every time we went down
14 the path there were more things that complicated it, either
15 from a time perspective, cost perspective, prioritization
16 perspective, customization perspective, that prevented us
17 from going on a path, and maybe you can balance some of
18 those things out with appropriate incentives.

19 But I will, you know, make just the observation.
20 As Chuck identified some places that are doing this, but
21 then you have these organizations here today, that proves
22 that, in some cases, it can be done and is being done. So

1 do we want to just see more of that? You know, I don't
2 know. I like the idea, if you want to add some incentives
3 in certain discrete areas, to help promote, get past some
4 of the challenges, that would make sense to me. But beyond
5 that, I think there are organizations that are finding ways
6 where there's a need, where's an interest, where a state
7 has expressed the need for help and that collaboration,
8 where it's working. I would like to see it more, but until
9 you get past those other hurdles, I don't see how you get
10 there.

11 CHAIR THOMPSON: Well, I mean, I think that's the
12 question, right? Is there something that we want to
13 recommend to try to address those hurdles, if we think the
14 end result is worth getting to?

15 COMMISSIONER GORDON: Yeah, that's where I say, I
16 think, to Toby's comment, the only thing that I can think
17 what that might look like would be if there are sufficient
18 incentives that are made available. So you're not forcing
19 them to collaborate. You're encouraging it to the extent
20 that you're willing to participate and devote the time. So
21 I like the choice aspect of it, because again, I don't
22 think you can force that collaboration. And that would

1 potentially help balance out some of the disincentives for
2 doing a collaboration approach.

3 CHAIR THOMPSON: Well, I mean, I think right -- I
4 mean, this gets a little bit back to Chuck's point, which
5 is do we have a problem, and do we have a way to address
6 that problem, which is if we're satisfied with the level --
7 I mean, with the level of cooperation and collaboration and
8 action that's going on, or do we think there could be more
9 of that if we took down some barriers, some of which are
10 described in Moira's paper, if we created some structures
11 that make it easier for states to access that.

12 For example, we talk about -- so it's not just
13 the financing issue. And, you know, to some extent, 90/10
14 is less about doing it on your own than the fact that you
15 have to give up customization to do it with others, right?
16 I mean, you have to come together and say, well, maybe the
17 way that I do this is not going to be exactly the way that
18 I do it in the future, because I'm going to have to agree
19 with some others that I'll do it in a way that's more
20 collective.

21 COMMISSIONER GORDON: If you asked me, as a
22 director, if the lack of multistate collaboration was a big

1 priority for me, something that needed to be addressed, I
2 would have said no. I would have said the lack of the
3 exchange of best practices, yes, that is a serious issue
4 that needed to be addressed. And again, I mean, we're not
5 a huge state but we're the 16th largest state. We did have
6 a lot of the capabilities to do things we needed to do.

7 So I think it's worth sitting here talking about
8 this, that, yeah, really, I think the question needs to be,
9 from the states, do they perceive there needing to be more
10 of that collaboration, because I didn't feel that, except
11 in the context of best practices, the exchange of how
12 states, and there's organizations that helped us facilitate
13 meetings to help spread some of that. But I still think
14 there's a lot more to be done there. We're almost like
15 saying two states is like we think you aren't collaborating
16 enough versus really hearing from them if they think this
17 is an issue for them.

18 COMMISSIONER DOUGLAS: Yeah, and maybe it is back
19 to the problem, our definition of collaboration, because I
20 would say the same from a collaboration of policy and
21 defining direction and strategy. But from administrative
22 collaboration or understanding, you know, technical

1 assistance of how to do it. Like, for example, we went out
2 to Tennessee and learned on managed care, and how to do
3 administrative capacity. Or if you asked state Medicaid
4 directors about their ability to actually execute on a lot
5 of very complex administrative functions that are
6 duplicative across states, then I think you've got a
7 problem of, okay, that is a problem. How do we really
8 share best practices but leverage the resources to get to
9 the same end goal, that doesn't impact my specific autonomy
10 and policy and strategic direction?

11 CHAIR THOMPSON: Okay. I kind of lost track, and
12 we're running out of time. But I know we had Sheldon and
13 Stacey and then Kit. So why don't we go ahead with that
14 order.

15 COMMISSIONER RETCHIN: Works for me. By the way,
16 Tennessee is 17th.

17 [Laughter.]

18 COMMISSIONER RETCHIN: I just wanted to -- maybe,
19 when you talked about this a year ago, about multistate
20 collaborations, and at the time I thought we had really
21 picked off the high-cost specialty drugs. We got back to
22 the hep C. And I must admit, I don't have a good sense of

1 how much multistate collaboration is on there. But I
2 remember asking Chris, like how much money is left on the
3 table, particular for these high-cost drugs? And just
4 sitting here reflecting on it, you know, it is interesting
5 that on the provider side, providers form these massive
6 GPOs to leverage maximum size in purchasing drugs. And I
7 would think size matters but I don't know

8 So I'm just curious. Is that an area, and how
9 much are we really -- I have no sense of scale in that.

10 CHAIR THOMPSON: Moira, did you want to jump in
11 on that?

12 MS. FORBES: There are several drug purchasing
13 pools, several focused on high-cost drugs. There are three
14 big ones and they save a ton of money, as far as I know.

15 COMMISSIONER RETCHIN: So --

16 CHAIR THOMPSON: But I think when you asked that
17 question, last time that we were talking with some of the
18 members of those --

19 COMMISSIONER RETCHIN: Oh, I asked that before?

20 CHAIR THOMPSON: I think you did, and they said
21 that they --

22 COMMISSIONER RETCHIN: That was brilliant.

1 CHAIR THOMPSON: -- felt like that they were big
2 enough to get everything that they needed to get.

3 COMMISSIONER RETCHIN: Is that true?

4 MR. PARK: That's what they said.

5 CHAIR THOMPSON: Okay. Stacey and then Kit.

6 VICE CHAIR LAMPKIN: Yeah. I'm just trying to
7 think where we -- how we advise staff about a productive
8 way to get us to a next step on this. I'm trying to think
9 about, I see the challenges with administrative capacity
10 from my time in a Medicaid program and as a consultant, you
11 know, from that perspective, and kind of where is the
12 problem? How do we define a problem?

13 It seems to me like there are two different
14 categories. There's the category where there's direct
15 savings and efficiency in leveraging like the MMIS, like
16 purchasing and procurement, those types of activities.

17 CHAIR THOMPSON: Where it's economy of scale.

18 VICE CHAIR LAMPKIN: Where it's economy of scale
19 issue. And then there's the much more challenging area of
20 where there's indirect savings for the program associated
21 with program improvement, improving program value, that
22 goes to technical assistance, staff extenders,

1 understanding best practices, being more sophisticated in
2 your management of a program that's increasingly more
3 complex, and how do you get there. And that's the area
4 where there are these other options, but are states taking
5 advantage of them? Do they cover all the territory that
6 they need to cover if states are not taking advantage of
7 them, or they don't cover all the area that they need to
8 cover, what are those barriers, and are those barriers
9 amenable to some recommendation or solution that we would
10 propose?

11 And it almost feels to me like there's a need to
12 catalog a little bit of this. And I apologize for asking
13 for that, but I really think it would be helpful for me to
14 understand, like, technical assistance. There's CMS
15 technical assistance opportunities. There's NASHP. You
16 know, just some basic foundational education for the
17 Commissioners about kind of where states can go to get some
18 of this stuff, so that may help us see some of the gaps.

19 CHAIR THOMPSON: Kit.

20 COMMISSIONER GORTON: Okay. Quickly, so I agree
21 with Chuck that as we talk about this realm of multistate
22 collaboration we shouldn't just limit it to the very

1 formal, you know, learning communities and all of those
2 other things. I think there's important collaboration that
3 happens amongst the national vendors. I think there is
4 important collaboration that happens on regional levels,
5 and I agree with Stacey that it might be useful to get some
6 sense of how much reach each of those models has, and for
7 me, one of the question is, is there room for those models
8 to do more? Would it be useful to have 40 states in DERP
9 as opposed to 25? Those kind of questions, because I do
10 think there's money to be saved.

11 Somebody earlier said that Massachusetts doesn't
12 have any problem running its program. I think the people
13 in Massachusetts would disagree. Massachusetts has one
14 contract manager, one single FTE supervising three managed
15 care plan. So that is not a robustly resourced oversight
16 capability. Now they use other things, and, you know, we
17 haven't talked about EQRO, but I think it's actually a
18 useful case in point. Because we have seen, over the last
19 20 years, consolidation of EQRO into some big vendors, but
20 then there's still a lot of onesy-twosies out there. I
21 mean, I love Ron Hanley, but what the heck is Arkansas
22 Foundation doing, trying to compete with the likes of

1 Qualis and others?

2 So it strikes me that we have a role to -- so I
3 don't think it's a matter of question that all states could
4 use more administrative capacity, whether it's in people
5 with the technical skills to be able to address the
6 problems that they confront in an ever-fluid environment,
7 or whether it's just processes and operational things. So
8 if we need to do more work to do that, then, you know,
9 let's send out a Doodle survey and ask the state Medicaid
10 directors whether they have enough administrative capacity.

11 So for me, that's not a question. The question
12 for me, then, is -- and this is the point that you were
13 making before -- are we getting the most efficient use of
14 the public dollars that we have available? We're spending
15 a lot on administering the Medicaid program. Are we
16 getting as much bang for our buck as we could get? And my
17 personal view is every time you have these onesy-two-sy one-
18 offs scattered around then there's money being wasted, and
19 I do think that if we can get to some level of scale -- and
20 we did hear from the drug collaboratives that as long as
21 you've got 10 or 13 of them you've got enough scale to make
22 it work. The managed care plans are all using PBMs of one

1 size or another, but even there, there are economies of
2 scale.

3 And so I think that there's useful, descriptive
4 work that we can do, and, at the end of the day, we can get
5 to a place where we can say, to the extent that states are
6 not taking advantage of these opportunities to either spend
7 a little bit of money to generate a lot of savings, or to
8 spend a little bit of money to do a much better job serving
9 their population, you know, then they should do that.

10 And I like Penny's lanes model. You should
11 figure out what lane you're in. And it's more than just
12 big, small, urban, rural. Because in New England, you
13 know, we've got some small states. Actually, everybody is
14 a small state except Maine, and Maine is big in space but
15 not big in anything else. So you have six small states.
16 They're spending a fortune -- that's why NESCSO was
17 created, right? You have six small states spending an
18 administrative fortune, serving a population that would fit
19 inside Pennsylvania, which, when I was there, was the
20 fifth-largest program.

21 And so I think that, you know, it is worth
22 looking at, you know, where there are opportunities for

1 regionalization and where that would make sense, where
2 there are opportunities for, you know, people to say, you
3 know, "I want to do it the blue way," and other people
4 saying, "I want to do it the red way," and other people
5 saying, "I want to do it purple," and somebody else saying,
6 "I want polka dots." But there probably doesn't need to be
7 the infinite variability that we see, those of us who used
8 to sell MMIS for a living. You know, you just don't need
9 all this complexity and variation. That creates cost, it
10 limits transparency, and it makes the program harder to
11 oversee.

12 So that's the question I would like to see the
13 Commission address, is what are we doing now that makes
14 sense, right, identifying best practices. We do that.
15 These collaboratives, the national vendors, all of those
16 other things. Where are there opportunities to extend
17 those models? And then, you know, where are there gaps?
18 Are there places where we simply are not capturing the
19 efficiencies that we could be capturing?

20 CHAIR THOMPSON: That's helpful. Thank you.

21 Okay. So Moira, this has been a great
22 conversation, and I think there is a variety of different

1 perspectives here that we're going to have to sort through.
2 And I think we should try to come back on this topic, with
3 taking some of this feedback into consideration, maybe with
4 some more peeling away the onion on the taxonomy and where
5 the activity is going on now, where it could produce some
6 additional benefit and action to sort of answer the
7 question as to whether or not we really have a problem that
8 can be solved through some of these additional mechanisms.

9 I think it would also be very useful to think
10 about getting back to some states on this and validating
11 some of our assumptions about where are the obstacles,
12 where are the barriers, where's the value for you in some
13 of these activities. And I would like to see us explore
14 not just what has been done but really try to promote some
15 different ideas of different models that have not existed
16 before, in the program, and try to get some reaction to
17 that, whether those kinds of models would have any traction
18 here. Because I believe that we are probably in a place
19 where we would want to create structures and processes and
20 funding that states could take advantage of but that don't
21 necessarily require states to gather together to do
22 something. And so what would it take to entice states, or

1 to interest states in those kinds of models, and where
2 would they want to prioritize their resources and
3 interests? So I think that could be maybe helpful.

4 EXECUTIVE DIRECTOR SCHWARTZ: Can I ask a
5 question about that?

6 CHAIR THOMPSON: Yeah.

7 EXECUTIVE DIRECTOR SCHWARTZ: I mean, is the
8 expectation, the piece about sort of taking what Moira has
9 already written and sort of, you know, expanding, providing
10 more detail, that I get. The piece around, you know,
11 testing model ideas or testing incentive ideas, would the
12 expectation be that we should come up with a list of
13 potential incentives, and then also sort of imagine and
14 build out and describe these models?

15 Because I'm not -- I just want to get some
16 clarification before we would go down that road, because I
17 don't know right now what we would build and how we would
18 go about describing that without having -- I mean, I
19 haven't heard somebody say a model that hasn't been
20 discussed here is something that would look like X. And,
21 you know, I need to know, and Moira will need to know, like
22 what is it we're supposed to do if we don't have that?

1 I mean, maybe, Penny, you have an idea of
2 something that we haven't had time to explore here, that we
3 can do, and that would be great. But I'm trying to get
4 some more clarity on how we could test those ideas when we
5 don't have like a thing.

6 CHAIR THOMPSON: Well, I mean, to me, some of
7 those kinds of models get built out by virtue of talking
8 about how do you address some of the barriers that we've
9 discussed. So, for example, if we said, well, one of the
10 barriers to states doing more work together is that they
11 have to create it every time they want to do it. So what
12 would an existing structure look like that had established
13 foundations and governance structure and existing staff
14 that people could call on? Would that have to be purpose
15 oriented? Would that have to be -- how big would that have
16 to be before it could grow by virtue of the demand?

17 So I think there are ways to just play out,
18 understanding some of the barriers and issues that we've
19 been discussing, in terms of, well, a potential answer to
20 that would be this. Would that work or does that not
21 answer that question? And that's the way that we have to
22 think about creating some kind of possible models that get

1 us out of just using the models that have existed, of
2 which, you know, I think there are lessons to draw from
3 that in today's conversation, are useful in that regard.

4 Okay. Let's go ahead and move on to the next
5 topic of the agenda, which is, we are going to have a short
6 discussion about changes to the MACPAC conflict of interest
7 policy, and Anne, you're on point for that.

8 **#### CHANGES TO MACPAC CONFLICT OF INTEREST POLICY**

9 * EXECUTIVE DIRECTOR SCHWARTZ: Okay. By way of
10 background, MACPAC does have a conflict of interest policy
11 that we adopted in May of 2016, after several months of
12 discussion. The policy defines the conflict of interest
13 principles to which Commissioners are subject and
14 establishes procedures by which a conflict of interest can
15 be identified and addressed in advance of a vote on a
16 recommendation to which that conflict relates.

17 So the policy establishes definitions of
18 reportable interests, it sets standards for when interests
19 may pose a conflict, it creates a committee to review
20 reportable interests, and the policy also outlines certain
21 prohibited activities, activities that are inconsistent
22 with service on the Commission.

1 The policy is published on our website.
2 Reportable interests are also published on the website for
3 all Commissioners, and you can find these by clicking on
4 the bio of each Commissioner.

5 In the time since this policy was adopted, the
6 Conflict of Interest Committee has met before each vote on
7 a recommendation. Today we're here because the current
8 policy states that the Chair will chair the Conflict of
9 Interest Committee. The proposed changes, outlined in your
10 materials, are to change to the Vice Chair, and also to
11 make a number of minor changes in the text to reflect that
12 the policy is in place. As originally drafted, some of the
13 text is anticipatory about how the procedures will work,
14 and we're now more than two years into this.

15 The original policy was adopted in public session
16 and was voted on, and so to maintain that transparency, in
17 consideration of these minor changes today, we thought it
18 would be appropriate to have a discussion of those changes
19 and to take a recorded vote.

20

21 So I'll open it up.

22 CHAIR THOMPSON: Does anyone have any questions,

1 comments, or interest in discussion on any of the changes
2 that Anne has mentioned? I think it is clear that these
3 are pretty technical and narrow changes to this policy.

4 COMMISSIONER CARTER: I think the comments -- the
5 changes make sense, and that they should be approved.

6 CHAIR THOMPSON: Any other comments before we go
7 to a vote?

8 [No response.]

9 CHAIR THOMPSON: All right. Let's take a vote.

10 EXECUTIVE DIRECTOR SCHWARTZ: Okay. So I'll call
11 the roll, and you can vote yes or no or abstain.

12 And so, in alphabetical order, Melanie Bella.

13 COMMISSIONER BELLA: Yes.

14 CHAIR THOMPSON: Brian Burwell.

15 COMMISSIONER BURWELL: Yes.

16 EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter.

17 COMMISSIONER CARTER: Yes.

18 EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise.

19 COMMISSIONER CERISE: Yes.

20 CHAIR THOMPSON: Kisha Davis.

21 COMMISSIONER DAVIS: Yes.

22 EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas.

1 COMMISSIONER DOUGLAS: Yes.

2 EXECUTIVE DIRECTOR SCHWARTZ: Leanna George.

3 COMMISSIONER GEORGE: Yes.

4 EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon.

5 COMMISSIONER GORDON: Yes.

6 EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton.

7 COMMISSIONER GORTON: Yes.

8 EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin.

9 VICE CHAIR LAMPKIN: Yes.

10 EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan.

11 COMMISSIONER MILLIGAN: Yes.

12 EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin.

13 COMMISSIONER RETCHIN: Yes.

14 EXECUTIVE DIRECTOR SCHWARTZ: I'm going to note

15 that Bill Scanlon is not present.

16 Peter Szilagyi.

17 COMMISSIONER SZILAGYI: Yes.

18 EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil.

19 COMMISSIONER WEIL: Yes.

20 EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno.

21 COMMISSIONER WENO: Yes.

22 EXECUTIVE DIRECTOR SCHWARTZ: And Penny Thompson.

1 CHAIR THOMPSON: Yes.

2 EXECUTIVE DIRECTOR SCHWARTZ: Okay.

3 CHAIR THOMPSON: Thank you, all.

4 EXECUTIVE DIRECTOR SCHWARTZ: Very good, and we
5 will publish the changes with the new adopted date on our
6 website next week.

7 CHAIR THOMPSON: Okay. We'll pause for public
8 comment on any of our discussions for this morning. Are
9 there any comments from any members of the public?

10 **#### PUBLIC COMMENT**

11 * [No response.]

12 CHAIR THOMPSON: Hearing none, we are adjourned.
13 We will pick back up at 1:30.

14 * [Whereupon, at 11:52 a.m., the public meeting was
15 recessed, to reconvene at 1:30 p.m. this same day.]

16

17

18

19

20

1 AFTERNOON SESSION

2 [1:30 p.m.]

3 CHAIR THOMPSON: Okay. Welcome back, and we have
4 Rob Nelb with us. We're going to spend some time talking
5 about hospital payments. Now Rob, I think this first
6 session, where you're going to talk about the themes from
7 interviews and sort of set the stage for us, for the
8 general context about hospital payment policies, we'll have
9 a half an hour for that. So you'll provide those findings
10 and results, and Commissioners, please ask any kinds of
11 questions or clarifications that you might want. But just
12 understand this a little bit of a stage-setting, a little
13 bit of a background. Let's understand the world in which
14 we're operating as we start to dive into later discussions
15 today about DSH and UPL.

16 So, Rob, go ahead and take us away. Thank you.

17 **#### THEMES FROM INTERVIEWS ON THE DEVELOPMENT OF**
18 **HOSPITAL PAYMENT POLICIES**

19 * MR. NELB: Great. Thanks so much, Penny. So,
20 yes, as you mentioned, there are a number of hospital
21 payment policy items on our agenda for this meeting. I
22 will have a closer look at DSH and UPL later today and

1 tomorrow. But before we begin that, I wanted to give the
2 sort of broader perspective about how states develop their
3 hospital payment policies by sharing some themes from
4 interview that we conducted with states and stakeholders
5 this summer.

6 I'll begin with a brief context for this study
7 and how it fits into our overall hospital payment work
8 plan, and then I'll share some of the methodology and key
9 findings from our interviews.

10 You have a full report in your material that
11 walks through all of our interview findings. For today's
12 presentation I'm just going to focus on some key findings
13 related to supplemental payments, related to managed care,
14 and related to value-based payments.

15 So as you will recall, back in January of this
16 year, the Commission outlined a long-term work plan to
17 broadly consider all types of Medicaid payments to
18 hospitals. The Commission has been doing a lot of work on
19 specific types of payments, such as DSH and UPL, but
20 Commissioners expressed an interest in understanding how
21 all these different pieces fit together, kind of
22 understanding that theory of everything.

1 As a result, we developed this work plan based on
2 MACPAC's provider payment framework, that really aims to
3 collect a broad set of information about hospital payments,
4 including information on payment methods, payment amounts,
5 and outcomes related to payments. Ultimately, the goal of
6 this work is to help inform the Commission as it evaluates
7 whether payment policies are consistent with the statutory
8 goals of efficiency, economy, quality, and access.

9 At our March public meeting of this year, we
10 began our work on payment methods by looking at some
11 national data about base and supplemental payments,
12 including this pie chart showing base and supplemental
13 payments in 2016. Base payments, as you will recall, are
14 payments for specific services, while supplemental payments
15 are lump-sum payments, usually made over a period of time,
16 that aren't directly related to a particular service.

17 At the meeting, we talked about the fact that
18 about half of fee-for-service payments in Medicaid are made
19 through supplemental payments nationally. However, there
20 is wide variation among states and their use of
21 supplemental payments and in the type of supplemental
22 payments that they make. In addition, we talked about the

1 fact that a large share of Medicaid payments to hospitals
2 are now made through managed care, but that these payments
3 are largely a black box. We don't really know much about
4 how much they are and who receives them within each state.

5 So even though we know a lot about what types of
6 payments states make, Commissioners really wanted to know
7 more about why states make the payments that they do. And
8 so based on the feedback from the March meeting, we
9 outlined a series of policy questions about why states use
10 certain payment methods, and we thought it would be good to
11 just ask states directly, to better understand some of
12 these key questions.

13 I won't read through each of them, but just want
14 to highlight a few. First, again, recognizing this large
15 role of supplemental payments, we wanted to know more about
16 what are the factors that affect the structure and mix of
17 base and supplemental payments in different states.
18 Second, since we don't have much data on managed care, we
19 wanted to know how fee-for-service payment policies affect
20 managed care payments to hospitals. And third, since we're
21 always looking ahead, we wanted to know how states are
22 planning to change their hospital payment policies in the

1 future.

2 To conduct these interviews we contracted with
3 Health Management Associates. I want to thank Tom Marks
4 and Tim Beger from HMA, who are with us here today, as well
5 as other members of the HMA team, for helping to make this
6 research possible in such a short time frame.

7 For this project, we ultimately selected five
8 states -- Arizona, Louisiana, Michigan, Mississippi, and
9 Virginia. We chose these states because they varied in
10 their use of supplemental payments and also because they
11 had recently made some changes to their hospital payment
12 policies, so we had a little bit of before and after to
13 look at.

14 For each state we researched what their current
15 payment policies were, and then we interviewed state
16 officials, a representative from the state hospital
17 association, as well as a managed care organization in each
18 state. We then supplemented these interviews by talking
19 with national experts and with staff from CMS.

20 This figure shows the distribution of hospital
21 payments in our study states in 2016. These data come from
22 some of the CMS-64 expenditure data that I presented

1 earlier, as well as some additional information provided by
2 states, particularly around managed care payments.

3 You can see here that the use of supplemental
4 payments varies widely by state, from 18 percent of
5 hospital spending in Arizona to 59 percent in Louisiana.
6 This is consistent with the variation we see across the
7 country. And in addition, there is variation in the types
8 of supplemental payments that states make.

9 I want to highlight, in particular, some of the
10 new data we were able to collect on what we're calling
11 managed care supplemental payments. These include what are
12 called directed payments as well as pass-through payments
13 that states make in managed care, where the state basically
14 increases the capitation rate to the health plan and then
15 directs the health plan to direct a portion of that
16 capitation rate to providers in the form of a rate
17 increase.

18 As you can see, in some states the use of these
19 directed payments is quite large, so 31 percent of hospital
20 payments in Mississippi. But there's also quite a large
21 variation among states. In 2016, Virginia was not making
22 any directed payments to providers. However, they are

1 actually in the process of adding some new directed
2 payments now, as they expand Medicaid.

3 Okay. So as I mentioned, again, the full
4 findings from our report are in your materials. I just
5 want to highlight three key findings today.

6 First, when we're looking at this question of
7 what are the factors that affect base and supplemental
8 payments, I think our key finding was that, really, the
9 sources of non-federal share had a really big role to play.
10 Second, when we're looking at, you know, how managed care
11 payments and fee-for-service payments relate, we found that
12 they were largely similar in our study states, and that the
13 use of Medicaid managed care had not substantially affected
14 Medicare payments to hospitals. And finally, as we look to
15 the future, we heard that even though there was interest in
16 adopting new payment models, especially value-based
17 payments, the progress was really slow, and states
18 highlighted a number of barriers, that I'll get into.

19 So let's dive into each of these findings in a
20 little more detail. First, again, as we're trying to
21 explain this increase in the use of supplemental payments,
22 the non-federal share is sort of the key theme that kept

1 coming up. And in pretty much all of the states that we
2 talked to there was pretty much a common narrative around
3 the growth of supplemental payments. First, there was a
4 perception that base payment rates were low. However,
5 states lacked the state general funds necessary to increase
6 base payment rates, particularly during the latest
7 recession.

8 In the absence of state general funds, states
9 then looked to providers to help finance the non-federal
10 share of these payments, using provider taxes or
11 intergovernmental transfers from public hospitals. When
12 they did so, both the states and the providers preferred to
13 receive those increased payments in the form of
14 supplemental payments rather than base payment increase,
15 because it provided more certainty that the amount of
16 payments that they were receiving were more than the amount
17 that they were contributing in the taxes or IGTs.

18 We found some variation among states in their
19 willingness to use provider taxes, but once they decided to
20 use those financing mechanisms they pretty much all chose
21 to use them to finance supplemental payments rather than
22 base rate increases.

1 One exception to this narrative I want to point
2 out is Louisiana, which is actually currently planning to
3 decrease its use of supplement patients and increase base
4 rates in response to pending DSH allotment reductions. As
5 you will recall, DSH payments pay for both Medicaid
6 shortfall as well as cost of care for the uninsured, and so
7 as a way of sort of mitigating the effects of pending DSH
8 cuts, Louisiana has identified the portion of the DSH
9 payments that are paying for shortfall and it is converting
10 those DSH payments to rate increases instead. They are
11 rolling this out as part of a new DRG payment system as
12 well.

13 Our next theme was around managed care, and we
14 found that in our study states managed care organizations
15 tended to use fee-for-service methods and rates for most
16 base payments to hospitals, even though managed care plans
17 do have the flexibility often to pay rates that are
18 different from fee-for-service. When we asked plans why
19 this was the case, they noted several reasons. For one,
20 capitation rates are often initially developed based on
21 fee-for-service rates, so the plans felt that they needed
22 to pay the fee-for-service rates to stay competitive.

1 Second, in some states, they required plans to
2 use fee-for-service rates as a rate floor for non-
3 contracted providers, so there was little incentive for
4 hospitals to accept less than the fee-for-service rate.
5 And finally, MCO representatives noted just the complexity
6 of developing alternative payment models that differed from
7 the fee-for-service rates, so they kind of went with the
8 state model for simplicity.

9 We also took a closer look at these directed
10 payments in managed care, and we found that they tend to
11 work pretty similar to upper payment limit, or UPL payments
12 in fee-for-service. So as you recall, states can't make
13 UPL payments for services provided in managed care, but by
14 doing these directed payments where they're requiring
15 certain rate increases, they could achieve some similar
16 goals of sort of increasing base rates, and these payments
17 are often financed in similar ways, using provider taxes or
18 other mechanisms.

19 The 2016 Managed Care Rule issued specific
20 guidelines for directed payments, so many of our states
21 were in the process of coming into compliance with the new
22 rules. The regulations required states to phase out

1 payments that don't comply with the new criteria, which are
2 referred to as pass-through payments. In all of our study
3 states they were able to sort of make this conversion.
4 There were some changes to having to use more current data
5 and some slight distributional changes as a result of the
6 new rules, but at the end of the day the states were still
7 able to make the same amount of payments that they were
8 making before.

9 However, states were a bit uncertain about how
10 some of these directed payment policies might change in the
11 future. Under the new rules, these program are only
12 approved for a year at a time, and so CMS will be re-
13 reviewing them in the future, so it's unclear whether
14 states may have to make any further changes.

15 Lastly, we talked to states about some of their
16 base payment methods. Three of our study states recently
17 converted from their inpatient hospital payment methods,
18 from a per diem method, to diagnostic related groups, which
19 is a policy that's been long used by Medicare and other
20 commercial payers. We asked the states why it took so long
21 to adopt these new methods, and they cited some common
22 reasons, including resistance from the hospitals who are

1 concerned about the redistribution effects of new policies,
2 and also they cited some of the operational and
3 administrative costs involved in making any change to their
4 payment methods. These often take several years and
5 require outside contractors to help support states when
6 making these transitions, and so it is resource intensive.

7 We also found that value-based payment models for
8 hospital services were used sparingly in the states that we
9 studied, and even though there was some interest in value-
10 based payment, progress was quite slow. Respondents noted
11 several barriers to adopting value-based payment. For
12 Medicaid in particular, they highlighted the fact that the
13 low base rates relative to costs made hospitals reluctant
14 to put any of their payments at risk. And then, in
15 addition, we heard some of the other concerns about
16 measures and about just the administrative challenges with
17 implementing any value-based payment program, which are
18 themes that we commonly hear among all the payers.

19 Some of the states in our study were planning to
20 increase the use of value-based payment through managed
21 care, so by requiring their managed care plan to direct a
22 certain portion of the payment through a value-based

1 payment model. However, when we talked to plans about how
2 they were planning to meet these goals, they noted that
3 they were prioritizing investments in physician-based
4 value-based payment models rather than hospital-based ones.
5 So there still doesn't seem to be much progress on the
6 hospital side.

7 So that concludes my presentation for today.
8 Hopefully this gives you some good context for our
9 discussions on DSH later today and our discussion about UPL
10 tomorrow. And, obviously, these findings will hopefully
11 help inform our long-term work plan, so I look forward to
12 any thoughts on that, as well. Thanks.

13 CHAIR THOMPSON: Sheldon.

14 COMMISSIONER RETCHIN: As usual, I always am
15 appreciative, Rob, of your work, and having this research
16 done is helpful. Just a couple of comments and maybe a
17 question embedded in there somewhere.

18 The statement by hospitals that they prefer
19 supplemental payments -- let me get this straight -- they
20 prefer supplemental payments because they are better able
21 to see the net gain after the provider tax. But there is
22 no provider tax on base payment, is there? Isn't that,

1 we'd rather see supplemental than a base payment increase,
2 but there's no provider tax on base payment increase, is
3 there?

4 MR. NELB: States could use a provider tax to
5 finance a base increase.

6 COMMISSIONER RETCHIN: Okay.

7 MR. NELB: They don't. So I think in the
8 hierarchy, what we heard is that states would prefer base
9 rate increases that are financed by state general funds.
10 That's sort of the preference. But that if it does have to
11 be financed by the providers they wanted some more
12 certainty that they were going to get the return. And
13 whereas base payments sort of vary based on your
14 utilization, if you serve more or fewer patients that the
15 supplemental payments can be kind of a fixed amount, that's
16 maybe proportionate to what they contribute.

17 COMMISSIONER RETCHIN: So and then I'll just make
18 one comment before I, I guess, get to the value-based
19 purchasing idea, the fact that hospitals -- I actually
20 didn't know this; I should -- are still doing, or have been
21 doing per diems, or that they have been paid on a per diem
22 basis. And, of course, the transition to DRGs, it's a

1 novel approach. It's only been around 35 years. But
2 saying it's hard to convert, when, you know, it's sort of
3 like there is another payment that has a DRG administrative
4 system already loaded, right? It's not like you have to
5 invent a new -- but there will be some, because it's
6 Medicaid and be different, but that seemed astonishing.

7 But the one discouraging element that I found in
8 the reports are that the value-based purchasing efforts are
9 really focused on physicians, because while hospitals have
10 other supplemental sources to get to costs, physicians
11 don't, and the payment rates are abysmal in most states. As
12 a percent of Medicare they wander between 60 percent and 80
13 percent of Medicare.

14 So that's a pretty thin area to now say, okay, we
15 know you've been paying terribly. Now we're going to
16 require you to do the following five quality measures.
17 That just seems discouraging to me. Just a comment.

18 CHAIR THOMPSON: There's a certain circularity in
19 this set of findings that the base rates are low, the base
20 rates inhibit value-based purchasing, but the increases in
21 funding are coming through supplementals.

22 So, Rob, I want to ask a question, and I know Kit

1 wants to jump in. Chuck wants to jump in. I just want to
2 clarify one point that I don't really understand very well,
3 inside of managed care, which is, you know, I was afraid
4 that the findings were going to be that what happens inside
5 of managed care is exactly what happens in the fee-for-
6 service system, in terms of how people are paid, you know.
7 But I am still not clear what the CMS regulations do with
8 directed payments, and how they really differ from pass-
9 throughs.

10 And so appreciating what CMS was faced with when
11 it issued its rule, thinking that such things didn't exist
12 and then finding out such things existed and needing to
13 find some way to accommodate them, I'm not throwing
14 aspersions on anybody for any decisions but I just -- I
15 don't actually understand, as a policy matter, how a
16 directed payment differs from a pass-through.

17 So I get something like telling an MCO, like when
18 there was a PCP bump you have to now pay these providers X
19 amount because we want them to receive that same amount
20 that they would have received in fee-for-service under a
21 managed care network. But setting aside that kind of an
22 example, what does a directed payment look like that's

1 really different from a pass-through?

2 MR. NELB: Sure. So the regulations provide
3 three different ways a state can make directed payment.
4 One is rate floor or rate ceilings, to like the PCP bump
5 example. Another is requiring participation in a value-
6 based payment model. But the third, what we saw most in
7 our states, was a percent increase to the base rates.

8 So under previous pass-through payment models,
9 you know, there's sort of a fixed amount of money that they
10 have that goes into the capitation rate, and sort of
11 indicated the amount that goes to particular providers. In
12 some of our study states, so like in Michigan, for example,
13 that amount was somewhat based on the utilization at those
14 hospitals. It was, in some ways, a percent increase to
15 their base rates, but it was sort of calculated using older
16 data, and sort of that amount was sort of fixed, and so it
17 ended up being, you know, a flat amount that kind of gets
18 added to those hospitals.

19 Under the new rules, converting into directed
20 payments, they had to kind of convert that flat dollar
21 amount into a percent increase to the base rates.

22 CHAIR THOMPSON: But the base rates would go to -

1 - so this goes back to the -- from a hospital standpoint,
2 in terms of how they see these dollars flowing. If they're
3 financing, you know, some portion of the directed payments,
4 when you're dealing with directed payments as opposed to a
5 pass-through, as opposed to a supplemental and a fee-for-
6 service, you're going to have more of that risk to the
7 hospital that their contribution is not necessarily coming
8 back to them. It's being disbursed to whomever is
9 delivering the services. Is that right?

10 MR. NELB: Yes. Yes. So that is the change.
11 And, you know, I think there was a bit of misunderstanding
12 on how the prior pass-through payment models worked,
13 because in some states that distributed it broadly they
14 sort of were based on utilization. But definitely under
15 the new models they have to use more current utilization
16 data, and that has resulted in some redistributions in
17 funding within states. However, there is still like this
18 same pot of money that's sort of determined up front, and
19 that's used to figure out the amount that goes to the
20 provider.

21 CHAIR THOMPSON: And when we say it's an add-on
22 to the base rate in a directed payment, can the base rate

1 have an add-on that qualifies who is billing and for what
2 kind of beneficiary and for what kind of service in order
3 to get the base rate add-on?

4 MR. NELB: There can be some distinctions for
5 different classes of providers.

6 CHAIR THOMPSON: Because that's traditionally
7 been one of the ways to ensure the money goes back to -- at
8 least in part.

9 MR. NELB: There is a piece that cannot --

10 CHAIR THOMPSON: So some of those options still
11 exist.

12 MR. NELB: -- be based on IGTs, but the way --

13 CHAIR THOMPSON: That's always been true.

14 MR. NELB: -- the taxes, yeah. So, yeah, so we
15 can definitely dive in more to those specifics, and make
16 sure I'm communicating it clearly.

17 CHAIR THOMPSON: Because you can reverse engineer
18 --

19 MR. NELB: Yeah.

20 CHAIR THOMPSON: -- to ensure that it ends up in
21 the hands that you want it to end up in.

22 MR. NELB: And that's, yeah, basically these

1 states had to a lot of calculations with the hospital
2 associations and others, but at the end of the day they
3 were able to figure out --

4 CHAIR THOMPSON: I'm just trying to understand
5 how different or similar it is to what we've seen before.

6 MR. NELB: Yeah.

7 VICE CHAIR LAMPKIN: Well, but is it also the
8 case that there is still some risk, not just to individual
9 hospitals with respect to distribution but to hospitals as
10 a group, based on utilization, if managed care plans are
11 able to manage more care out of the inpatient setting, for
12 example? In a directed payment model, that means less
13 funding to the hospitals, as I understand it.

14 COMMISSIONER DOUGLAS: Yeah, I mean, I would say
15 the fundamental difference, which makes it harder, is
16 exactly what Stacey is saying, is before it was a
17 retrospective, in essence, approach of states would figure
18 out what was actually the utilization was and then added
19 on, and then the plans would divvy it out to the hospitals.
20 How it's got to be a perspective of looking at what
21 utilization, based on actuarial principles, and it could
22 turn out that utilization is way different from that, and

1 then they don't get all the money.

2 CHAIR THOMPSON: Okay. All right. Thank you.
3 Kit and then Chuck.

4 COMMISSIONER GORTON: So two things. One is what
5 Stacey just brought up, right. So while it is true that in
6 many cases the managed care plans have mirrored what the
7 states were paying, or sometimes the state plus will take
8 state Medicaid rates plus 5 percent, or something like
9 that, the managed care plans are trying to control
10 utilization and that's where they create the delta, maybe
11 be able to pay a little more than the state rate.

12 But again, the hospitals want to be held
13 harmless. If you're going to do a value-based payment
14 that's based on shared savings, the hospitals want
15 visibility and the way that comes, and just in the interest
16 of simplicity, you get, okay, well, let's talk about
17 Medicaid Plus, and so keeping the states' payment
18 methodology makes that a far more straightforward
19 conversion. When the state agrees to go to DRGs, the plans
20 are usually cheering on the sidelines, but, I'm sorry,
21 Sheldon, it's a hell of a lot of work doing a DRG
22 conversion. It's an 18-month migraine headache. And

1 that's for companies that were already doing it in other
2 product lines.

3 So that is a big shift, because all of the
4 weighting factors and everything else has to be taken care
5 of. So I just wanted to make that point.

6 The other point that I wanted to make is -- and
7 not to take this back to the theory of everything, but
8 since this is the context setting piece, it is important to
9 recognize that least on the managed care side but my
10 experience running the fee-for-service system in one state
11 suggests it was the same there, while it is true that you
12 negotiate inpatient acute rates and inpatient post-acute
13 rates and physician rates and outpatient rates, the
14 entities that you're negotiating with consider that to be
15 their entire revenue stream, and there is some horse
16 trading that goes on in terms of, you know, well, we'll do
17 this here or we'll do that there. Right?

18 So it's sometimes easier to get the value-based
19 payments done in the physician groups, because within an
20 integrated delivery system the physician groups are
21 generally less powerful than the hospitals. So the
22 hospital that's negotiating for everybody says, okay, we'll

1 do that over here, but over here we want to do this.

2 So the balloon will be poked out and poked in in
3 various places. At the end of the day, what everybody
4 wants is their revenue to be at least equal, if not going
5 up. And so I think it's right for us, in this exercise, to
6 focus on hospital inpatient acute and the way it gets paid
7 for, but at the end of the day, all of the pieces are
8 linked together and we just need to keep that in mind, in
9 terms of why some of these things play out the way they do.

10 CHAIR THOMPSON: Chuck.

11 COMMISSIONER MILLIGAN: So I wanted to talk about
12 the supplemental payments, Rob, and pick up on something
13 that you said a few minutes ago about it's kind of
14 protection against utilization reductions.

15 So the context -- and when I read the materials
16 on the way to the meeting, that particular point hadn't
17 been drawn out very much, I thought, in terms of how states
18 get to the supplemental payment methodology. In some ways,
19 it's a protection for the providers about utilization
20 reductions because the base rates and all the rest of that
21 is based on volume.

22 My question is, in a couple of the states, where

1 I'm most familiar, New Mexico and Maryland, there's a move,
2 in some ways, to get the hospitals engaged around value-
3 based purchasing and the desire to have fewer admissions,
4 fewer readmissions, keep people treated at home, that is
5 leading in some ways to, depending on how you define it,
6 global budgeting models or almost like block grant models
7 to hospitals, so that they are going to have some level of
8 fixed guaranteed revenue, but that's not dependent on
9 utilization.

10 And the incentive for the hospital is try to
11 reduce admissions, readmissions, et cetera, because their
12 revenue is guaranteed entirely outside of utilization in
13 various forms.

14 So I guess my question is, in the work that HMA
15 did or in the work that you've done generally, I had been
16 kind of a skeptic about supplemental payments, because I
17 had thought it was like a way of kind of burying a lot of
18 the revenue in a bunch of kind of potentially questionable
19 financing arrangements, but I'm coming around to the point
20 of view where a lot of the supplemental payments are the
21 path to value-based contracting for hospitals to get a line
22 because revenue is protected in certain ways. And if you

1 step down that supplemental payment or if you cap the
2 trend, if you will, on the global budgeting, you can get
3 the benefit of utilization reductions without leaving the
4 hospitals at the side of the road.

5 My question is, Did any of that kind of
6 thematically pull through in these interviews or not?

7 MR. NELB: It didn't pull through in the five
8 states we studied.

9 I mean, later today I'm going to talk about the
10 Global Payment Program in California, which has that global
11 -- it's converting DSH into a global payment. It has that
12 same concept.

13 Remember, we've talked previously, done reviews
14 of the DSRIP programs, which are efforts to use
15 supplemental payments as a tool for value-based payment.

16 But in these states, really the supplemental
17 payments are really more about offsetting low base rates.
18 There was interest maybe in the future, tying it to some
19 quality goals, but nothing that we saw that was really
20 actually doing that in a really meaningful way.

21 COMMISSIONER MILLIGAN: Just a quick follow-up.
22 So one of the things going on in New Mexico, and it

1 happened the last 1115 waiver. And as part of a pending
2 1115 waiver is really moving a lot of that supplemental
3 payment into a very overt 1115 waiver guarantee kind of
4 structure so that it's completely transparent and aligned
5 to more of the delivery system reform about that revenue
6 guarantee.

7 So I guess a question that I had as a follow-up,
8 Rob, is, Are we seeing more use of waivers, outside of the
9 DSRIP history, as a mechanism for some of these kinds of
10 payments?

11 MR. NELB: You know, I don't think so because I
12 think as we shared with our latest round of DSRIP, there
13 was a big -- that was sort of the prior method for
14 maintaining UPL payments when converting to managed care,
15 was to go through a waiver, and that's what New Mexico did
16 and a lot of the DSRIP states.

17 But I think with this new directed payment option
18 that's now in regulation, where you can do this without a
19 waiver, there is sort of interest in doing it without a
20 waiver.

21 One piece on the directed payments, it's
22 technically a part of the regulation where you're supposed

1 to tie it to the state quality strategy. So, in talking to
2 CMS and others, there is a view that maybe in the future,
3 more of these directed payments will be tied to quality,
4 but for now, a lot of these states in making the conversion
5 are just still keeping pretty much the same amount of
6 payments that they were making before.

7 CHAIR THOMPSON: I did have a little bit of that
8 same thought that you did, Chuck, in thinking about what
9 would it mean if we called the supplemental payments "base
10 payments" and the base payments "supplemental payments".
11 Would that change how we thought about what each was
12 supposed to be doing?

13 So I do actually think there's something there,
14 and I did pickup on the same nugget about some of the
15 supplementals, though clearly, this was not the main thrust
16 of why we've had the growth in supplementals. But there
17 were at least some supplementals that were intended to
18 offset for smaller hospitals, the variation in volume, for
19 rural hospitals, and that we're intending to try to achieve
20 some of these policy goals.

21 I was also trying to distinguish between the
22 supplementals that are there to promote a financing stream

1 and the supplementals that are there to acknowledge certain
2 kinds of situations inside of hospitals that need to be
3 acknowledged. Maybe there's something for us to think
4 about there.

5 I want to be able to go on -- go ahead, Alan.

6 COMMISSIONER WEIL: I'm trying to restrain
7 myself.

8 I feel like this segment needs a reality check,
9 which is I like the narrative if it's really happening with
10 the docs, not the hospitals. I don't think it's primarily
11 what's happening.

12 I like the narrative that this is about trying to
13 move to more of a capitated financing model. I don't think
14 that's mostly what's happening.

15 What's happening is institutions are protecting
16 the revenue, and if they're going to be asked to contribute
17 to a politically challenging thing, which is pay some
18 taxes, they want to see the benefits of it. And that's
19 what's happening, and I just worry that we tell ourselves
20 stories that are not really true.

21 CHAIR THOMPSON: Yeah. And I do think that that
22 comes through in these interviews.

1 Go ahead, Fred.

2 COMMISSIONER CERISE: I agree with Alan. As long
3 as the source of the state match is tied to the payment,
4 you're going to have that because that's the condition that
5 the hospitals will agree to be taxed. And that's the only
6 way you're going to do those taxes, is if they all agree,
7 because if they don't, then the legislature is not going to
8 pass it. And that's what creates the distorted payments.

9 You can try to back out of it and say, "Okay.
10 So, if that's going to happen, then what do we want to
11 attach to those payments? What do we want to expect with
12 those types of things?" But it does not promote a policy
13 agenda because states will assign less scrutiny when the
14 state is not coming up with the state share, when it's
15 coming from the provider system, and so they're more likely
16 to be loose in how those payments get made.

17 CHAIR THOMPSON: Chuck.

18 COMMISSIONER MILLIGAN: Can I just defend my
19 honor for a second.

20 [Laughter.]

21 CHAIR THOMPSON: That you're under no illusions?

22 COMMISSIONER MILLIGAN: Yeah.

1 I always enjoy Alan's comments. They always get
2 the blood flowing.

3 The reality I was describing was reality because
4 -- and let me just stay in New Mexico for a second. The
5 supplemental payment funding source isn't local provider
6 taxes. It's the view that, as Medicaid expanded under the
7 ACA, but otherwise, a lot of previously counter indigent
8 funds that were -- it was generated with local government
9 taxes, were less necessary to do indigent care at a local
10 level.

11 When I worked in California back in the day -- I
12 don't know if it still exists, but the medically indigent
13 adult program was very similar. It was locally driven,
14 local taxes, outside of the state general fund. So as
15 Medicaid expanded, capturing that local county indigent
16 fund then became the government funding source for the
17 match for a lot of those local hospitals.

18 And it was almost like akin to a Medicare
19 critical access hospital. It was a rural hospital, a long
20 way away, away from someplace else, but it wasn't
21 gerrymandered form a provider tax framework.

22 So it was a view that the counties want to see

1 their money coming back, but it wasn't quite as cynical as
2 you might think, Alan.

3 CHAIR THOMPSON: Okay. Any final questions or
4 clarifications on the work that Rob has presented here
5 before we move on to DSH?

6 [No response.]

7 CHAIR THOMPSON: Okay. Let's change gears and
8 get into -- not change gears too much -- DSH payments.

9 **#### DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS:**
10 **POLICY CHANGES AND POLICY OPTIONS**

11 * MR. NELB: Yeah. Well, great. So now that you
12 have the broader context, let's dive into our favorite
13 topic, which is DSH, disproportionate share hospital
14 payments.

15 I will begin by providing some brief background
16 on DSH and review some recent DSH policy changes, including
17 the recent delay in DSH allotment reductions.

18 These changes create an opportunity for the
19 Commission to potentially make recommendations about ways
20 to better distribute DSH reductions among states, and so
21 I'll be discussing a variety of policy options for the
22 Commission to consider.

1 In addition, I'll be presenting other policy
2 options to address other goals that the Commission has
3 articulated, such as better targeting DSH payments to
4 providers within states.

5 So, first, the background. As you know, DSH
6 payments are statutorily required payments that help offset
7 two types of hospital uncompensated care. First, they paid
8 for unpaid costs of care for the uninsured, and second,
9 they paid for Medicaid shortfall, which is the difference
10 between a hospital's cost of serving Medicaid patients and
11 the payments that it receives for those patients.

12 States have a lot of flexibility to distribute
13 DSH payments to virtually any hospital within their state,
14 but they are required to make DSH payments to deemed DSH
15 hospitals. These hospitals serve a high share of Medicaid
16 and low-income patients.

17 State DSH payments are limited by annual federal
18 allotments. These allotments vary widely by state based on
19 state DSH spending in 1992, and the ACA included reductions
20 to DSH allotments under the assumption that increased
21 coverage would reduce hospital uncompensated care and thus
22 reduce the hospital's need for DSH payments.

1 The ACA reductions were initially scheduled to
2 take effect in 2014, but they've been delayed several
3 times.

4 Most recently, the Bipartisan Budget Act of 2018
5 delayed DSH reductions until FY 2020. Under current law,
6 reductions will now be applied at \$4 billion in 2020, which
7 is about a 31 percent reduction, and the amount of
8 reductions will increase to \$8 billion a year in 2021
9 through 2025, which is a reduction of more than half of
10 state's unreduced allotment amounts.

11 The statutory factors used to distribute DSH
12 allotment reductions are unchanged by the new law. As
13 you'll recall, CMS initially proposed a methodology based
14 on these statutory factors, and it will need to finalize
15 that methodology before the reductions are implemented.

16 In addition to the delay in DSH reductions,
17 another important change to be aware of is the recent
18 change to the DSH definition of Medicaid shortfall. So in
19 March of 2018, the U.S. District Court of D.C. ruled that
20 CMS could no longer consider payments from third-party
21 payers when calculating Medicaid shortfall. However, the
22 full cost of care for these patients is still included.

1 So a good example is a patient who is dually
2 eligible for Medicare and Medicaid, the cost of care for
3 those patients in the hospital is counted as Medicaid
4 shortfall, but the payments that the hospital receives from
5 Medicare for those patients is no longer included, even
6 though Medicare is the primary payer of hospital services
7 for duals.

8 CHAIR THOMPSON: Rob, could I just interrupt you
9 on this point?

10 MR. NELB: Yes.

11 CHAIR THOMPSON: Because it's kind of a technical
12 detail, but I want to be sure to understand it. In full
13 disclosure, one of my consulting clients is a major TPL
14 provider to states, so I get concerned about third-party
15 payment.

16 So, in this case, we are talking about a
17 situation in which -- because Medicaid is a payer of last
18 resort, it may not be law make a payment that actually
19 should be made by another payer. Once having complied with
20 that rule and indeed having a hospital receive appropriate
21 and proper payment from another provider, potentially to
22 cover the full cost of care for that individual, the amount

1 that that third party properly paid to cover the cost of
2 care is counted as a Medicaid shortfall. Do I have that
3 right?

4

5 MR. NELB: Yes. And the court ruled that the
6 statutory definition only mentioned Medicaid payments and
7 didn't mention other payments that the hospital --

8 CHAIR THOMPSON: So the court was not opining as
9 a policy matter whether that makes any sense. The court
10 was talking about the interpretation of a particular piece
11 of legislative language and said this is where we're left
12 because of the nature of the language.

13 MR. NELB: Yes. Yeah. That's their ruling about
14 the statute.

15 CHAIR THOMPSON: Okay. Just to stop on that
16 point. Thank you.

17 MR. NELB: There's a quote about Medicaid, the
18 statute being an abuse of the English language or
19 something. It's very complicated.

20 [Laughter.]

21 MR. NELB: Okay. So, as a result of this change,
22 the amount of Medicaid shortfall that will be reported on

1 future DSH audits is expected to more than double in the
2 aggregate.

3 This has a lot of different effects. So one is
4 the maximum amount of DSH payments that a hospital could
5 receive will increase because their shortfall will
6 increase. However, this change may also result in a
7 redistribution of funds within states from hospitals that
8 serve a high share of uninsured individuals to hospitals
9 that serve a lot of Medicaid patients with third-party
10 coverage. Children's hospitals are a particular case that
11 serve a lot of kids that also have commercial coverage, and
12 so they're likely to be affected.

13 All right. As a result of these changes, there
14 is interest in MACPAC recommendations. At this point,
15 Congress appears unlikely to further delay DSH reductions,
16 and so we've heard that folks are interested in MACPAC
17 exploring some statutory changes to better distribute
18 reductions among states.

19 While doing so, the Commission could also develop
20 a package of recommendations to address other policy goals,
21 such as better targeting DSH payments to providers or
22 dealing with this recent change in the Medicaid shortfall

1 definition.

2 Because allotment reductions are currently
3 scheduled to go in effect in FY 2020, which begins in
4 October of 2019, it would be useful for the Commission to
5 make recommendations in the spring.

6 Either way, recall that we're statutorily
7 required to report on DSH payments in our March 2019
8 report.

9 So to help facilitate your discussion of
10 potential DSH policy options today, we've summarized some
11 of the DSH policy goals that Commissioners have expressed
12 in prior meetings. These include some short-term goals,
13 such as minimizing disruption for hospitals that currently
14 rely on DSH payments, as well as some long-term goals, such
15 as better targeting DSH payments to states and hospitals
16 based on objective measures of need.

17 In MACPAC's most recent DSH report, the
18 Commission talked about the importance of aligning DSH
19 policies with other Medicaid payments to hospitals, and
20 that's why we've begun the long-term hospital payment work
21 plan that I talked about earlier.

22 And, finally, Commissioners have also expressed

1 interest in using DSH payments to advance quality and
2 access to care in the most appropriate settings.

3 So although the Commission has come to some
4 consensus that allotments should be based on objective
5 measures of need, rather than historical spending, the
6 Commission hasn't yet come to consensus on sort of which
7 measures of need to use.

8 Last fall, we held a policy roundtable with
9 states, hospitals, and other experts to talk about a
10 variety of DSH issues, and we talked about the pros and
11 cons of different potential measures that could be used to
12 base DSH allotments on.

13 I'll just walk through some of the pros and cons
14 here. First, allotments could be based on the number of
15 uninsured individuals in a state, which has the advantage
16 that it's related to a hospital's unpaid cost of care for
17 the uninsured.

18 A disadvantage of this approach would be that it
19 would result in larger reductions for states that have
20 expanded Medicaid because these states have lower uninsured
21 rates.

22 To address some of that differential effect,

1 allotments could be based on the number of Medicaid and
2 uninsured individuals in the state. This could be
3 justified by the fact that DSH also pays for Medicaid
4 shortfall, which is somewhat related to Medicaid
5 enrollment.

6 However, Medicaid shortfall is also a function of
7 state's Medicaid base payment rates. So you could argue
8 that Medicaid enrollment really isn't a good proxy measure
9 to use.

10 DSH allotments could also be based on the amount
11 of uncompensated care in the state, and for this, we have
12 two different data sources we could use. We could use
13 Worksheet S-10 from Medicare cost reports, which includes
14 uncompensated care data for all hospitals in a state.

15 Unfortunately, the exact definitions of
16 uncompensated care for the cost reports don't quite align
17 with DSH definitions. They don't include Medicaid
18 shortfall, and they also include some costs of care for
19 people with insurance. It's a bad debt for them.

20

21 Another option is that we could use DSH audits,
22 which do align with the DSH definition of uncompensated

1 care. However, we only have them for a subset of DSH
2 hospitals, and there's a something data lag of about four
3 years. We currently just got the 2014 DSH audits, but it's
4 2018 right now.

5 Okay. So, with that, let me dive into some
6 potential policy options to consider.

7 So, first, Congress could change the schedule of
8 reductions to apply the same amount of reductions over a
9 longer time frame in order to minimize the disruption for
10 states and hospitals.

11 Specifically, because under current law, the
12 reductions only go until 2025, they could be extended, and
13 by extending the reductions, it would result in some budget
14 savings that could be used to reduce the amount of
15 reductions in earlier years.

16 Another option that could be implement alongside
17 this change would be to tie future DSH funding to an
18 objective measure of need rather than having the amount of
19 allotments fixed in statute.

20 So, for example, if future DSH funding were tied
21 to the number of uninsured nationally, it would
22 automatically increase or decrease if there are future

1 unexpected changes in the number of uninsured.

2 To help illustrate these options, this graph
3 shows DSH funding during the 10-year budget window
4 considered by the Congressional Budget Office. So remember
5 that without reductions, DSH allotments increase each year
6 with inflation, and that under current law, there's a big
7 reduction between 2020 and 2025, but after that, the
8 reductions return to their higher unreduced amount.
9 Overall, there's \$44 billion in cumulative reductions over
10 this period.

11 So that same amount of reductions could be
12 applied across the full 10-year budget window to minimize
13 some of the effects on providers. In this example, we
14 illustrate a five-year phase-in that evens out to a 31
15 percent reduction in DSH allotments, which is proportionate
16 to the decline of the number of uninsured since 2013, but
17 there are a variety of other options we could model for
18 you, if you'd like.

19 So once the total amount of DSH reductions is
20 set, then there's the question about how to best distribute
21 the reductions among states first.

22 So we illustrate several policy options here.

1 First, we've talked about before the option of applying
2 reductions to unspent DSH funding first. As you'll recall
3 in 2014, about \$1.6 billion in federal DSH funding was
4 unspent, and so if you reduce the unspent funding first,
5 that means fewer reductions for states that are currently
6 spending their full allotment.

7 CHAIR THOMPSON: And, Rob, just to be clear on
8 that, we made that comment in response to CMS's last
9 regulation --

10 MR. NELB: Yes.

11 CHAIR THOMPSON: -- as a recommendation to
12 consider and taking into account any allotment reduction.

13 MR. NELB: Yeah, yeah. Sorry. I should clarify
14 CMS proposed a reduction methodology. We sent in several
15 comments. One of these was to apply reductions to unspent
16 DSH funding first. Another one was about some technical
17 changes to the DSH allotment reduction formula, which is
18 another option we could consider reiterating as a
19 recommendation.

20 So remember that the DSH allotment reduction
21 formula is -- there are two parts. About half of
22 reductions is based on some factors of how well states

1 target their DSH funding to hospitals, and about half of
2 reductions is based on this uninsured percentage factor,
3 the amount of uninsured in the state.

4 And so there are two different options you may
5 want to consider. First, you could modify some of the
6 targeting factors that are in the DSH reduction formula to
7 better align with how the Commission would like states to
8 target their DSH funding.

9 But then, second, a sort of different option
10 would be to just base DSH reductions on the uninsured
11 percentage factor alone, since that may be a better measure
12 of hospital's need for DSH payments rather than the
13 targeting factors, which are really measures of sort of
14 state policy choices.

15 Finally, another option I want to throw out is
16 rebasing DSH allotments based on objective measures of
17 need. You could use some of the different measures that we
18 talked about earlier, such as the number of uninsured or
19 the number of Medicaid and uninsured individuals in a
20 state.

21 In your materials, you have some information
22 about how current allotments compare to some of those

1 factors, and I just want to point out that rebasing could
2 be accomplished in two different ways. First, you could
3 lower allotments for states that are currently above some
4 sort of threshold amount, and second, you could also use
5 the rebasing process as an opportunity to increase
6 allotments for states with historically low DSH allotments
7 that are below some target amount.

8 When you are talking about increasing allotments
9 for states, it's important, though, to remember the fact
10 that not all DSH funding is spent, and so it's unclear
11 whether states would actually spend the additional funding
12 if they received an increased allotment.

13 CHAIR THOMPSON: And the other point, apropos
14 what we just talked about in Louisiana, is that states will
15 take any rebasing or reduction into account when they
16 contemplate what other steps they might want to take with
17 their hospital payment policies.

18 MR. NELB: Yeah. Under interactions here.

19 So, finally, sort of once the total amount of
20 funding and the funding by states, there are also options
21 you could consider about how to better distribute the
22 funding to hospitals within each state. So, as you'll

1 recall, MACPAC previously examined the number of different
2 policy approaches to improve targeting of hospitals within
3 states by raising the minimum eligibility criteria for DSH
4 payments, and we published some of the effects of those
5 different options in our March 2017 report.

6 At the time, the Commission wasn't able to
7 identify a clear improvement over current law in part
8 because of a lack of data, but also because of some
9 concerns about disrupting DSH payments for hospitals that
10 are currently receiving them.

11 As a result, we're proposing sort of a different
12 approach to better target DSH payments, which would be to
13 change the total amount of DSH funding that hospitals are
14 eligible to receive, and this could be done by changing the
15 DSH definition of uncompensated care.

16 I would highlight three options in particular.
17 First is just revising the definition of Medicaid shortfall
18 to account for third-party payments; thus, reversing the
19 effects of the recent court ruling.

20 Second, the Commission could go further and
21 eliminate DSH payments for Medicaid shortfall entirely,
22 which would focus DSH payments on unpaid cost of care for

1 the uninsured.

2 And then, finally, to promote some delivery
3 system reform goals, the DSH definition could be changed to
4 include some of the costs of care outside the hospital
5 setting, such as nonhospital community services and some
6 physician services.

7 So one example of an initiative to change what
8 DSH pays for is California's Global Payment Program, which
9 is authorized under the state's Section 1115 demonstration.
10 This program targets DSH payments to unpaid cost of care
11 for the uninsured, and it limits DSH payments to a few
12 large public health systems that meet the deemed DSH
13 criteria.

14 In California, DSH payments are now distributed
15 as a global payment to incentivize reduced hospital use,
16 and hospitals can use the global payment funds to pay for
17 nonhospital services that DSH doesn't normally pay for.

18 The program has been in place for about two and a
19 half years, and the early interim evaluation results were
20 just published this summer.

21 They show that the health systems are making some
22 positive changes to expand primary care, and they also find

1 that the hospitals report that they're in a better
2 financial position as a result of the Global Payment
3 Program.

4 While it's likely too complicated to require all
5 states to follow California's model, one option the
6 Commission could consider is recommending that CMS provide
7 enhanced technical assistance to states that are interested
8 in following a similar approach.

9 So that concludes my presentation for today. I
10 look forward to your feedback on policy options you're
11 interested in pursuing as well as whether there's some
12 other policy options we should consider.

13 Based on your feedback, we'll further develop
14 these options, and in order to provide recommendations by
15 the spring, we have a goal of voting on specific
16 recommendations no later than the January meeting.

17 Thanks.

18 CHAIR THOMPSON: Thank you, Rob. I'm going to
19 ask Stacey to kick off our questions.

20 VICE CHAIR LAMPKIN: Yeah. Thank you, Rob, very
21 much. This was a really good package, really helpful, and
22 I think the reward for your good work is going to be lots

1 more good work over the next couple of months, to hit this
2 timeline.

3 I do think it's a great opportunity, you know,
4 the conversations that we heard and the desire that we
5 heard, for recommendations on this, and as we've got our
6 feet under us with DSH, after a couple of years now, this
7 is really good opportunity to weigh in, not just on the
8 reduction logic itself but how to achieve some other goals
9 with DSH, either in the short term or in a phased-in,
10 longer term, especially as we are continuing to learn about
11 the potential implications, or avenues for affecting other
12 streams of hospital funding.

13 So with that, my own opinion about the different
14 options that you've shared here, and kind of where I'd like
15 to see some additional exploration and work is really
16 around -- I'm most interested in opportunities to change
17 allocation across states and rationalize that a little bit,
18 and take out some of the historical strangeness that
19 underlies that, and really get in line with our goals of
20 transparency and understanding what you're paying for
21 where, is recognize the uncompensated care element of DSH
22 and really think about Medicaid shortfall differently, and

1 pulling the Medicaid shortfall out, since we know that
2 states have other opportunities to retain those dollars and
3 deploy them as Medicaid payments.

4 I also really like the concept of the service
5 delivery reform aspect of expanding it beyond the hospital-
6 specific services, but I have a question for you about
7 that. Is a waiver and something as complex as what
8 California is doing the only way to achieve that type of
9 expansion or reform, or are there definitional changes
10 around what qualifies as uncompensated care that could
11 potentially achieve some of those same goals?

12 MR. NELB: Yeah. So you could make a
13 definitional change to include some of those costs of care
14 outside of the hospital setting, which would allow all
15 states to sort of pay a little more in DSH than they do
16 now. In order to switch, really, from a cost-based model a
17 global payment model, like California does, you really do
18 need that waiver, because you're getting away from the --
19 current DSH payments are sort of reconciled against the
20 hospital costs, and if you are converting that to a fixed
21 funding stream the waiver is part of it.

22 There could be -- you could put in statute, you

1 know, this option to make it a little easier for states,
2 but I think California also found that there were a lot of
3 state-specific issues as they were implementing it that
4 might make it hard to come up with a uniform definition of,
5 you know, all the different services you want to include
6 and quality metrics and evaluation requirements.

7 VICE CHAIR LAMPKIN: And a definitional solution
8 would lose some of the incentive aspects of a global
9 payment approach, I assume. Okay. Thank you. That was
10 helpful and that makes sense.

11 So having said the things that I just said about
12 the things that I think are the most appealing, I do think
13 that we still have to keep our eye on the disruption
14 effects, you know, for hospitals in the short term, and I
15 would love to see you come back with a little bit more
16 fleshed-out mitigating things for that. So if we were to
17 phase it in over a period of time, kind of what might be
18 some options for how a rebase gets phased in. And even if
19 we have an example of how that affects particular states
20 and the allocation and the amount of time it would take to
21 transition.

22 It's appealing to say maybe your solution 1A is a

1 part of that, that distribute over the longer period of
2 time. Maybe that's worth looking at. And then, finally,
3 kind of -- I'm not sure that I have thought through all of
4 the ramifications of this but I just throw it out there.
5 Is there any kind of match-related mitigating factor,
6 either as a part of a phase-in or otherwise, where the non-
7 federal share of DSH goes away, is phased out, is changed
8 over time to facilitate states adapting to this change?
9 I'm just kind of curious about the group thinking about
10 that a little bit more. Thank you.

11 CHAIR THOMPSON: Great. We've got Alan, Fred,
12 Chuck, Toby.

13 COMMISSIONER WEIL: A question and then I'll try
14 to follow on to Stacy's. Just a technical issue. It's
15 alluded to in the materials. I know, like in tax policy,
16 sometimes they have them phase out the year before the end
17 of the window so that they can have a different baseline.
18 So I'm just trying to think about the unintended
19 consequences of spreading the cut over an extra few years.
20 That leads to a lower final-year level. Like is Congress
21 going to say we can't do that because we need to have a
22 higher baseline for the future?

1 MR. NELB: I mean, so in order to do these DSH
2 delays in the past, the way Congress has done it is to
3 apply larger reductions in the future, to pay for it. So
4 if you do extend the DSH cuts that limits the ability of
5 Congress to use those savings for something else. But this
6 is a different issue.

7 CHAIR THOMPSON: But you're saying Alan doesn't
8 need to jump back up --

9 COMMISSIONER WEIL: Yeah. To me the question is,
10 did they run through the budgeting period or did they stop
11 before the budgeting period ended so that they could have a
12 higher baseline? Have they always run all the way through
13 the budgeting period?

14 MR. NELB: In some bills they have and then in
15 others they didn't. So this past one actually didn't end
16 up extending it for the full 10-year period. But from
17 CBO's perspective it will -- either way, under current law,
18 it will jump up to that higher amount in future years.

19 COMMISSIONER WEIL: I just ask because if we're
20 trying to give guidance I don't want to recommend something
21 that they all go, "No, no, no. We have to end up at this
22 year."

1 MR. NELB: Yeah.

2 COMMISSIONER WEIL: So just -- I actually, just
3 following on Stacey's comments, I completely agree that at
4 this point the focus should be on the state-level
5 allocations, not so much on the inside-state decisions,
6 which, based on the conversations earlier and all the
7 things we've talked about, how states should get those
8 funds are part of a much larger set of considerations. I'm
9 not saying they're not important. I'm not saying we should
10 never get to that. But in this time window, I think that
11 would be hard for us to do.

12 I think it's totally appropriate to begin with
13 the notion that the existing allocations are quirky,
14 inequitable, and that some path towards something that is
15 more rational makes sense. I would just note that it is
16 the Disproportionate Share Hospital program, and so the
17 targeted beneficiaries are supposed to be hospitals. I'm
18 not sure in a world where hospitals are now, what, \$1.2
19 trillion, that they need this, but some clearly do. So I
20 think we have to remember its origins.

21 So from a substantive perspective, just two
22 really minor thoughts of guidance. I hate the term

1 "Medicaid shortfall." I much prefer "private sector
2 overpayment," which I think is a far more accurate
3 description. But I think the guiding principles really do
4 need to be around objective need, setting aside state
5 policy decisions that might play with what that is,
6 particularly around shortfalls and numbers of uninsured.

7 I'll just say, from my perspective the notion of
8 saying because you made this policy decision over here your
9 hospitals are serving a large share of Medicaid patients,
10 and you don't need as much help, I think we don't have the
11 math to support that, although overall levels of
12 uncompensated care we know are affected by the expansion.

13 This is a targeted program, so to me, I'd love to
14 push states more to target the higher -- you know, the
15 higher-need hospitals, but that's probably not where we can
16 go now. Sorry.

17 Just the last spot. I think it's great, the
18 DSRIPs. I think it's great, the California model that
19 you've described. Again, I think at this stage the notion
20 of having sort of a national push for states to figure out
21 how to reallocate towards performance-based, I just
22 wouldn't take it on.

1 CHAIR THOMPSON: And there could be an argument
2 that when you're looking at these kinds of reductions you
3 ought to actually let the states have more maneuvering
4 room, to deal with that and to respond to that, in light of
5 their specific circumstances.

6 Fred.

7 COMMISSIONER CERISE: First, Rob, great piece,
8 and I think the recommendations are really well thought
9 out.

10 On the Medicaid -- I can't help myself -- the
11 Medicaid shortfall definition, I mean, that is a -- I don't
12 know how we got to this point of saying if you got paid
13 more than your costs, that doesn't count and you're
14 eligible to get paid more than your costs. And that does
15 shift a number of hospitals into a category that will get
16 reimbursed higher than their costs and hundreds of millions
17 of dollars floating around right now, I know, in Texas,
18 doing just that. And so I'll probably have to abstain when
19 it's time to vote for that, but I think it's something that
20 needs attention.

21 Also, things like the unspent -- how the DSH cuts
22 are distributed, unspent DSH dollars, that seems to make a

1 lot of sense, you know, starting there, and I don't
2 disagree with the idea that, you know, looking at statewide
3 distribution, using objective measures for that. But that,
4 in and of itself, is going to cause, you know, winners and
5 losers, and it's hard to imagine how we get away from that
6 if we move to some objective needs-based formula there.

7 CHAIR THOMPSON: Even status quo has winners and
8 lowers.

9 COMMISSIONER CERISE: Well --

10 CHAIR THOMPSON: I mean, there's no way to avoid
11 that some people benefit or are disadvantaged by any
12 particular policy option that we would choose.

13 COMMISSIONER CERISE: And I do agree with moving
14 to something more objective rather than what you got in
15 1992.

16 The question, Rob. What's your sense -- let's
17 say, you know, this \$4 billion in cuts happens, and then \$8
18 billion in cuts happens. How much of that are states just
19 going to make up in other supplemental areas, and, you
20 know, are we working on something that's just going to
21 shift over to another supplemental stream?

22 MR. NELB: Yeah. So I think there's definitely

1 an interaction and a portion of the cuts will probably be
2 offset by increases in base rates, like we're seeing in
3 Louisiana, or UPL payments or direct payments. We'll talk
4 more about UPL payments tomorrow. I mean, the UPL data we
5 got from states, states think there's a lot of room to make
6 additional UPL payments, but we're not sure that that data
7 is fully accurate. But the new directed payment option
8 also gives states another mechanism that they could use to
9 increase base rates.

10 So I don't think they can offset the full \$8
11 billion reduction but definitely a big portion of it, and
12 we can do some more math and come back to you, looking by
13 state at sort of whether or not the state would be able to
14 offset the reductions.

15 COMMISSIONER CERISE: And then finally, you know,
16 with DSH and other supplemental payments, as long as, you
17 know, as Medicaid rates are not covering the costs and
18 states are going to try to plug the hole with various
19 supplemental payments instead of addressing base rates and
20 your Medicaid program that way, I do think it's worth
21 thinking about putting some expectations along with that.
22 I know that's a hard thing, because state by state it's

1 just difficult to push that.

2 But I'll keep beating the drum of with
3 supplemental payments you can expect, rather than sort of
4 hospitals just getting paid for after-the-fact costs I
5 incur to my emergency department for people showing up,
6 which is a real cost, but you could press them and say we
7 want to see something more than that, whether you do it
8 yourself or you partner with others, to show us what you're
9 doing to avoid those ED visits and do better care
10 management.

11 CHAIR THOMPSON: I have Chuck, Toby, Sheldon.

12 COMMISSIONER MILLIGAN: Excuse me. I want to
13 align myself with some comments of Stacey, Alan, and Fred.
14 I think addressing the core decision about the shortfall I
15 think would be a good avenue for us to pursue. I do think,
16 Rob, just speaking personally, I think that the longer
17 phase-in makes sense, and my understanding would be that it
18 would need to be within kind of a 10-year CBO kind of
19 window, to avoid cloture and all that kind of stuff. But
20 that seems sensible to me.

21 I do think that it's sensible to pursue something
22 that has cross-state winners and losers. That's more

1 objective. And partly for me it's not simply kind of the
2 fact that DSH is locked in, in some ways based on a lot of
3 state behavior in the early '90s, primarily.

4 But I think the other part of it is this whole
5 DSH cut exercise is really coming out of the ACA. It was
6 premised on a view many had at the time that states would
7 be required to do the Medicare expansion. The Sebelius
8 decision held otherwise. And so if states have discretion
9 about whether to expand Medicaid or not it seems to me that
10 there is a cross-state implication to DSH embedded in the
11 Sebelius decision, based on state discretion to make that
12 choice. And I think the DSH cuts, which came out of the
13 ACA and the Medicaid expansion, ought to follow that same
14 logic. And, to me, if a state made a decision not to do
15 the Medicaid expansion it should -- part of, to me, that
16 state sovereignty element in the Sebelius decision is that
17 their DSH cuts shouldn't be as if they expanded.

18 So that's just my own personal view, that there
19 is embedded in the ACA and the Sebelius decision a view
20 that states should not be punished by their Medicaid
21 expansion decision or not. So that's just my own view
22 about kind of the redistributive aspects of our DSH

1 conversation to come.

2 I don't know how much the UPL can be a substitute
3 for this, and maybe we'll talk about this tomorrow, because
4 UPL, underneath, still is utilization based, at a class of
5 hospitals, not in an individual hospital, whereas DSH has
6 no utilization basis at all. And so I think UPL can only
7 get you so far based on utilization at a hospital class
8 level, but I think that that would be an interesting thing
9 to better understand.

10 And the one last thing I just want to say about,
11 there's been a lot of comment -- and I don't mean to carry
12 on the kind of Alan-and-Chuck throwdown, which I'm
13 enjoying, by the way. But I think if it's a \$1.2 trillion
14 or whatever the figure is, when states go through economic
15 challenges or recessions, hospital rate cuts is the
16 absolute first play in the playbook for a state Medicaid
17 director, because brick-and-mortar providers can't go
18 anyplace and they are dependent on Medicaid. And so brick-
19 and-mortar providers like hospitals tend to be the ones
20 that get the first-rate cuts and the deepest rate cuts
21 because they're not going to move to another state, or
22 they're not going to stop serving Medicaid patients, by and

1 large.

2 And I do think, therefore, that how we deal with
3 hospital financing matters, in terms of just recognizing
4 that there are different provider type altogether, in terms
5 of those other elements of the lifecycle of a Medicaid
6 budget and economy.

7 The last thing I want to say is, in our theory of
8 everything moment about all of this, one of the things that
9 we've taken off the table, and I'm fine, personally, taking
10 it off the table but I want to make explicit about it, in
11 the past we've talked about the Medicaid shortfall also in
12 the context of nonprofit, tax-exempt hospital tax exemption
13 status, and how hospitals, to defend their tax-exempt
14 status, often claim the Medicaid shortfall as an element of
15 their community benefit, that they confer exchange for the
16 avoided taxes. And we had talked about that in previous
17 Commission meetings as part of the hospital financing.
18 We're not talking about that so much anymore. I think it's
19 probably unnecessarily complicating things.

20 But I want to be explicit that hospitals can kind
21 of seek subsidies from public financing in different ways,
22 that might have double-counting elements about the Medicaid

1 shortfall, if part of it is to defend avoidance of taxes
2 for nonprofit taxes in hospitals, if part of it is Medicare
3 cost reports, if part of it is Medicaid DSH. So I just
4 want to flag that, and then I'll top there.

5 CHAIR THOMPSON: Toby and then Sheldon, and then
6 we'll wrap, I think.

7 COMMISSIONER DOUGLAS: So first I agree that we
8 should look at this over a long period of time, in terms of
9 reductions and assessing that, as well as the definition on
10 the shortfall and then thinking through different
11 definitions on need.

12 I think where I would question is aligning first
13 around the state redistributing across different states,
14 partly because of this issue of DSH. When I see DSH I see
15 this part of an overall appropriation of the different
16 funding sources for hospitals. And so I don't know that we
17 need to be doing that, given a state can be filling it in
18 with other types of funding if they're not using DSH. And
19 so maybe it will follow with our conversation on UPL
20 tomorrow, and whether there is a need to look at that.

21 And that gets to my final point, and this kind of
22 aligns with both what Alan was saying and then Fred. You

1 know, I'm still struggling on viewing DSH just in isolation
2 when it's connected to so many of the other different
3 funding sources, and the policies that we've set on this of
4 how do we use the decision on this to get back to the
5 question of how supplementals are flowing through, and are
6 there opportunities here to be policies that are tied to
7 DSH that are related to whether it's movements to DRGs or
8 to how, you know, states and hospitals are not just using
9 the other funds to fill in gaps but are more tied to
10 quality and outcomes.

11 And so I think that we have to view a state as
12 well as hospitals, see all this different funding,
13 including DSH, as just one piece of the overall puzzle.
14 And so from a policy standpoint, how are we setting up the
15 policies around this, to align back to all the other
16 funding sources?

17 CHAIR THOMPSON: All right. We'll do Sheldon and
18 then we'll ask for public comment, and then we'll wrap.

19 COMMISSIONER RETCHIN: So we've been talking
20 about this since I've been on the Commission, and I'm sure
21 it antedated me anyway. But I'm probably going to differ a
22 little bit. I do think that we ought to be looking at some

1 equilibration formula amongst the states over a period of
2 time, but I'm not willing to give up on going into the
3 states, as well.

4 So I'll go back to a couple of things maybe that
5 Stacey started out with, as sort of an out-of-the-box
6 comment, but then we really didn't discuss it. And that is
7 the tie to provider tax, which I think has created a lot of
8 perverse incentives. Moreover, recognizing that the states
9 themselves actually don't make distribution or allocation
10 policies, or many don't. They actually -- which was
11 astonishing to me -- they abdicate this and give it to
12 hospital associations. So the hospitals are making the
13 choices. Well, of course it's going to be peanut butter
14 smoothed out over hospitals. I can't imagine how that ever
15 really got started, other than the political persuasiveness
16 of the hospital associations.

17 I think we ought to weigh in on the whole
18 provider tax and allocation business -- it's just me -- and
19 I will get back to what Fred said in terms of setting
20 expectations. We have hospitals that have double-digit
21 margins that are still recipients of supplemental payments.
22 There are no expectations in terms of comprehensive

1 management or ambulatory sensitive conditions, and this is
2 the opportunity to do it. Maybe it's just the
3 recommendation would have to be soft, but I think after
4 being and seeing this discussion for three years, this
5 isn't new, and I think we ought to be making some pretty
6 hard recommendations. That's me.

7 CHAIR THOMPSON: Were you trying to jump in,
8 Stacey?

9 VICE CHAIR LAMPKIN: Maybe. I was just wondering
10 whether -- I agree with you and I wonder if our challenge
11 is what can we do in the short term, i.e., the next two
12 months, versus what can we do along our longer work plan
13 that we have around hospital payment.

14 COMMISSIONER RETCHIN: I'll disagree. Just that
15 we've said that all along. But that's okay. I think we
16 have to make a commitment and set the stage for it.

17 CHAIR THOMPSON: I agree, and I think there's
18 this balancing where we can directionally make things
19 better, from the standpoint of how to accommodate this
20 budget exercise in a way that's consistent with where we
21 want to see the larger view of hospital payments go, which
22 isn't to say that what we would suggest now is something

1 that solves all of those larger problems. But it's better
2 than what we might have in front of us otherwise. And so I
3 think this might be one of those circumstances where we're
4 saying, okay, how can we make this better without making it
5 necessarily all that we want it to be, while we're also
6 thinking more broadly about a whole set of interconnected
7 issues.

8 Let me just stop and ask for public comment, so
9 that we can take that into consideration as we ask Rob for
10 follow-up work on this subject. Are there any public
11 comments?

12 **### PUBLIC COMMENT**

13 * [No response.]

14 CHAIR THOMPSON: Okay. Rob, it sounds like we
15 have a lot of interest in some of the options that you've
16 played out here. I think the question for you will be,
17 what additional insights or views associated with some of
18 these options can you bring us.

19 I will say I do think that we still have a little
20 bit of sorting to do about -- on something like Medicaid
21 shortfall, are we inclined to say let's not include
22 Medicaid shortfall, or are we inclined to say let's make

1 some changes as to how you calculate Medicaid shortfall,
2 which could include, you know, what's included or not
3 included, as well, third-party payments among others,
4 right?

5 So I think we need to play out some of those
6 options and also see where the Commission might have the
7 most support for different approaches. So I think that
8 level of granularity in the next conversation will help us
9 make some firm decisions about direction.

10 MR. NELB: Sounds good. Yep, and I think at our
11 next meeting, we now do have the new 2014 DSH audit data,
12 so we now have actual Medicaid shortfall data post-
13 expansion, and so we'll be bringing that along with other
14 data that will be part of our annual DSH report, as well,
15 to help inform the conversation.

16 COMMISSIONER RETCHIN: Rob, on that, so the data
17 you have forthcoming would be under the new guidance from
18 case law, or the old?

19 MR. NELB: No. So we still don't know the full
20 effect of that court change, but we're finally starting to
21 get some information about the effect of Medicaid
22 expansion, which, you know, due to that DSH data lag is

1 quite a while ago, but we're finally getting the data now
2 so it's new to us and so we'll add that to the
3 conversation.

4 CHAIR THOMPSON: I think that would be a very
5 helpful addition.

6 All right. Let's take a quick break, 10 minutes,
7 back at 3:00 to continue on with the rest of our afternoon
8 agenda.

9 * [Recess.]

10 CHAIR THOMPSON: I'm going to go ahead and give
11 the one-minute warning to reconvene, so if everyone could
12 wrap up conversations. Thank you.

13 [Pause.]

14 CHAIR THOMPSON: Okay. Kacey, you're kicking us
15 off for the last part of our afternoon conversation on
16 Operational Considerations for Work and Community
17 Engagement Requirements.

18 **#### OPERATIONAL CONSIDERATIONS FOR WORK AND COMMUNITY**
19 **ENGAGEMENT REQUIREMENTS**

20 * MS. BUDERI: Great.

21 So today, we're going to continue our discussion
22 of Medicaid work and community engagement requirements, and

1 previous MACPAC work on this issue has focused on policy
2 design and the effects of similar requirements in other
3 programs. This presentation will build on that work by
4 discussing the operational details states are considering
5 or will need to consider as they implement these policies
6 and what we know so far about the approaches they're
7 taking.

8 So I'm going to start by providing some
9 background information on these policies in Medicaid. I'll
10 talk about the current status of waiver approvals and
11 implementation, and then I'll talk about some of the key
12 operational procedures states have set up or will need to
13 set up. I'll conclude by talking about state monitoring
14 and reporting obligations.

15 So four states were granted Section 1115
16 demonstration authority to implement work and community
17 engagement requirements, and they include Arkansas,
18 Indiana, New Hampshire, and Kentucky, although as I'm sure
19 you're aware, a U.S. district court vacated the Kentucky
20 approval. So that waiver is currently undergoing another
21 review at CMS.

22 Additional states have formally applied for

1 similar waivers. It just became nine this week. Michigan
2 became the ninth to apply, and other states have also
3 expressed interest in doing so.

4 These states and CMS view the requirements as
5 likely to increase employment and participation in job
6 search and training programs among affected populations and
7 earned income among those who leave Medicaid.

8 So these states are at varying stages of
9 implementation. Arkansas is the only state with
10 requirements currently in effect. It began phasing them in
11 by beneficiary renewal date on June 1st for those age 30 to
12 49 with incomes below 100 percent of the federal poverty
13 level.

14 Kentucky planned to begin phasing them in by
15 county on July 1, but as I mentioned, that approval was
16 vacated, so implementation is on hold. Because Kentucky
17 was about two days away from starting these requirements
18 when that ruling came down, they already have a lot of the
19 operational processes set up, and they have left those in
20 place because they are anticipating a new approval at some
21 point.

22 New Hampshire and Indiana are both on track to

1 implement January 1, 2019, though Indiana is planning to
2 gradually phase in the number of hours required to meet the
3 requirements.

4 And because of these implementation timelines, we
5 know a lot more about some states and the approaches
6 they're taking than we do about others. We particularly
7 know more about Arkansas.

8 In addition to knowing more about Arkansas'
9 approach to implementation, we have some initial figures on
10 beneficiary compliance, and I just want to say this slide
11 is different than what the audience has because the August
12 numbers came out at about 4:30 p.m. yesterday, so apologies
13 to the audience. And we will get the new numbers in the
14 slides that go up on our website.

15 So in the first three months, June through
16 August, most enrollees subject to the requirement were
17 deemed exempt by the state, and so they weren't required to
18 report their work or community engagement activities. And
19 these include people with income consistent with working
20 over 40 hours a week, who are exempt from SNAP work
21 requirements, and who have other exemptions the state can
22 identify through administrative data, and you can see here

1 that that number is represented by the green bar. And it's
2 about 15,000 in June, 30,000 in July, and 40,000 in August.

3 Of the remaining people who were required to
4 report, you can see that a very small portion reported
5 meeting the requirements, and this number was 445 in June,
6 844 in July, and 1,218 in August. In all three months,
7 about 70 percent of those people were compliant because
8 they were meeting the SNAP work requirements already.

9 A slightly larger group, which is the dark blue
10 bar, reported an exemption not initially identified by the
11 state, and then the remainder failed to meet the
12 requirements. That's the light blue portion at the top,
13 and it's about 72 percent of people without an initial
14 exemption in June and then a little bit over 80 percent in
15 July and August.

16 CHAIR THOMPSON: So, Kacey, can I stop you on
17 this slide --

18 MS. BUDERI: Yeah.

19 CHAIR THOMPSON: -- and ask a few questions?

20 MS. BUDERI: Sure.

21 CHAIR THOMPSON: So this is rolling?

22 MS. BUDERI: Yeah. So for June, it's the initial

1 group. So I believe that's people who were in that age
2 group, but whose renewal date is between January and March,
3 and then July would include those same people plus the next
4 group.

5 CHAIR THOMPSON: Right. Okay. Just to be clear
6 on that point.

7 MS. BUDERI: Yes.

8 CHAIR THOMPSON: Okay. And do we know -- so in
9 the light blue, in June we've got 7,500 people.

10 MS. BUDERI: Right.

11 CHAIR THOMPSON: We're characterizing as failing
12 to meet requirements. Do I understand that that can be "I
13 don't meet the requirements" or "I didn't report at all"?

14 MS. BUDERI: It's a combination of people who
15 didn't report anything at all, and then there were a
16 handful of people who might have reported working for maybe
17 10 hours, for example, but not meeting the full 20-hour
18 requirement.

19 CHAIR THOMPSON: So do we know how many people
20 just didn't come in and complete the information versus how
21 many people came in and gave the information that said,
22 "Here's what it is, and that causes me not to meet the

1 requirements"?

2 MS. BUDERI: Let me just take a look.

3 CHAIR THOMPSON: I'm just trying to get at
4 whether we have a reporting problem or an engagement
5 problem.

6 MS. BUDERI: Well, so I think the breakdown here
7 shows people who -- I would have to take a closer look at
8 what Arkansas put out.

9 CHAIR THOMPSON: Okay. Sure. Okay.

10 CHAIR THOMPSON: Melanie, you want to jump in?

11 COMMISSIONER BELLA: Yeah, just to clarify that.
12 I found myself asking how many people just didn't sign up
13 for the two systems and then get a piece of paper at a post
14 office address that they may or may not have anymore. So
15 I'd be really curious understanding that.

16 CHAIR THOMPSON: Right, the administrative
17 process. In the larger world, when we've talked about
18 eligibility and enrollment, we all know that as simple and
19 as straightforward as we can make it, we lose people who
20 don't understand what they're supposed to be doing, or life
21 happens and they don't get to it. And they don't
22 understand a lot of issues around that. So I think all of

1 us are concerned, and I would CMS and the states are
2 concerned --

3 CHAIR THOMPSON: -- about those people who simply
4 aren't able to absorb the new requirements, understand how
5 it applies to them, and go through the steps necessary to
6 demonstrate that they actually do meet the requirements, so
7 just that pure administrative process. And that's true
8 anytime you roll out any kind of new requirement on people
9 where you say, "Well, now you have to do this," or "You
10 have to show me this," or "You have to go someplace new,"
11 or "You have to give me a different document." It's a
12 fraught process for both the state side in terms of knowing
13 that they're implementing correctly and for the
14 beneficiary.

15 So I'm just wanting to be sure that we're parsing
16 the issue enough that we understand what's happening with
17 these individuals.

18 MS. BUDERI: Sure. So --

19 COMMISSIONER GORTON: Well, could I just add onto
20 that, Kacey?

21 MS. BUDERI: No, that's okay. I found the
22 numbers, so I can give you the number if you want it.

1 CHAIR THOMPSON: Oh, yes. Okay.

2 MS. BUDERI: Okay.

3 COMMISSIONER GORTON: But I do want to pay
4 attention -- I mean, anytime you mail something to a
5 population of Medicaid recipients, 15 to 25 percent of
6 those bounce back as undeliverable. So we need as third-
7 party reviewers to be posing those questions to the
8 evaluators in the field in terms of "What is this the
9 denominator of? Have you already subtracted the bad
10 addresses?"

11 So I just think that there are technical things
12 since we're early on in the implementation stage that we
13 need to try and get our arms around before we draw
14 conclusions.

15 CHAIR THOMPSON: Yeah.

16 Go ahead.

17 MS. BUDERI: Yes. So for August -- and I can get
18 you the June and July numbers later, but for August, out of
19 those 16,357 people who failed to meet the requirement, 225
20 reported something, and the remainder, which is about
21 16,100, didn't report anything, so the vast majority not
22 reporting anything through the portal.

1 CHAIR THOMPSON: And what is the process by which
2 they're terminated from the program as a result of that?

3 MS. BUDERI: For Arkansas?

4 CHAIR THOMPSON: Yeah.

5 MS. BUDERI: Okay. So in Arkansas, because the
6 portal is linked with the eligibility system, the portal
7 can process that those people were not compliant for that
8 month. So if you have the third month of noncompliance,
9 you would disenrolled, and I'm going to talk about that a
10 little bit later.

11 CHAIR THOMPSON: Okay.

12 MS. BUDERI: I can keep talking about it now.

13 CHAIR THOMPSON: Yeah, I know. We're jumping all
14 over.

15 MS. BUDERI: No, that's okay. I can --

16 CHAIR THOMPSON: Immediately before you get
17 anything.

18 Okay. I think it's just important to recognize
19 that that is a harbinger of something that should be of
20 great concern to people, and we should be looking closely
21 at what's happening with those individuals. Are they not
22 reporting because they know they don't meet the

1 requirements and they -- "There's no point in me, you know,
2 I'm not going to meet the requirements. I don't need to
3 jump through some hoops to tell people I don't meet the
4 requirements"? Do they not understand that they need to
5 provide this reporting?

6 And what process will we use to evaluate where we
7 are with those individuals and what's happening to them.
8 Is there a monitoring effort that tries to follow up with
9 those non-respondents to say let's try to understand what's
10 happening with these people and get a sense about whether
11 our message isn't getting through, whether they need more
12 assistance in meeting the requirements and are feeling
13 hopeless and helpless in terms of being able to demonstrate
14 compliance, or they simply have exited the system
15 voluntarily, effectively?

16 Okay. Keep going, Kacey.

17 MS. BUDERI: Okay, great.

18 Okay. So going to the next slide, after August,
19 the state reported that 4,353 people were out of compliance
20 for all three months, and they were disenrolled. So this
21 represents about 17 percent of all people who are subject
22 to the requirements for all three months, so people who

1 became subject in June the first month or a little bit over
2 40 percent of people who weren't identified as initially
3 exempt by the state.

4 So these individuals could still apply for a
5 good-cause exemption. They can also come back on if they
6 qualify through a different eligibility pathway, but
7 otherwise they won't be able to reenroll until January 1,
8 2019.

9 So turning to how states are implementing the
10 requirements and some of the processes they have set up, in
11 terms of identifying exempt beneficiaries, states have a
12 few different ways of doing this. They can use
13 administrative data to identify some kinds of exemptions,
14 like I said, for people whose income is consistent with
15 working full-time. They've also required to seek data from
16 other sources, including SNAP eligibility databases, to
17 identify people who are exempt from similar requirements in
18 other programs.

19 And then in all four states, beneficiaries who
20 are not initially identified as exempt can submit
21 information to the state if they believe they qualify for
22 an exemption that's new or that the state wouldn't be able

1 to identify.

2 And so for beneficiaries who aren't identified as
3 exempt, states have set up different processes for them to
4 report their work and community engagement activities. In
5 New Hampshire, beneficiaries will be required to report
6 monthly, and they have options for how they can do this.
7 They can do it by phone, by fax, in person, through an
8 online portal.

9 Beneficiaries in Arkansas and Kentucky are
10 required to report monthly through the online portal, and
11 these portals allow beneficiaries to self-attest to their
12 participation in qualifying activities or any new
13 exemptions they have. But there have been concerns about
14 the challenges the portals are posing for beneficiaries.

15 They don't require much manual staff
16 intervention, but they require enhancements to the
17 eligibility system.

18 And then Indiana is going to be reviewing
19 beneficiary compliance for the calendar year every
20 December, and we don't know many additional details about
21 their compliance review process at this point.

22 So in order to enforce the requirements, states

1 need the capability to process what beneficiaries report
2 and what that means for eligibility, and this includes
3 having the capacity to suspend or terminate enrollment, or
4 if a beneficiary comes back into compliance, resume
5 eligibility in a timely manner.

6 They also need to be able to suspend and resume
7 payments to plans, as appropriate. For example, as I
8 mentioned, because the portals in Kentucky are linked with
9 an eligibility system, they can automatically process
10 information that's entered and automatically suspend or
11 resume eligibility and payments to plans.

12 And then another piece here is the ability to
13 receive and process good-cause exemptions, which
14 beneficiaries can request if they experience some kind of
15 hardship to meeting the requirements.

16 And then as with other eligibility determination
17 criteria, states need to ensure minimum beneficiary
18 protections.

19 So in terms of the outreach that states are doing
20 -- and we know from our past work on implementation of
21 similar waiver features, like premiums and healthy behavior
22 incentives, outreach is one of the biggest challenges to

1 successfully engaging with beneficiaries and an ongoing
2 challenge.

3 And some of the activities states are doing are
4 required by CMS, and that includes the timely and adequate
5 notices.

6 And beyond this, the states are also --
7 particularly Kentucky and Arkansas at this point have
8 posted announcements, instructional videos, fact sheets,
9 and the like across different formats, including social
10 media.

11 And then states are also collaborating with their
12 health plans and other organizations to perform outreach
13 functions. For example, Arkansas has a contractor
14 specifically for beneficiary relations.

15 And we also know that states have been engaging
16 with other stakeholders, including through public advisory
17 forums and efforts to work with providers, employers, and
18 nonprofit organizations, both to get their feedback on
19 implementation and to get their help reaching out to
20 beneficiaries.

21 So the last major operational piece I'll talk
22 about has to do with work supports, and I'll note that CMS

1 has specified that no federal funds can be used for this
2 purpose. So this involves coordination with other programs
3 and organizations.

4 One strategy is to make referrals to existing job
5 training and assistance programs, and Arkansas, Kentucky,
6 and Indiana each do this.

7 And to help beneficiaries overcome barriers to
8 meeting the requirements, states have also tried to make
9 available information about how to access other types of
10 supportive resources, which could include housing,
11 transportation, or child care assistance.

12 So those are the major buckets states are
13 thinking about as they implement these requirements, and as
14 with other Section 1115 demonstrations, states will need to
15 submit quarterly and annual monitoring reports describing
16 their progress on implementation, any challenges they're
17 experiencing and the strategies they're using to address
18 those challenges.

19 The reports also need to include information on
20 key metrics, and all the states will need to propose a
21 list. However, CMS did specify some metrics to be included
22 for Arkansas and New Hampshire, which include the number

1 and percentage of individuals who are exempt from the
2 requirements, who were required to report, who were
3 disenrolled or suspended, and who requested and received
4 good-cause exemptions.

5 So for our next steps, we'll continue to monitor
6 implementation in these and any other states that win
7 approval, and we'll track the specific metrics states are
8 reporting on and their performance on those metrics as
9 those reports come out. And we can also publish the
10 information in your materials as an issue brief if you want
11 to get the details out there.

12 So I'll turn it back over.

13 CHAIR THOMPSON: Martha and Toby and Alan.

14 COMMISSIONER CARTER: Thank you, Kacey.

15 Of course, I'm concerned about access to care for
16 Medicaid beneficiaries. I'm also concerned about other
17 parts of the safety net system in terms of what happens
18 when there's an abrupt change. We've talked about states
19 electing not to expand Medicaid, but we're also then
20 looking at states electing to allow, I guess, abrupt
21 disenrollment of large parts of their Medicaid population.
22 So my questions are a couple.

1 One, are the states required to specify what
2 their plans are for providing care for this population?
3 You know, in Arkansas, 4,300 people in the first quarter,
4 so what happens to them? Is there more uncompensated care,
5 other money, other places to handle this care? And then --
6 well, let's start there.

7 MS. BUDERI: So one of the assurances that CMS
8 included in the special terms and conditions of all these
9 waivers is that when people are disenrolled, or they have
10 their eligibility suspended for noncompliance, the state
11 needs to provide them with information about where they can
12 access free to low-cost care, but I haven't heard about
13 anything specific from the states in terms of what their
14 actual plans are.

15 COMMISSIONER CARTER: Right. You would need
16 additional funding someplace else, need additional funding
17 someplace else in order to handle the care for those
18 people.

19 We were just talking about DSH, and I actually
20 thought about bringing this up when we were talking about
21 DSH because if you've got an abrupt increase in
22 uncompensated care, then how does a state manage that, and

1 how do the other safety net providers?

2 CHAIR THOMPSON: Martha, did you have another
3 question that you would --

4 COMMISSIONER CARTER: No.

5 CHAIR THOMPSON: Okay. The microphone spoke.

6 COMMISSIONER CARTER: It was picking up my angst
7 over this.

8 [Laughter.]

9 CHAIR THOMPSON: Okay. Toby, Alan, Melanie,
10 Chuck, Peter.

11 COMMISSIONER DOUGLAS: Great. Thanks for the
12 presentation.

13 Back on the slide on the Arkansas data, if you
14 can go back to that, so -- and this, a question, Kacey, on
15 the terms and conditions. So if I look at that -- so we're
16 talking almost of those that weren't exempt, 90, over 90
17 percent have not -- didn't -- and based on your data,
18 almost 90 percent didn't respond. Nothing of those who
19 needed to comply, is that a fair analysis?

20 MS. BUDERI: I believe the number in June is 72
21 percent and then about a little over 80 in July and August,
22 and those are the people who were not backed out by the

1 state. So those were the people who received notices that
2 told them they would need to report their work activity.

3 COMMISSIONER DOUGLAS: So of the 16,000 plus the
4 1,218, right, that's really the -- so 1,218 out of 17,500
5 or something?

6 MS. BUDERI: And then also the people who
7 reported that they had another -- that they did have an
8 exemption, that the state just wasn't --

9 COMMISSIONER DOUGLAS: Okay. Yeah.

10 MS. BUDERI: And that's the dark blue bar.

11 COMMISSIONER DOUGLAS: I guess the question, the
12 percent is extremely high, and I just wondered in the terms
13 and conditions if there was anything about CMS putting a
14 pause or anything to understand underlying what's going on,
15 why if that was a part of the terms and conditions.

16 MS. BUDERI: I believe CMS can suspend a
17 demonstration at any time, but there's nothing in
18 particular about -- there's nothing in the special terms
19 and conditions about, for example, if there were a high
20 portion of beneficiaries becoming disenrolled, that they
21 would suspend it.

22 COMMISSIONER DOUGLAS: Second question on that,

1 if we looked -- you mentioned about incentive -- other
2 types of healthy incentives or other ones that have tied to
3 participation. If we could look at kind of what the
4 disenrollment rates were for those compared to this, I
5 think it would be good.

6 CHAIR THOMPSON: Although those were not
7 disenrollment, but there was consequences, right?

8 COMMISSIONER DOUGLAS: Yeah.

9 CHAIR THOMPSON: Like how many people reported or
10 --

11 COMMISSIONER DOUGLAS: Or they went from one tier
12 of benefits to another.

13 CHAIR THOMPSON: Yeah.

14 COMMISSIONER DOUGLAS: So maybe seeing, just
15 understanding this.

16 MS. BUDERI: We can look at the states that have
17 disenrollment or lock-out for nonpayment of premiums and
18 see if there was something similar.

19 COMMISSIONER DOUGLAS: Yeah. As well as kind of
20 moving from the Indiana -- there were different benefits.

21 MS. BUDERI: Yes.

22 COMMISSIONER DOUGLAS: Then on outreach, a couple

1 questions on the outreach, again, maybe if you could -- one
2 is how this information is being shared back with the
3 managed care plans, using them to engage, again, before
4 disenrollment. Are they part of the process?

5 MS. BUDERI: Yes. So I believe in each state --
6 so in Arkansas, I'll just say that they have this premium
7 assistance system. So it's actually the exchange plans in
8 Arkansas' case. I think in Kentucky as well as Arkansas
9 and New Hampshire --

10 Indiana, I'm not sure about because I wasn't able
11 to get in touch with them --

12 The managed care plans are playing a role, but I
13 don't believe they have any contractual obligations at this
14 point. They are getting data. The plans are getting data
15 from the state right now in Arkansas about beneficiaries to
16 try and identify the ones who might need extra outreach,
17 and the plans are taking on some of those outreach
18 responsibilities. But I don't believe that the plans in
19 Kentucky or New Hampshire are contractually responsible for
20 anything at this point, other than their own interest in
21 keeping beneficiaries enrolled.

22 COMMISSIONER DOUGLAS: Okay. Then the final

1 question on outreach, again, this is kind of this
2 connection back to supporter services and requirements to
3 link them to job training. Is there anything that's --
4 looking again at -- was there any of this 80 -- 80, 90
5 percent that aren't responding, are they getting linked?
6 Just a way, again, to be able to understand different ways
7 from outreach and noncompliance.

8 MS. BUDERI: So in Arkansas, there's an automatic
9 referral made to the Department of Workforce Services when
10 people are, I think, at eligibility determination or
11 renewal. So, theoretically, they would be getting
12 referred, but they would have to take action to get those
13 services.

14 COMMISSIONER DOUGLAS: So it's not the Department
15 of Workforce that's actually engaging?

16 MS. BUDERI: Well --

17 COMMISSIONER DOUGLAS: They're just getting a
18 referral?

19 CHAIR THOMPSON: What does it mean to be
20 referred?

21 COMMISSIONER DOUGLAS: So that there's no -- I
22 thought the workforce agency would be reaching out.

1 MS. BUDERI: They have that contact information,
2 so they might be reaching out, but they can't force the
3 beneficiary to participate in their training programs.

4 COMMISSIONER DOUGLAS: Yeah. I just meant more
5 again to understand, to peel a little deeper, to understand
6 why no one -- why we're having such a high rate there.

7 CHAIR THOMPSON: I agree, and I think both from
8 the standpoint of did the plans have the information, are
9 they making contact, what is that contact telling them; and
10 other state agencies, if they are reaching out, what is
11 that contact telling them? So, again, are people in
12 situations where they're just not responding to a lot of
13 outreach and information, or is something else going on?

14 Alan.

15 COMMISSIONER WEIL: This is very important
16 information.

17 My sense is that these waivers were granted on
18 the belief that they would yield an increase in work, and
19 clearly, it takes time to determine the validity of that
20 hypothesis.

21 But I'm not really comfortable with us just
22 offering some sort of a retrospective reporting on how many

1 people lose coverage. It does seem to me, even on the
2 basis of this pretty preliminary information, that as of
3 now, we don't have any evidence of increased engagement in
4 work-related activities, much less work, and we have
5 significant evidence of a large number of people losing
6 coverage. And it feels to me, as MACPAC, we have an
7 obligation to state that rapid implementation of large-
8 scale change of this nature across multiple states is a
9 really risky proposition.

10 And I'm sitting next to someone who heard that
11 message with respect to the duals, and there was a very
12 significant response and a scaling back of the original
13 plans based on concerns about the potential harm to
14 enrollees.

15 I don't want to wait for us to see that happen.
16 I don't think we have to get in the way of answering the --
17 or I don't think we have to presuppose the answer to the
18 hypothesis, but I do think the pace of rolling out of this
19 kind of policy, we have a very strong early warning signal
20 that should not be ignored.

21 CHAIR THOMPSON: Melanie, Chuck, Peter.

22 COMMISSIONER BELLA: Yeah. I just have a

1 question. It's sort of along where Alan was going. What
2 are the kind of data collection mechanisms, and is there
3 something or someone other than the state who wants this
4 policy doing anything collection-wise or evaluation-wise?
5 And how can we make that more real-time? Because it's not
6 going to do us any -- even if we had a really nice
7 academically rigorous evaluation, it's not going to do us
8 any good three or five years from now.

9 So to Alan's point, Medicaid has a history of
10 needing to have like early warning systems and checking
11 these sorts of things. Is there anything in place for
12 that?

13 MS. BUDERI: I think the data that's going to be
14 coming out that's in real-time is going to be from the
15 state.

16 I mean, Arkansas isn't required by its STCs to be
17 releasing these monthly reports. They're being
18 transparent. They're required to do quarterly monitoring
19 reports and report those to CMS, but they haven't submitted
20 one yet that is for the period where the work requirements
21 were in effect.

22 In terms of an outside -- you know, they also

1 have to have independent evaluations, but like you said,
2 those wouldn't be until three or five -- a few years down
3 the line.

4 CHAIR THOMPSON: Okay. I have Chuck, Peter, then
5 Kit.

6 COMMISSIONER MILLIGAN: Thanks for the
7 presentation, Kacey.

8 I had been following pretty closely the Kentucky
9 litigation. There was not litigation in any of these other
10 states?

11 MS. BUDERI: I believe there's a similar case
12 that was brought on behalf of beneficiaries in Arkansas,
13 and it's going to be with the same judge that ruled on the
14 Kentucky case. But that's still pending.

15 COMMISSIONER MILLIGAN: So there's no decision in
16 that process. The waiver started, and it's sort of working
17 its way through the court process. Is that the status?

18 MS. BUDERI: The Arkansas waiver?

19 COMMISSIONER MILLIGAN: Yes.

20 MS. BUDERI: Yeah. It's in process.

21 COMMISSIONER MILLIGAN: Okay. I just wasn't sure
22 if there was litigation in the other states as well.

1 MS. BUDERI: I don't believe so.

2 COMMISSIONER MILLIGAN: I think I know the answer
3 to this question, but for the people who are disenrolled,
4 the 4,300 or so, do we know anything about their health
5 status, their particular diagnostic or other situation?
6 I'm thinking partly, Kacey, from an actuarial point of
7 view, if the folks getting disenrolled are very different
8 from the people staying. There's that kind of element in
9 terms of the managed care piece of it, but I'm also
10 wondering whether it's associated with behavioral health
11 issues, homelessness issues in terms of just getting the
12 mail. Do we know anything about the characteristics of
13 those 4,300 people?

14 MS. BUDERI: I don't know anything about their
15 characteristics in terms of numbers. I can say there's
16 been media reports about some of the concerns with homeless
17 people in Arkansas not getting the letter in the mail that
18 has the reference number that you need to report these
19 activities, but in terms of health status, I haven't seen
20 anything.

21 COMMISSIONER MILLIGAN: And I guess the last
22 comment I'll make is I'm sensitive to -- I don't mean to

1 keep playing this game, Alan -- the comment about the rapid
2 kind of implications of this. But I am aware that a lot of
3 the states maybe would not have done the Medicaid expansion
4 but for having this kind of program around it.

5 And, Martha, to your comment earlier, I want to
6 articulate that I think the context of a state choosing not
7 to expand versus a state choosing to expand, but doing it
8 in this manner, creates some interesting implications for
9 our role as a commission about how to weigh in because
10 there are a lot of people in states that aren't doing this
11 kind of model and chose not to do the Medicaid expansion
12 that have higher rates of uninsured, higher burden on
13 safety net providers.

14 And I just think that we need to be sensitive
15 that in a lot of these states, the alternative might have
16 been no expansion at all.

17 I do think one of the important takeaways from
18 what you've learned and what Arkansas has published,
19 though, is in some ways this puts to bed the implication
20 that the majority of these people aren't working, aren't
21 engaged in workforce, aren't engaged in activities, because
22 we're seeing a lot of folks getting exemptions for doing

1 that very thing.

2 Thank you.

3 CHAIR THOMPSON: Peter and then Kit and then
4 Toby.

5 COMMISSIONER SZILAGYI: Yeah. I could almost
6 pass because I had about six points, but everybody made
7 them. And it was mostly about trying to find the truth
8 about how many people are actually working or how many
9 people got notifications, or what exactly was the job
10 training.

11 The past experience with work requirements in
12 other programs, there was a big variability in job
13 training, and the programs -- or job referrals, and here,
14 it sounds like it's some kind of an automatic referral.

15 My understanding of the evidence is that the
16 programs that had intensive and somewhat expensive job
17 training did achieve increased work, which was one of the
18 goals, and it's certainly one of the goals of these
19 programs. But I'm unclear about exactly what Arkansas is
20 doing.

21 So maybe my only new question in addition to
22 maybe a little bit of a comment, if I needed to report

1 every month about my work, I'm positive I would be
2 uninsured because I would just forget, but that's a
3 comment.

4 The question is, if we modeled ahead to
5 September, October, and November, do we know how much the -
6 - what's the denominator? How much is this going to go up?
7 Do we know?

8 MS. BUDERI: I think the total number of
9 beneficiaries who are going to be subject to the
10 requirement is about 170,000, and that's in the first
11 group. So that's the people who are age 19 to 49. I think
12 it would be most of them would be backed out ahead of time.

13 I mean, I can't model ahead to see how many
14 people would continue to be disenrolled, but I think the
15 number is about 70,000 over the whole year who would be
16 having to report something.

17 I know that wasn't very clear, so sorry about
18 that.

19 CHAIR THOMPSON: I'm going to go to Kit, and then
20 I'm going to try a little bit of a wrap-up and then get
21 some reaction to that.

22 COMMISSIONER GORTON: I want to align myself with

1 Chuck in terms of this was the price of the ticket to the
2 dance in these states, and I think we need to be very
3 careful about criticizing their decisions that were made,
4 clearly by people who were informed by their contexts.
5 And, in general, I think that we should be open. If the
6 states are going to be laboratories, then the states need
7 to get to try stuff that maybe some of us are not
8 comfortable with.

9 But, with that said, I want to align myself with
10 Alan and say I hope these data scare the pants off the
11 people in Arkansas because, if you're running as program,
12 this is not very good. Any of us who have ever tried
13 massive outreach to a Medicaid population -- in this case,
14 this may be people -- since they're using a premium support
15 model and what we're focusing on is adults, these are
16 people who may have two and three part-time jobs who are
17 all over the place, who may not know where the nearest
18 public library is that they can use a computer on, let
19 alone may not be able to get to the nearest public library
20 during the hours that the library is open because they're
21 working two and three jobs, and they didn't get the mail
22 anyway because that address was bad.

1 I think the plans will be madly trying to find
2 these people because they will want to keep them in. They
3 don't need to be required to do it; they will want to do
4 it.

5 My experience certainly in Massachusetts and in
6 Virginia is that the state will be unable to provide them
7 with the information they need to actually do that
8 outreach, and so what happens then is people get
9 disenrolled. And then, retroactively, they get reenrolled,
10 but in the meantime, they miss necessary care or we
11 generate uncompensated care. And you create an access and
12 retrospective payment nightmare.

13 So I'm inclined to -- and maybe this meeting is
14 sufficient. I'm inclined to just simply align myself with
15 Alan and say the Commission has raised its eyebrows at
16 these -- they are very preliminary, but they're scary
17 preliminary. And we should pay attention to that. People
18 should be looking closely. Maybe they don't want to report
19 on all of these things on a monthly basis in Arkansas,
20 because if I was the operational manager responsible for
21 that in Arkansas, I would hate to have to report on all of
22 these things, and you wouldn't have data streams. And the

1 plans would hate it too.

2 But somebody should be paying attention to this,
3 and there ought to be a war room in place just looking at
4 whether or not people are being negatively impacted by this
5 policy who shouldn't be negatively impacted by the policy.

6 CHAIR THOMPSON: Yeah, go ahead, Toby.

7 COMMISSIONER DOUGLAS: I actually -- and the more
8 I think about this and from experience on the other side,
9 when we did enrollments, when things were going wrong,
10 there were times where CMS came in and put the pause button
11 on. Our role at MACPAC is not just to advise Congress, but
12 the Secretary and the states. Looking at these numbers and
13 without -- unless Kacey can go back and figure out all
14 these questions and answer it, I think the recommendations
15 right now should be putting the pause button on Arkansas
16 until -- not stopping the work requirements, not taking
17 judgments on whether it's good or bad, but understanding
18 what's going on in the state and why people are not
19 responding before they continue to disenroll people.

20 CHAIR THOMPSON: I'm trying to wrap up, so let me
21 try to wrap up and see if I can get this. And we really
22 need to get the public in, right, So we can get some

1 commentary from them as well?

2 So here's my concern about coming up now on the
3 basis of this information, which I find very concerning. I
4 find the numbers to be very worrisome, and I think we've
5 identified a number of different questions that we have
6 about what these numbers represent. One is that I am
7 concerned about whether or not we simply don't have -- that
8 there is an explanation, there is information about
9 additional follow-up from the plans, there is information
10 about what people have gotten or not gotten, there is some
11 kind of monitoring effort that gives us some better sense
12 about what's happening with these individuals, or there
13 isn't. So that makes a difference, right, as to whether or
14 not we have all the information or we don't have the
15 information?

16 We're not the regulatory agency, as CMS would be.
17 Presumably, CMS should be taking a look at this and perhaps
18 considering whether it needs to take additional action or
19 not.

20 I don't know to what extent this is about the
21 fact that if people are not in circumstances where they can
22 meet the requirements, that they haven't been given

1 adequate time to engage in job training or the other
2 connections that are necessary in order for them to meet
3 the requirement, whether this is about the fact that there
4 is only an online portal available for people during
5 certain limited hours, and therefore, that's the problem
6 because they can't get there.

7 So I think we have a number of questions about
8 what's happening, and I would feel better if we could get
9 some additional answers to those questions before deciding
10 whether we're in a position to say we believe we have
11 enough insight based on what we know about what's happening
12 to suggest that there needs to be some additional follow-up
13 with beneficiaries, there needs to be some additional time
14 given to beneficiaries to comply, there needs to be some
15 other steps taken with respect to the waiver as a whole.

16

17 So my suggestion is that we give Kacey the
18 opportunity to go back and collect some of the information
19 in response to the questions that we've raised, so that we
20 can have a better understanding about whether we have
21 sufficient concerns, to be wanting to write letters or
22 suggest a different course of action with respect to the

1 waiver.

2 So, Martha, do you want to tell me if --

3 COMMISSIONER CARTER: I did, and I think those
4 are good questions.

5 I'd like to add one, and that was I would assume
6 that Arkansas did make an estimate about how many people
7 would not meet the requirements and fail to report. So is
8 this a surprise? Are the numbers that they have out of
9 their first quarter -- I think the requirement was that
10 people had to report for -- they couldn't miss three
11 quarters, and I don't think that they were consecutive
12 quarters, but I could -- I mean months. I'm sorry. They
13 had to report three months, and since there have only been
14 three months, we don't know.

15 But was this a surprise? What was their
16 projection about the number of people who would lose
17 coverage, and how did that compare?

18 MS. BUDERI: I think the projections that
19 Arkansas made in its waiver application, when Arkansas
20 initially applied for this waiver, it was also talking
21 about rolling back eligibility to 100 percent of the
22 federal poverty level, so most of the coverage loss

1 estimates include that proposal as well. And it's hard to
2 separate out the coverage losses estimated for people
3 because of the work requirement itself.

4 CHAIR THOMPSON: And then, Kacey, the only other
5 thing that I would want to add to this mix is these
6 requirements under the waivers are conditions of
7 eligibility, and there are rules about how eligibility
8 processes work and how you audit eligibility processes and
9 how you test eligibility processes; for example, that there
10 are multiple channels for beneficiaries to come in and
11 submit information related to eligibility. So I don't know
12 if some of those were waived as part of the waiver to allow
13 only an online process or not.

14 MS. BUDERI: The multiple means of submission
15 requirement was waived for Arkansas only.

16 CHAIR THOMPSON: So I'd like to think about
17 whether or not there's some lessons learned there or some
18 activities there that we should be thinking about where --
19 a lot of the standards have been developed over time as
20 people understand how to retain people in coverage and
21 avoid some of the losses that are associated with confusion
22 or process, and so if some of those particular requirements

1 are not being maintained under this waiver, how are they
2 being monitored? Are there opportunities to change some of
3 those STCs in light of some of these early findings and
4 with respect to ongoing monitoring?

5 Alan, did you want to say something?

6 COMMISSIONER WEIL: I know you want to get the
7 public comment in.

8 I will just say I appreciate that there are
9 questions we can't answer, and I very much appreciate the
10 notion that we are certainly on a position to say the work
11 requirement concept is fatally flawed, no suggestion
12 anywhere like that.

13 I am concerned about people's real lives and the
14 meeting cycle of a group like us, which is periodic.
15 Thankfully, we're in fall, so it's not as long a gap as it
16 would be.

17 I think my only feedback would be to you as
18 Chair. I would hope that we could come in next month with
19 some willingness to not just ask questions, but to say
20 something, because I think waiting longer than that -- I'm
21 uncomfortable waiting that long. I understand the reason
22 to, and I understand this is all fresh, but I would not

1 want us to just keep saying, "Oh. Well, now we have the
2 answers to these three questions, but we have six more."

3 CHAIR THOMPSON: I completely agree, and it's my
4 sense from the Commissioners that as a group, we have a
5 serious level of concerns with the information that we're
6 seeing. I think we just need to make sure that we're
7 following up on some of the lines of inquiry that we've
8 identified here, and I agree completely that in addition to
9 having those responses that we should be prepared at the
10 next meeting, should those responses indicate that our
11 concerns continue rather than are ameliorated or mitigated
12 by the answers, that we have an opportunity then to
13 consider some communication to the agency around these
14 issues in terms of what our suggestions are for next steps.

15 Okay. So let's open it up to public comment.

16 I just can't generate any kind of public comment.

17 Andy. Andy, will you mosey over to the
18 microphone?

19 We will ask you to use the microphone for
20 recording purposes.

21 **### PUBLIC COMMENT**

22 * MS. COWEY: I'm just curious if MACPAC has a role

1 in commenting on these waivers beyond just their
2 operationalization and more in terms of whether they align
3 with underlying statutory purpose of Medicaid.

4 CHAIR THOMPSON: And just again for purposes of
5 recording, can you just identify yourself and your
6 organization? Sorry.

7 MS. COWEY: Apologies. My name is Taylor Cowey.
8 I'm with Wynne Health Group.

9 CHAIR THOMPSON: Thank you.
10 I think that the Commission feels that it could,
11 if it wanted to, comment on whether it thinks a particular
12 kind of an approach to the program is a good or a bad idea.
13 I think as we've talked about some of these questions, it
14 gets caught up into a question of Secretarial discretion as
15 well as what deserves evaluation as well as how solid is a
16 hypothesis and does it deserve to be tested. So I think it
17 was the sense of the Commission that we would be watchful
18 on these waivers and continue to monitor events and I think
19 particularly focus on some of these issues around operation
20 and organization.

21 MS. PIFER: Hi. I am Rebecca Pifer, Healthcare
22 Dive.

1 I was just wondering if the Commission has taken
2 the results of the JAMA studies that were published just a
3 couple days ago around work requirements and their
4 scalability to a national model. I was just wondering if
5 you all had seen those and if you're going to take those
6 results into account when you're deliberating around the
7 program.

8 CHAIR THOMPSON: Kacey, do you want to respond to
9 that?

10 MS. BUDERI: Yeah. So two things came out in
11 JAMA this week. One of them was looking at the number of
12 beneficiaries who would meet the requirements -- excuse me
13 -- who are subject to the requirements -- in other words,
14 don't have an exemption -- and then of those, who would be
15 failing to meet the requirements, so people who weren't
16 exempt but wouldn't be working for the required number of
17 hours.

18 And then the other one, I believe, was looking at
19 nationally the portion of beneficiaries who would be
20 subject to and not meeting the requirements and then the
21 portion of Medicaid spending.

22 And I can send you more details on those, if

1 you'd like, but --

2 CHAIR THOMPSON: So I think --

3 MS. BUDERI: -- I can send you the articles too.

4 CHAIR THOMPSON: I think the commenter is
5 suggesting that we ought to take a look at that in the
6 context of what does that mean for the program, for the
7 objectives of these waivers, how does that relate to
8 potentially giving us some insight into some of the
9 dynamics that we're seeing here and the operational
10 contract that we're talking about. So perhaps that's just
11 something, Kacey, you can take a look at and decide how to
12 -- I think circulating the information is very helpful to
13 the Commissioners, but I think maybe looking at that and
14 seeing if that provides any additional thought or for
15 additional conversation among the Commission.

16 Chuck.

17 COMMISSIONER MILLIGAN: I'd love to see the
18 articles.

19 And going back to the first commenter about the
20 statutory purpose of Medicaid too, if there was a way to do
21 a synopsis of the Kentucky decision -- because I think a
22 lot of what the Kentucky decision in the litigation is

1 raising is whether the Secretary in fact has the discretion
2 to approve a waiver that would condition Medicaid
3 eligibility on work requirements and whether that's within
4 the Secretary's discretion statutorily.

5 So I think, Kacey, if you're going to be sending
6 more stuff our way ahead of the next meeting, if there was
7 a good synopsis of the Kentucky decision, I think that
8 would be helpful context for this.

9 CHAIR THOMPSON: Yep. I agree.

10 MS. COWEY: Taylor Cowey with the Wynne Health
11 Group again.

12 Just on sort of a related point, I think earlier
13 you were talking about this being implemented in expansion
14 states. Are you planning at all to look at the states who
15 are considering this where they have not expanded? I
16 believe Missouri may be considering. It's nothing that I
17 believe has been submitted to CMS yet, but --

18 MS. BUDERI: I can bring you summaries of the
19 states that have requested these work requirements that
20 aren't expansion states. I can bring you summaries of
21 those waivers. I don't know what would be the most helpful
22 for you in terms of the non-expansion waivers.

1 EXECUTIVE DIRECTOR SCHWARTZ: But I think the
2 point is that Kacey knows as much about this as almost
3 anybody who is not actually working in one of the states or
4 doing the approvals at CMS.

5 Yes. Presumably, if one of those got approved,
6 that would be information we would share with you.

7 I may get myself in trouble, not being a lawyer
8 on the Kentucky case, but it's my understanding that the
9 decision in the Kentucky case was not based on whether the
10 Secretary had discretion to do the waiver, which would
11 have, I think, probably been the plaintiff's preferred
12 result, but that it didn't further the objectives of
13 providing medical assistance.

14 So we'll have to wait and see what happens with
15 CMS, and then also now that a case is going to proceed in
16 Arkansas, we'll see in that as well.

17 I also just want to make sure we underline one
18 more thing before we leave. That both Arkansas -- well,
19 actually, all four of these states are states that had
20 previously expanded. So their decision to expand initially
21 was not predicated on having a work requirement. We now
22 have another group of states that face a very different

1 scenario: Virginia, North Carolina, maybe some of the
2 others.

3 COMMISSIONER BELLA: As one of two new people,
4 just as a point of process, I mean, there's a difference in
5 getting information with like a letter from MACPAC that
6 says we want to know these 10 things versus saying, "Kacey,
7 go make calls, and go sort of dig around." Which one are
8 we going?

9 CHAIR THOMPSON: The second.

10 COMMISSIONER BELLA: Oh.

11 CHAIR THOMPSON: So Kacey is going to go, taking
12 in all of the questions that the Commissioners have had in
13 response to the data that we're seeing here, digging into
14 that, is going to come back at the next meeting, "Here's
15 what we now know. Here's what we now understand," we've
16 checked with, we've looked at, we've examined, we've
17 conversed with, and give us some additional insight.

18 At that point, the question will be for the
19 Commission whether those answers allay our concerns, don't
20 allay our concerns, raise new concerns, and at that point,
21 we're back to -- which we've done before -- then a question
22 of do we write a letter to the agency, to the Secretary

1 expressing the concerns about the state of the waiver, how
2 it's being operated, and the potential impact on
3 beneficiaries' access to care. And if that's the case,
4 then Kacey will have that piece available for us to
5 consider based on those answers.

6 So we'll sort of be -- and we'll probably do it
7 over two days. We'll probably have a Thursday conversation
8 about here is what we found that will elicit some
9 Commissioner conversation and response, "Yes, that then
10 we're not ready to send a letter," or "That's a different
11 situation than we thought," or "No, we're ready to send a
12 letter and express concern," in which case we'll probably
13 come back the following Friday, that next Friday, to look
14 at a letter and vote on it in terms of sending it over to
15 the agency.

16 COMMISSIONER BELLA: Just a question. Why would
17 we not just send a note saying we want answers to these
18 things, we're going to be exploring these things? Do we
19 not do that?

20 CHAIR THOMPSON: We may send a formal request for
21 information, or we may just reach out to the people that we
22 work with on a regular basis to get the answer.

1 For the most part, the staff work with CMS and
2 the states in a very collegial fashion, and generally, that
3 additional process is not necessary in order for us to
4 collect the information that we need.

5 EXECUTIVE DIRECTOR SCHWARTZ: I can't think of
6 one instance in which we have actually sent that formal
7 kind of letter seeking information.

8 Kacey has reached out to all four of these states
9 in advance, had conversations with a number of them, and
10 that is always the better path.

11 CHAIR THOMPSON: Okay.

12 MS. McDONALD: Ruth McDonald with Avalere Health.

13 There are a couple of things. Arkansas actually
14 did open up a phone reporting line at some point, but it
15 was, I think, sometime in August. And then, of course,
16 getting the information out that the phone line had opened
17 is another challenge of how are you communicating that with
18 folks.

19 I think the other piece is I'm not sure why CMS
20 decided to waive the multiple reporting requirement for
21 Arkansas in particular. I don't know how it measures
22 against some of the other states, but I think the internet

1 connectivity in Arkansas, compared to some of those other
2 states in particular, but looking at it alone and then
3 especially with this population, did the state actually do
4 any work to try to measure how many folks in Medicaid had
5 internet connectivity in Arkansas? And regardless of the
6 Medicaid population, how many people in Arkansas have
7 internet connectivity? And a lot of folks also have
8 temporary phones, that kind of thing.

9 The other comment I just want to have is -- I
10 don't know. Has Arkansas put out explicit data about --
11 the number of folks meeting the work requirements, I think
12 are below a thousand. So if you have -- I don't know how
13 that aggregates up for each month, but if you have those
14 number -- you know, if you're dropping more people than you
15 are helping with the -- a thousand, you know, who -- or
16 less than that who have gained employment, I don't know if
17 anyone has any comment on that or if there's sort of any
18 precedent in sort of a new policy that may help a quarter
19 of Medicaid beneficiaries, but may actually hurt coverage
20 for another three-quarters.

21 CHAIR THOMPSON: Well, and that's the -- I mean,
22 states have always had the opportunity to refer people for

1 supportive services in order to do job search and other
2 kinds of activities that can help achieve employment, and
3 so the theory of this, right, is that the additional
4 incentive on the part of the Medicaid program to make a
5 requirement that this is condition of coverage solicits
6 more traffic, right, over -- and I think that's the
7 proposition that the evaluation is intended to measure.

8 I think part of the process here is can we get
9 people into a process where that's what they're doing, is
10 seeking those new kinds of opportunities and engagement.

11 So, here, I think your point about internet
12 connectivity -- Kacey, you've made this in your background
13 material about what we might be looking at there, and that
14 is also part off, again, the eligibility processes and
15 systems using user-centered design to understand the
16 profile of the users that will have to come into contact
17 with the system and how much of that was done here in order
18 to understand people's circumstances and what would make it
19 easier for them to submit reports and comply and how that
20 fits within things that they might otherwise be doing. I'd
21 be curious to know how much of that was taken into
22 consideration.

1 Then, again, there's the issue of timing where
2 people may not meet requirements today, but may need help
3 to get into education, get into an employment arrangement,
4 and are we giving them adequate time to engage the state
5 resources that are being identified for them to do that?
6 That may be another issue here, which I think we had
7 Commissioners asking that question about how many people
8 are over there on the other agency side now linked up
9 looking for employment, and has there been an increase in
10 volume over on that side of the question?

11 MR. WEINSTEIN: Dan Weinstein from NHeLP.

12 I'd just like to ask you all if you have the
13 spare time to read the court decision. It's a good read.

14 And I have a question regarding tracking of the
15 cost of care for the population that is disenrolled. Is
16 there anything being done regarding monitoring of that
17 population, seeing how that impacts the larger state
18 Medicaid expenditures?

19 CHAIR THOMPSON: And that goes back to, Martha,
20 your question: Are those people ending up in the DSH
21 formula?

22 COMMISSIONER CARTER: Where are they ending up,

1 and who is paying for them?

2 MS. BUDERI: I think that's something we can look
3 at as we see the monitoring reports, when they come out,
4 and then when we see the evaluation design plans, we can
5 look for things like that.

6 CHAIR THOMPSON: Do you have a sense about
7 whether the monitoring plans -- have we looked at the
8 monitoring plans?

9 MS. BUDERI: So only one state's monitoring plan
10 is available right now, and that's Arkansas. And I don't
11 believe it's tracking the cost of care for people who are
12 disenrolled for noncompliance.

13 CHAIR THOMPSON: So I think that's something,
14 again, that -- I guess the question would be, Does Arkansas
15 not have that in its monitoring plan because it considers
16 that to be part of what could be a formal evaluation down
17 the line, a distinction that they're making between kind of
18 monitoring for the objectives of the waiver specifically as
19 opposed to the longer term or other impacts of the waiver?

20 But it would be helpful to understand what people
21 think they're looking at now versus looking at later and
22 making sure that we have an opportunity to weight into

1 that.

2 Okay. Let's wrap up this part of our
3 conversation.

4 Kacey, thank you very much. We appreciate the
5 work that you're doing and continuing to do on this
6 subject.

7 We're going to turn our attention now to high-
8 cost drugs.

9 [Pause.]

10 CHAIR THOMPSON: So Chris, Rick, we're going to
11 be sure to give this the proper amount of attention. We're
12 running a little bit behind time so our plan will be to
13 power through, in a saying, and give you your full 45
14 minutes for this session, so that we're giving it adequate
15 attention.

16 **#### MEDICAID COVERAGE OF NEW AND HIGH-COST DRUGS**

17 * MR. VAN BUREN: Thank you, and I will try to
18 speak quickly.

19 So good afternoon. This is the -- this session
20 is going to focus on prescription drugs. It continues the
21 Commission's work in this area. Last cycle, as you will
22 recall, the Commission made technical -- recommended

1 technical changes to the rebate program. This cycle we
2 will be looking more broadly at issues related to the
3 coverage of complex, high-cost drugs. Specifically, today
4 we'll be looking at challenges states face in covering new
5 drugs, accelerated approval drugs, high-cost drugs. We'll
6 talk about some issues surrounding the rebate cap, and then
7 discuss some of our upcoming work in this issue.

8 First up, we are going to talk about covering new
9 drugs, and just to level-set, recall at the grand bargain
10 of the Medicaid Drug Rebate Program is that states get
11 rebates from drug manufacturers for the drugs they pay for.
12 In exchange, states have to cover essentially all of
13 participating manufacturers' covered outpatient drugs as
14 soon as they approved by the FDA.

15 The state Pharmacy and Therapeutics committees,
16 or the P&T committees are responsible, generally, for
17 putting drugs on the formulary, which under Medicaid is
18 called the preferred drug list or PDL. State P&T
19 committees will review evidence to determine coverage
20 criteria. They will look at the label, they will look at
21 the studies that were used to approve the drug, and then
22 they'll compare the drug's relative safety, relative

1 effectiveness, and finally cost to other therapies in the
2 class.

3 This is relatively easy for some drugs, for new
4 statins or drugs that states are used to seeing, if it's
5 not particularly complicated. For other drugs,
6 particularly first-in-class or complex therapies, this can
7 be a pretty time- and labor-intensive process.

8 You will recall that at the December meeting you
9 heard from Renee Williams from the Tennessee Medicaid
10 Program, who talked about some of the challenges that the
11 state faces in establishing coverage criteria, figuring out
12 prior authorization, and utilization management for these
13 drugs. I also note that CMS does not actively monitor
14 states to ensure they are complying with the coverage
15 requirement, and there have been some instances of states
16 taking substantial time to develop this coverage criteria.

17 Medicaid is unique among federal payers in the
18 requirement that it cover new drugs as soon as they are
19 approved by the FDA. For Medicare Part D, plans have to
20 make a reasonable effort to review new drugs within 90 days
21 and make a coverage -- a formulary determination within 180
22 days. If a drug is one of the six protected classes, where

1 Part D plans are required to include substantially all of
2 the drugs on the formulary, plans have 90 days to make a
3 decision. After that, the drug is added to the formulary.
4 Qualified health plans offered on the exchanges follow the
5 Part D rules for non-protected class drugs, so they have 90
6 days to review and 180 days to put on the formulary.

7 One of the options in this space that could ease
8 the strain on state Medicaid programs would be to allow for
9 a formal grace period before coverage is required. This
10 could align with the Part D QHP model of 90 days and 180
11 days, or with the accelerated Part D protected class
12 standard. One benefit of the grace period would be it
13 would give states time to review the drug and the FDA
14 approval documents to make clinically informed coverage
15 decisions. Note that this policy could be combined with a
16 policy comparable to the Part D protected class standard
17 that could require, after the grace period, the drug is
18 mandated to be placed on the PDL, and that might ensure
19 that states use the grace period to develop clinical
20 coverage criteria.

21 A few things to keep in mind about this policy.
22 Access would likely be limited during the grace period. We

1 expect manufacturers would be opposed to this, given kind
2 of the overall structure of the drug rebate grand bargain.
3 And it is worth noting that drugs on the preferred drug
4 list can still be subject to relatively restrictive
5 coverage criteria.

6 So moving right along to accelerated approval
7 drugs, just a very quick, very high-level overview of the
8 FDA approval process. FDA approval generally has three
9 rounds of clinical trials to show that a drug is safe and
10 effective. Effective, in this instance, means that it
11 achieves a clinical outcome. The beneficiary, or the
12 patient -- sorry -- feels better, functions better, or has
13 improved survival rates.

14 The accelerated approval pathway allows FDA to
15 approve drugs that have not yet shown a clinical benefit
16 but have shown an effect on what's called a surrogate
17 endpoint, which is essentially a proxy that's supposed to
18 predict a clinical benefit. So blood pressure is an
19 example, HIV viral load, those are examples of surrogate
20 endpoints.

21 For accelerated approval drugs, manufacturers are
22 required to perform post-approval studies once the drug is

1 on the market, to confirm a clinical benefit. If a drug
2 fails to show a clinical benefit in these post-approval
3 studies, it can be withdrawn from the market.

4 There are a few characteristics of accelerated
5 approval drugs that are concerning to state Medicaid
6 programs. The first is cost. As you can see from the
7 chart, in fiscal year 2017, the average cost per claim on
8 an accelerated approval drug under Medicaid was \$6,600, and
9 27 accelerated approval drugs approved since 2014 cost
10 Medicaid programs \$686 million.

11 The second issue that's concerning to states is
12 there are some questions about the effectiveness of these
13 drugs. There have been drugs approved through accelerated
14 approval even though it's unclear if they work. Some drugs
15 have had small study sizes. For some it's not clear if the
16 surrogate endpoint is predictive of a clinical benefit, and
17 the post-approval studies that are supposed to confirm a
18 clinical benefit for these drugs can take years to complete
19 and, in some instances, some of them have never been
20 completed.

21 There are also concerns about safety around these
22 drugs. A study in the Journal of the American Medical

1 Association found post-market safety events were more
2 common among accelerated approval drugs. These are all
3 taking place against a policy backdrop right now that seems
4 to be favoring getting drugs to market faster. 21st
5 Century Cures made some headway in this, and the FDA has
6 been really prioritizing getting drugs out faster, even
7 under the accelerated approval pathway.

8 So what are some policy options that this
9 Commission could consider? The first would be value-based
10 purchasing. This could be optional or mandatory, possibly
11 linking payment through outcomes for these drugs. Another
12 policy option would be to require a higher statutory rebate
13 on drugs approved through the accelerated pathway. That
14 could be required until the manufacturer completes the
15 post-approval study confirming a clinical benefit. A
16 benefit of this approach would be to ensure beneficiary
17 access while mitigating costs to state Medicaid program and
18 providing an incentive to manufacturers to complete those
19 post-approval studies.

20 Finally, the Commission could consider coverage
21 flexibility around these drugs. That's similar to what
22 Massachusetts requested in its waiver that was, of course,

1 not approved by CMS.

2 A few things to keep in mind in this space.
3 Value-based purchasing may not be an option for all of
4 these drugs. Value-based contracts can be difficult to set
5 up, it can be hard to agree on outcomes, hard to validate
6 outcomes, and there are data limitations for some of these
7 drugs. Additionally, coverage flexibility obviously could
8 affect access, and there would probably be concerns about
9 what it means for the bargain that's at the core of the
10 rebate program.

11 I am now going to turn it over to Chris.

12 * MR. PARK: Thanks, Rick. The next section here
13 is focusing on high-cost drugs, and to kind of set the
14 stage, overall, in Medicaid spending, a lot of the spending
15 trends have been driven by spending on brand drugs. As you
16 can see on the slide, the brand drug share of total claims
17 went down a couple of percentage points, from 2014 to 2017.

18 However, kind of the inverse happened, that their
19 share of total spending, even though the proportion of
20 claims went down, actually went up about 4 percentage
21 points. And this inverse relationship reflects an increase
22 in the average price for a brand drug, which increased

1 about 40 percent since 2014, from about \$294 per claim to
2 \$411 per claim. And that should actually say FY17 on the
3 slide and not '18.

4 This increase in the average cost of a brand drug
5 is due, in part, to an increase in use and price of high-
6 cost drugs, which we'll see on the next slide here.

7 This table focuses on the number of claims and
8 gross spending, which is the spending before rebates, on
9 drugs that are over \$1,000 per claim. We just kind of
10 chose this threshold. It's not like a formal definition of
11 a high-cost drug, but it was kind of representative of what
12 a lot of people kind of think would be high cost.

13 As you can see on this table, in 2017, these
14 drugs are only about 1.2 percent of total claims but they
15 made up about 44 percent of total gross spending. And, you
16 know, this shows, in the trend, that the proportion of
17 total claims increased slightly, from 0.9 percent in 2014
18 to the 1.2 in 2017, but the proportion of total spending
19 increased substantially, from 31 percent in 2014. And also
20 you can see on this table that the average spending per
21 claim went up from about \$2,600 to over \$3,000 per claim.

22 And so this price increase reflects not only just

1 general price inflation for the existing drugs but the
2 introduction of new high-cost drugs over these last few
3 years.

4 High-cost drugs span a wide variety of cases.
5 You know, some are widely used medications such as
6 antipsychotics, while others are used by a small number of
7 individuals, such as treatments for muscular dystrophy or
8 other orphan drug designations. These recent trends in
9 spending for high-cost drugs are expected to continue in
10 the future. While there is no official definition of
11 specialty drugs, a lot of the industry reports have
12 indicated and project that specialty drug spending for all
13 payers will continue to grow at rates that exceed the
14 spending growth for traditional drugs, and most of these
15 specialty drugs would be considered to have a high cost.
16 As well, a large proportion of the upcoming drug pipeline
17 will be for specialty drugs and orphan drugs, which, again,
18 are expected to be high-cost and really create additional
19 spending pressure for all payers.

20 So as far as policy options, these essentially
21 mirror the policy options we just talked about for
22 accelerated drugs, but we could expand those concepts to

1 drugs that exceed a certain cost threshold. You know,
2 value-based payment arrangements could be used. Some of
3 these could be outcomes-based, or another model that has
4 recently been proposed by Louisiana for hepatitis C drugs
5 is a subscription model where they would agree to pay a
6 certain amount of dollars over several years but would have
7 immediate access to an unlimited supply of the drugs up
8 front. So essentially, that would just be kind of
9 stretching the cost over several years, while they would
10 get the drug immediately.

11 Additionally, high-cost drugs would be subject to
12 a higher statutory rebate. One way you could do this could
13 potentially be to tie it to some independent assessment of
14 economic value, such as the work, you know, like we heard
15 this morning from the DERP group, or ICER, which is another
16 group that does that type of research. And additionally,
17 you could create additional flexibility to either exclude
18 coverage or further restrict use of some of these drugs.

19 Again, these considerations are all pretty much
20 the same that you heard for accelerated approval, but they
21 would apply to a larger scale. Particularly, you know, we
22 expect manufacturers would be opposed to any higher rebates

1 since these high-cost drugs are making up the greater
2 percentage of their revenues. And additionally, you know,
3 that could lead to some actions by them to try to increase
4 launch prices or try to cost-shift to other payers. And
5 also any type of coverage flexibility could affect access.

6 This next part is on the cap on the Medicaid
7 rebate. So it's not quite in the same areas as the other
8 pieces of our presentation but it does come into play a
9 little bit later. And so under the statute, Medicaid
10 rebates are capped at 100 percent of a drug's average
11 manufacturer price. So generally speaking, this cap will
12 come into play for drugs that have a significant
13 inflationary rebate due to large price increases over time.
14 Some policymakers believe that the cap reduces a
15 manufacturer's incentive to limit price increases. Once a
16 drug hits the cap the manufacturer can continuously raise
17 prices without being subject to a corresponding increase in
18 Medicaid rebates.

19 And so a manufacturer may be willing to basically
20 give Medicaid the drug for free because they're getting
21 about a 100 percent rebate, but could raise prices on other
22 payers substantially without any additional losses on the

1 Medicaid side.

2 A possible policy option would be to remove this
3 cap on the rebates. We have previously mentioned this as
4 an option in prior Commission meetings, among a package of
5 other options. Additionally, this option has gained recent
6 attention as it was included in the administration's
7 blueprint to lower drug prices. Removing the cap on rebate
8 will result in savings to Medicaid through increased
9 rebates. We don't have an official CBO score but we were
10 able to get some summary data from CMS for a quarter, and
11 based on that information, removing the rebate cap would
12 have increased rebates by about \$690 million for that
13 quarter.

14 Also, this policy could create downward pressure
15 on price increases and cause manufacturers to kind of
16 moderate price increases over time, and this would
17 potentially be very helpful to other payers as well. And
18 also this policy may be needed to amplify the effect of
19 other policy options that we may choose to propose, that
20 increase rebates. Increasing the rebates would mean drugs
21 would hit the cap sooner. So removing the cap would allow
22 these other policies to achieve their full effect.

1 Considerations for this policy, you know, we
2 would expect manufacturers would oppose this policy because
3 it would essentially require them to pay Medicaid for using
4 some of their drugs once they exceed the cap. In response
5 to the administration's blueprint, they mentioned that such
6 a policy would lead to further market distortions.
7 Presumably, you know, they're talking about cost shifting
8 and higher launch prices.

9 Also, this policy doesn't necessarily address all
10 high-cost drugs, just those with large price increases over
11 time. If a drug launched at a high price but only raised
12 prices at or below the rate of inflation, then the cap
13 would likely never be hit and this policy wouldn't have any
14 effect on those drugs.

15 And so with that we'll turn it back over to the
16 Commissioners. We are particularly interested in any
17 feedback you have on the information we've provided today
18 and any of the options that we've presented that you may
19 want to move forward with, need further research and
20 analysis on. As well, you know, if there are specific data
21 or analysis that would be helpful in making a decision on
22 these options, that would be nice to know.

1 As an additional point, we just want to bring up
2 the fact that we do have work ongoing to compare Medicaid
3 preferred drug lists, you know, their formulary coverage
4 decisions, as well as utilization management restrictions
5 and see how they compare to other payers, such as Medicare
6 Part D and commercial payers, and we hope to bring that
7 information to you in a future meeting.

8 CHAIR THOMPSON: Okay. I'll jump off and then,
9 Alan, you join in.

10 You know, of the different options that you've
11 presented, I'm pretty comfortable with some version of the
12 grace period, just as a practical matter, to allow states
13 to figure out what their coverage rules are going to be and
14 how that's going to operate. And I'm inclined towards
15 lifting the cap, but I'd also like to understand if it's a
16 matter of lifting it entirely or if there's another point
17 at which raising it to 125 percent, you know, or something
18 like that, gives us most of the benefit of that.

19 So I'm a little uncomfortable with the couple of
20 options that have to do with attacking high-cost or
21 accelerated approval drugs in the ways that we're talking
22 about, because I'm not sure that that's the right

1 categorization of concern.

2 The FDA is doing accelerated approval because
3 there is a desire to get drugs onto market faster, to make
4 them more available to people. No doubt, inside of the
5 drugs that are being subject to accelerated approval, just
6 like drugs that are subject to regular approval, there are
7 people who would say that drug isn't very useful or isn't
8 really working as it's expected to work, et cetera, et
9 cetera.

10 So I'm not sure that the fact that it's going
11 through that process, given the fact that it's identified
12 an acceptable FDA process for determining whether a drug is
13 ready for market, ought to be the distinguishing
14 characteristic that determines what the rebate is, or
15 whether states have to cover it or not, under different
16 circumstances.

17 And the same with high-cost drugs. You know, as
18 you point out, in that category are a lot of life-changing,
19 life-saving drugs, orphan drugs, and drugs of widespread
20 applications. So I'm just worried that by looking at that
21 category as an entire category that we're mixing a lot of
22 apples and oranges, and that the way that we're thinking

1 about attacking some of the pricing issues will have
2 negative impacts on access to important drugs that are
3 critical for our population.

4 So I'd just like to understand a little bit
5 better, maybe at a subcategory level, are there other ways
6 to slice and dice some of those kinds of drugs, in terms of
7 understanding and being a little bit more precise about
8 which drugs we're targeting and for what reason.

9 I don't have great suggestions for, even if we
10 found the right things that we wanted to target, is it
11 about the rebate amount, is it about VBP, is it about
12 something else? So I'd be interested in hearing about
13 whether there are any other different options that we can
14 think of there. Both of those approaches seem like they
15 could work, but as you point out, VBP will only take us so
16 far on certain drugs, and, you know, increasing rebates,
17 you know, maybe that would be something that we could look
18 at. But I would like to understand some of the impacts and
19 effects of that in terms of what gets returned back to the
20 states, and whether or not that simply just substitutes
21 federal rebates for what states could get on supplemental
22 rebates, in any event.

1 Alan, Chuck, Fred.

2 COMMISSIONER WEIL: Well, you read my notes so I
3 will just very quickly say I think a delay, given that it
4 exists in other programs, is understandable. I think
5 changing payment policy on the basis of approval process is
6 not defensible. Value payment is a lovely idea but it's
7 not ready, and it's certainly not ready for new drugs,
8 because that's part of the problem is you don't have the
9 value proposition. I'm all in favor but I don't think that
10 gets us anywhere. So, I mean, Penny, my notes are exactly
11 the same as yours.

12 The only thing I'll add is that you quickly noted
13 the denial of the Massachusetts waiver. I think, as a
14 Commission, if we're going to move into this area and we're
15 trying to find more than little things, this is the big
16 question. And I'll put it in the same context as our past
17 discussion about the work requirements, which is this is --
18 it's complex, it's unclear what the implications of these
19 approaches are, it's got to be done carefully and monitored
20 as it goes. But I think, you know, the excessive caution -
21 - and I don't know the statutory basis for the denial of
22 the waiver for Massachusetts -- but the cautious approach

1 to something designed to, you know, in an evidence-based
2 way, try to save some dollars in Massachusetts, you know, I
3 think the question of what we can learn from that kind of
4 approach, whether states should be permitted to try that,
5 under what circumstances, I think that's worth exploration,
6 more so than some of -- that's where I would put our
7 energy, as a Commission.

8 CHAIR THOMPSON: You know, that's very
9 interesting, Alan. I mean, I think it was the President's
10 budget that had a proposal for up to five states to do some
11 rebate alternative program. Was that it?

12 MR. PARK: That's correct. It had a proposal for
13 five states to do a demonstration, where they would waive
14 out of the rebate program but would have the option to
15 exclude coverage of certain drugs.

16 CHAIR THOMPSON: You know, I think something
17 along those lines may be something worth thinking about,
18 whether, again, in the sense of recognizing the complexity
19 of the problem and the risks associated with impeding
20 access to prescription drugs for the beneficiary
21 population, to ensure that we have a contained opportunity
22 for innovation and experimentation.

1 But it also, as I was reading your paper and
2 thinking about some of the areas where we're like, well,
3 maybe this class of drugs we handle differently, and this
4 class of drugs, is there a way to provide a little relief
5 to states where they have some way to create a little bit
6 of maneuvering room for themselves, based on a proposition
7 about specific drugs, specific drug costs, that would, you
8 know, allow them to have a way to vent some steam from the
9 program in a way that allowed to say, well, you know, we
10 want to have an exemption or an exception to the rebate
11 program, or to the coverage requirement for these
12 particular prescription drugs, for these particular
13 reasons. Would that be a more targeted, focused way to
14 address some of the issues that we have concerns about?

15 In any event, I'm agreeing with Alan that maybe
16 there's some way that some kind of experiment or some kind
17 of ability to give states a little bit of wiggle room is
18 some of what we need to consider here.

19 EXECUTIVE DIRECTOR SCHWARTZ: That couple well,
20 though, when we have the results of this project, that we
21 could --

22 CHAIR THOMPSON: I think that's absolutely true.

1 We need to take that into view, yeah.

2 Okay. Chuck, Fred, Kit.

3 COMMISSIONER MILLIGAN: Thanks, guys, for your
4 good presentation, as always. The one that I feel the most
5 aligned to is the grace period issue. I think the panel
6 that spoke in the spring did a very good job of
7 articulating the rationale for that.

8 My question is, is that a statutory change,
9 regulatory change, and, in general, as we come back to this
10 topic over the next few meetings, the more you could
11 articulate statutory, regulatory, sub-regulatory, you know,
12 is it agency discretion, is it congressional action, that
13 would be helpful, just framing, I think. But with respect
14 to the grace period, does that require statutory change?

15 MR. VAN BUREN: That's a good question. I believe
16 it would. Yeah, I can't think, off the top of my head, why
17 it wouldn't. So yeah, I believe it will be a statutory
18 change.

19 COMMISSIONER MILLIGAN: Okay. Thank you.

20 CHAIR THOMPSON: Fred and then Kit and then Toby.

21 COMMISSIONER CERISE: Yeah. It's a great
22 summary, guys. Thank you for this. I would agree with

1 much of what's been said, that a grace period, I think,
2 makes sense. I would tie that to some independent
3 analysis, just because I don't think the state Medicaid
4 programs have the fire power to do these drug evaluations.
5 And, you know, we heard from the Oregon group earlier
6 today, and I think it makes a lot of sense to tie that,
7 because you use the example of the drug that was approved
8 in a trial with 12 or 13 people in a trial. That may have
9 significant cost implications and you would like to hear
10 the experts weigh in on whether you make a drug like that
11 available for wide-open use or what sort of use
12 restrictions that you would put around that.

13 CHAIR THOMPSON: So you would like to see us say
14 something about what are you doing inside of that grace
15 period, to come up to that conclusion about who gets
16 covered and under what conditions?

17 COMMISSIONER CERISE: Yeah. And I worry about
18 value-based purchasing arrangements, just because, as
19 others have said, I mean, it can get real gimmicky, I'm
20 sure.

21 And then the other thing you mentioned, and I
22 actually talked to Rebekah recently about the subscription

1 program. That's intriguing. And it goes beyond just sort
2 of smoothing out your expected costs over some period of
3 time. But the way she described it to me, if I've got my
4 numbers right, she said they had like 90,000 people with
5 hep C in the state and they treated 235 in their program.
6 I mean, it's some dramatic delta like that.

7 And so the idea would be those people aren't
8 getting treated anyway, and so if you gave the manufacturer
9 some expectation that they're going to get some amount --
10 because they're worried about that going down. As people
11 get treated, pressure on prices comes down. If you give
12 them some assurance that they're going to get those dollars
13 then they would open it up to treat a lot of people who
14 would not otherwise be treated.

15 It's an intriguing idea. It seems like you have
16 to move to exclusivity with, you know, with a particular
17 manufacturer to do something like that, and it doesn't work
18 for a lot of conditions. But things that are time limited,
19 curable, like hep C or vaccines or an outbreak, some things
20 like that, I think it's an intriguing idea. But I would
21 also tie that to some independent analysis, somebody
22 outside of, you know, just state-by-state Medicaid agencies

1 looking at that.

2 CHAIR THOMPSON: And is Louisiana seeking -- do
3 they need a waiver to do that?

4 COMMISSIONER CERISE: She said they're writing a
5 waiver and, you know, writing an RFP. They would need a
6 waiver to do it.

7 MR. PARK: Yeah, I think if it was solely for the
8 Medicaid population and done under a supplemental rebate
9 agreement, I don't think they need a waiver, but they might
10 need to get the contract approved by CMS, because it might
11 be different than a normal supplemental rebate agreement.
12 I think where they may need a waiver is they are
13 considering trying to expand that to like the corrections
14 population as well as maybe uninsured individuals. And so
15 if they try to bring some of those individuals in, there
16 may be some need for a waiver to get them under kind of
17 like a Medicaid rebate agreement, that wouldn't affect best
18 price.

19 CHAIR THOMPSON: Well, I was going to ask about
20 best price implications for an arrangement like that.

21 MR. PARK: Yeah, if it was just done under like a
22 state supplemental rebate agreement it would not affect

1 best price. But depending on how many populations are
2 covered it may have some implications.

3 CHAIR THOMPSON: Okay. Kit, Toby.

4 COMMISSIONER GORTON: So I'll agree with
5 everybody else. I think the grace period idea makes sense,
6 from a purely operational point of view, either in the
7 state agency or in the plans. Ninety days is really
8 pushing it. You know, you've got to hold your breath and
9 turn blue, stand on one foot and spin around and try to get
10 it done. And this stuff comes up too often.

11 So I would argue, from an operational point of
12 view, if you want to have the kind of evaluation that Fred
13 is talking about then you need the 180 days. That's the
14 usual formulary amendment timeline. You have to go in
15 front of multiple committees on multiple occasion, and the
16 committees generally meet quarterly. So just 180 days
17 gives you the time to get all of that done in an organized,
18 thoughtful, evidence-based way. And so I would suggest
19 that if we're going to opine on a length of time that it
20 would be the longer one rather than the shorter.

21 CHAIR THOMPSON: So for both QHPs and Medicaid,
22 they review within 90 but make a coverage decision within

1 180. Is that right?

2 MR. VAN BUREN: Yeah, that's right. That's for
3 the --

4 CHAIR THOMPSON: Presumably we would follow some
5 existing standard --

6 COMMISSIONER GORTON: Yes.

7 CHAIR THOMPSON: -- rather than to put a --

8 COMMISSIONER GORTON: Well, there's an expedited
9 standard, right?

10 CHAIR THOMPSON: And then for Medicare, if you're
11 in a protected class --

12 MR. VAN BUREN: Right. Yeah.

13 COMMISSIONER GORTON: Yes. So I think, as a
14 general rule, we might want to say, okay, for a protected
15 class. But as a general rule we should go for the longer
16 period of time.

17 Value-based purchasing, interesting idea.
18 Unproven, right? So let's do some work and figure out
19 whether it works or not. Nobody's ever shown actual value
20 over a period of time from a value-based purchasing
21 pharmaceutical program, and so it might be interesting to
22 see. But certainly I don't think we're in a position, as

1 an evidence-based organization, to recommend that we move
2 forward with that.

3 And then -- what was the last thing I wanted to
4 say? I'm getting too old for this. Oh, with respect to --
5 I agree with you with respect to the approval processes.
6 FDA's got to do its job. You know, if they're not doing
7 their job, well, then that's FDA's problem. It's not our
8 purview to say yes or no.

9 I do think that removing the rebate cap is an
10 interesting piece. I personally would be interested, both
11 in the grace period and in removing the rebate cap, in
12 understanding whether it's from a staff estimate or whether
13 it's from actually going to CBO and getting a number, what
14 the saving associated with that would be. I think,
15 actually, a six-month grace period for the Medicaid plans,
16 for these new drugs, my suspicion is that it will result in
17 substantial savings. And that's worth tagging a number to
18 so people understand the cost of the decision that they're
19 making.

20 I would be interested in seeing the numbers on
21 the rebate cap.

22 And so those were the things I wanted to say.

1 CHAIR THOMPSON: Toby.

2 COMMISSIONER DOUGLAS: So a couple of quick
3 points or questions. Grace period, I'm definitely
4 supportive of that as well. I was wondering, on the
5 analysis on the brand, is there a way to add in the net of
6 expenditures net of rebates for state and federal and then
7 compare that, in part to get to this issue about changing
8 the cap on rebates. It would be interesting to look at,
9 for all brand, and then looking at for the high-costs, net
10 of, and then for the accelerated.

11 And one concern is when you get into the high-cost and
12 accelerated, the leverage and the ability to get some of
13 these supplemental, state supplementals decreases, and
14 understanding what's going on just with the net of, and how
15 that changes for these different subsets of brand drugs
16 would be interesting to see, to get at, to Kit's point.

17 MR. PARK: Yeah. So currently we do not have
18 access to specific rebate data for individual drugs. So we
19 might be able to get some kind of high-level summary on
20 certain groupings of drugs from CMS, to try to get a net
21 estimate of like what the rebates are for, like,
22 accelerated approval drugs or drugs that have a certain

1 cost threshold. But that would require working with CMS to
2 try to get kind of this high-level data. We wouldn't
3 necessarily be able to cut the data in multiple different
4 ways once we got it. We would have to kind of come up with
5 specific groupings so that they could provide that data to
6 us.

7 COMMISSIONER DOUGLAS: Part of the legislative --
8 okay. Well, I think this is important, I mean, to really
9 answer this question, or, you know, know what, because, I
10 mean, just again --

11 CHAIR THOMPSON: If we're making the right slices
12 and dices.

13 COMMISSIONER DOUGLAS: Yeah, and just qualitative
14 back to what we hear from, you know, medical directors, the
15 leverage. There's just no leverage on a lot of these
16 issues.

17 CHAIR THOMPSON: And so say more about that. Why
18 --

19 COMMISSIONER DOUGLAS: Well, I'm thinking back to
20 hep C --

21 CHAIR THOMPSON: -- certain of these classes,
22 there would be less leverage than in others?

1 COMMISSIONER DOUGLAS: Well, let's go back to hep
2 C and Sovaldi. So there was no --

3 CHAIR THOMPSON: Alternatives.

4 COMMISSIONER DOUGLAS: -- yeah, and it has to be
5 provided. So there's no ability, whether you're a
6 California or you're a consortium, what can you do? They
7 just look at you and say, "Well, we're paying the federal
8 rebate." It's not like saying, "Well, I'm going to go with
9 an alternative class," which happens with a lot of the
10 other brands. So I think being able to illustrate those
11 differences would help on determining the right policy.

12 CHAIR THOMPSON: Yeah. I mean, I think that that
13 is part of why I think the categorization is not quite
14 precise enough when we talk about some of these categories,
15 because some of these places are, you know, a drug comes on
16 the market and it's coming on through the accelerated
17 approval process because it is an important therapy that
18 isn't otherwise available. Same with a particular
19 specialty or orphan drug, or not. And so distinguishing
20 between those cases seems very important, because it not
21 only goes to the question of delivering good care to
22 beneficiaries, but also the extent to which a state would

1 have some kind of market leverage to exercise over pricing
2 otherwise.

3 And so I think those are the hardest cases that
4 we're talking about here.

5 Okay. I'm very interested in seeing the
6 formulary information, because I think if we can bring that
7 into view as well, maybe that will give us some ideas, as
8 well, as to how to think about some of these cases and
9 where to draw some exceptions or different policies or
10 focus innovations. So that will be very useful.

11 When, Chris, did you say that you were going to
12 have that for us?

13 MR. PARK: This project is going in two phases.
14 The first is just looking at the criteria, and that should
15 be done shortly, and we may be able to bring that to you in
16 October, or December by the latest, probably. The second
17 phase would actually be trying to tie that kind of
18 formulary and qualitative information to actual drug
19 utilization. And so like if you have a certain policy in
20 place, does it actually lead to shifting in that particular
21 therapeutic class? And that would probably be done in the
22 spring.

1 CHAIR THOMPSON: Can we ask, though, because I
2 think I feel like we have an agreement among the Commission
3 about the grace period, and some potential interest in
4 maybe raising the cap, at least. At least on those two
5 issues, can we come back in the next meeting, potentially
6 with the idea of trying to promote some potential
7 recommendations along those lines so that we can dispense
8 with those matters as we grapple with some of these other
9 difficult questions?

10 Okay. Any final comments from the Commissioners?

11 [No response.]

12 CHAIR THOMPSON: Any final comments from the
13 public?

14 **#### PUBLIC COMMENT**

15 * [No response.]

16 CHAIR THOMPSON: We are adjourned, and we'll see
17 you tomorrow.

18 * [Whereupon, at 4:39 p.m. the meeting was
19 recessed, to reconvene at 9:30 a.m. on Friday, September
20 14, 2018.]



PUBLIC MEETING

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

Friday, September 14, 2018
9:40 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
MELANIE BELLA, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
CHRISTOPHER GORTON, MD, MHSA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
ALAN WEIL, JD, MPP
KATHERINE WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA	PAGE
Session 8: Managed Care Oversight	
Moirra Forbes, Policy Director.....	252
Session 9: Oversight of Upper Payment Level (UPL)	
Payments: Additional Analysis and Policy Options	
Robert Nelb, Principal Analyst.....	284
Session 10: Mandated Report: Therapeutic Foster Care	
Martha Heberlein, Principal Analyst.....	311
Public Comment.....	333
Adjourn Day 2.....	333

P R O C E E D I N G S

[9:40 a.m.]

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

CHAIR THOMPSON: Okay. We're going to kick off today's meeting with a conversation about managed care oversight, and Moira Forbes is going to lead us through this conversation.

MANAGED CARE OVERSIGHT

* MS. FORBES: Thank you.

So it's been a while since we've talked about managed care generally, so here's what we'll cover this morning -- a little bit of background and context, just to remind you of what we've done and why we're talking about this today; the purpose and framework for managed care oversight specifically. We'll talk about the oversight approach in a few key areas, and then I'll remind you of some of the policy questions that the Commission has raised.

So a little context for why we're talking about this now: Commissioners have raised questions about the adequacy of managed care oversight as part of streamlining conversations that were held earlier this year, also just as the general importance of the issue, given the number of

1 enrollees receiving care under managed care arrangements.

2 You may have also seen the state oversight
3 processes and accountability mechanisms are receiving a lot
4 of media scrutiny in a number of states.

5 CMS is continuing to issue guidance to states on
6 implementing the 2016 rule, although it has also indicated
7 that it may propose changes. Our understanding is that a
8 Notice of Proposed Rulemaking is under review at OMB right
9 now.

10 So the Commission has previously raised, but not
11 answered, several policy questions, such as how do we
12 assess compliance versus performance and what data are
13 needed for oversight. But rather than take on managed care
14 oversight as a whole right now, we suggest examining four
15 areas that correspond to issues the Commission has
16 previously raised, which are appeals and grievances,
17 network adequacy, readiness, and care for populations with
18 complex health care needs.

19 To begin with, I'll just restate why managed care
20 has its own oversight framework. Over the past 20 years,
21 Congress has amended the Social Security Act to provide new
22 flexibilities for states to use managed care and also to

1 spell out specific mechanisms for the federal government to
2 hold states accountable and for states to hold MCOs
3 accountable for the services they've agreed to provide
4 under capitated contracts.

5 CMS then published rules to implement the statute
6 and create a comprehensive regulatory structure that
7 applies across the multiple authorities states can use to
8 implement managed care.

9 The accountability tools provided for in statute
10 and regulation include standards such as quality strategies
11 and access standards; the various assurances that are
12 documented in state plans, waivers, and contracts;
13 prospective reviews such as readiness and rate-setting
14 reviews, ongoing performance monitoring; and retrospective
15 reviews including external audits and encounter data
16 analysis.

17 So over the next few slides, I'll walk through
18 how this plays out in the four areas I mentioned before and
19 a little about what we know about how the current rules
20 support effective oversight.

21 Managed care has its own procedures to authorize
22 services. MCOs and primary care providers are responsible

1 for determining whether enrollees need specialty or
2 ancillary services and managing the service authorization
3 process. If the MCO denies a service or authorizes fewer
4 services than were requested, there are procedures
5 enrollees follow to appeal the coverage decision within the
6 MCO, and if it is not resolved, the enrollee can then
7 access the state process.

8 Federal rules require MCOs to establish specific
9 processes. So there is a lot of consistency across states
10 in the timelines and notices. The rules also require
11 states to provide oversight of the process.

12 Grievances and appeals can suggest problems with
13 access or quality care. Some of the specific metrics that
14 can be used to monitor this include the type, numbers, and
15 reasons for grievances and appeals, which you can look at
16 by MCO, by population; whether grievances and appeals are
17 resolved within required time frames; the number of
18 grievances that are later reversed on appeal; the number of
19 appeals that go on to state for hearings and so on.

20 However, there aren't any federal requirements
21 that states collect or use any of these specific grievance
22 and appeals metrics for oversight or for program monitoring

1 activities. States have flexibility in what they require
2 MCOs to report, how often they need to report it, how the
3 data are analyzed, and what form the data are made public.

4 We see a lot of variation among states in how the
5 data are used for oversight. They conduct routine
6 monitoring. Some do focused quality studies using
7 grievance data to identify quality-of-care issues. They
8 use it for assessing compliance with federal and state laws
9 and regulations. Some use it for public reporting.

10 Just one example, Iowa publishes quarterly
11 performance reports that include summary data on grievances
12 and appeals, including the percentage of grievances and
13 appeals resolved within 30 days, the top reasons for
14 grievances and appeals, and the number and reasons for
15 state hearing requests. And they break all that out by
16 plan.

17 But little is known about how states use these
18 data to identify concerns or follow-up. Not one has looked
19 sort of across states for this. Many of the state reports
20 we see are mostly descriptive, and they don't indicate how
21 the states monitor trends, identify concerns, or follow up
22 with the plans.

1 It's possible that we may have better information
2 in the future. The 2016 rule requires states to develop a
3 comprehensive quality strategy. Those were due to CMS by
4 July 1 of 2018, so they were just due this summer. The
5 plans must include goals and objectives and a description
6 of quality metrics and performance targets. I looked at a
7 few of them, and they did discuss using grievance and
8 appeal data. So they may be a useful source of information
9 on how states will use these data to monitor and improve
10 performance. They were just due this year. So the first
11 information on how states are using the data and actually
12 reporting on them won't be available for a few more years.

13 In terms of network adequacy, MCOs are required
14 to provide access comparable to that in fee-for-service.
15 To demonstrate that they meet this, states must have
16 network standards, and MCOs must document that they have
17 adequate networks.

18 Some of the metrics include showing that they
19 have the capacity to serve the expected number of
20 enrollees; that they provide an appropriate range of
21 services; and that they have a sufficient number, mix, and
22 geographic distribution of providers.

1 More detailed rules for Medicaid managed care
2 networks went into effect on July 1st of this year. For
3 example, states must now have time and distance standards
4 for several specific provider types.

5 Each state is allowed to develop its own
6 standards and approach. CMS declined to develop national
7 standards. It allows each state to set its own time and
8 distance standards and ratios. This approach allowed CMS
9 to sort of standardize the processes while still promoting
10 state flexibility by allowing each state to have its own
11 standards.

12 A variety of data and reports, again, can be used
13 to monitor compliance and access to care. These include
14 geomapping, encounter data analysis, provider participation
15 reports, enrollee surveys, enrollee and provider complaint
16 data analysis, secret shopper studies, and a review of
17 authorization and referral data.

18 A lot of these approaches are costly and time-
19 intensive. They may require frequent data from the health
20 plans.

21 Mathematica developed a tool kit to assist states
22 in developing access plans, and they looked at what states

1 are doing now. They found that states use, of course,
2 different combinations of these tools at different
3 frequencies. They also found that there's really no
4 standards or best practices for how they should be used to
5 monitor network adequacy. The hope is that as these plans
6 go into effect, CMS may be able to learn which state
7 methods result in better access outcomes. Again, so it may
8 be a few years before we have better information on this.

9 We also note that states have conflicting goals
10 for network adequacy oversight. While they must ensure
11 that MCOs comply with their contractual obligations,
12 states' immediate object is really access for enrollees,
13 often in the immediate term.

14 So when network deficiencies are identified, many
15 states prefer to work with the MCO to resolve the access
16 problem first rather than address it as a contract
17 compliance issue.

18 Readiness is an important oversight issue when a
19 state implements a new managed care program or makes major
20 changes, such as when a new contractor enters an existing
21 program or when the state adds new benefits, populations,
22 or expands to a new geographic area.

1 CMS and states conduct pre-implementation MCO
2 readiness reviews that assess the ability and the capacity
3 of the MCO to perform in major operational areas, ensure
4 that they are prepared to comply with program and contract
5 requirements, and that they are ready to deliver services
6 to enrollees.

7 Before 2016, readiness reviews were typically
8 required as a waiver condition. Since 2017, they have been
9 required by regulation.

10 There's a mistake on this slide. It's actually a
11 significant mistake. The process must include both desk
12 and on-site reviews.

13 Darin and I were talking yesterday. He couldn't
14 be here today, so he shared his notes with me on this
15 presentation. It says that the findings must be submitted
16 to CMS at least three months before the effective date.
17 Actually, the requirement in the regulation right now is
18 that the review must be started at least three months
19 before the effective date and must be complete in time to
20 ensure a smooth implementation.

21 And what Darin and I were talking about is that
22 the timeliness of the readiness review is really actually

1 the key aspect of the readiness review. Readiness isn't
2 really a check-the-box kind of activity. If it's not done
3 well, then you don't really know if you're ready. So
4 that's an important correction I should make because the
5 timeliness of the review and sufficiency of the review is
6 really important.

7 It is submitted to CMS as part of the contract
8 review process, and CMS can delay the program
9 implementation date based on the readiness findings.

10 While states, of course, can and do conduct
11 readiness reviews for many aspects of their programs, the
12 federal requirements do focus mainly on the MCO readiness.
13 It is worth pointing out that some of the other aspects of
14 program operations that have been problems in some of the
15 states that we have recently been hearing about are some of
16 those areas that aren't addressed in the regulations, such
17 as enrollment broker readiness, state staff training,
18 provider education, member education, and identifying
19 enrollees with special health care needs who require care
20 transition planning. There is nothing in the regulation
21 about state readiness, for example.

22 The last area is oversight for MCOs to enroll

1 individuals with significant or complex health care needs.

2 Managed care enrollment may be advantageous for
3 people with disabilities when plans take responsibility for
4 coordinating care and ensuring that enrollees can access a
5 range of needed services.

6 However, certain aspects of managed care,
7 including defined provider networks and incentives to
8 contain costs, may counteract these objectives. For these
9 reasons, there are significant federal rules in place to
10 protect the best interests of persons with significant or
11 complex health conditions. These include provisions
12 relating to access to care, continuity of care, standards
13 for timely referral, and expedited authorizations.

14 Federal rules specify a lot of these beneficiary
15 protections; for example, the requirements for MCO networks
16 specify that the network must be sufficient for all
17 enrollees, specifically including those with physical and
18 mental disabilities. Federal rules also detail care
19 coordination and continuity of care responsibilities,
20 including ensuring that enrollees have an ongoing source of
21 care appropriate to their needs and access to full a range
22 of community support services. However, again, the rules

1 say very little about how a state should monitor compliance
2 and performance or how a state should respond to any
3 problems.

4 A quick review of state data showed variation to
5 which states collect data in a way that supports oversight
6 of the care provided to individuals with significant or
7 complex health care needs. We saw that some states show
8 utilization or grievance data broken out by population,
9 risk or acuity score, diagnosis. We found a state that
10 specifically monitors and reports on utilization of care
11 management, that reported on out-of-network referrals,
12 things like that.

13 Again, this was a very quick review. It was not
14 a comprehensive study, but some states are specifically
15 looking at some of these things, and other states do not
16 appear to.

17 Prior MACPAC research: we did a study a few years
18 ago looking at contracts, contract provisions specifically
19 around children with special health care needs, and found
20 that while states are likely to include protections for
21 individuals with significant or complex health care needs
22 in their contracts, they are more likely to include the

1 specific provisions when there's a federal requirement to
2 include specific language.

3 So the Commission has raised several policy
4 questions in prior discussions about managed care oversight
5 including, How do we balance between flexibility and
6 control? Where are national standards appropriate, and
7 where is state variation acceptable? How do we assess
8 performance versus compliance? Where is process review
9 sufficient? Where is outcomes monitoring valuable? What
10 data are needed for oversight? What metrics should we use?
11 When is self-attestation sufficient, and where are external
12 audits needed?

13 It would be helpful for staff to hear from the
14 Commission about the types of information that you would
15 find useful in assessing the adequacy of oversight in these
16 areas and then forming any action steps.

17 As I noted, as I've gone through the slides,
18 we've done some quick reviews of online information. Some
19 things we could do would be conduct interviews with a
20 variety of states. We could do a roundtable. We could
21 review contracts, other types of qualitative research that
22 might shed some more light on the issues and concerns with

1 managed care oversight.

2 We do remember your caution about focusing on the
3 practices of the high-performing states because of the
4 unique focus in history on those states. Darin did remind
5 me of that yesterday.

6 But if there are other research approaches you
7 suggest, particularly that we could pursue in the short
8 term, we certainly welcome your thoughts.

9 CHAIR THOMPSON: All right. Wonderful. I think
10 this is such an important topic, and I think we spend a
11 fair amount of time talking about payment issues. And I
12 think this is central to our access agenda in thinking
13 about how beneficiaries served in these particular settings
14 and whether or not we have the right kind of confidence and
15 the right kind of action to respond to information.

16 So I'm very happy that we're taking on this work,
17 and I think largely, you've hit the mark in terms of both
18 what we've talked about in the past and what I think is a
19 way to shape the conversation and the research so that it's
20 not boiling the ocean of everything that a managed care
21 plan does or everything that a state does in contracting
22 with and overseeing managed care.

1 I'll just make a couple of comments and then open
2 it up for other Commissioners to weigh in.

3 I just want to be sure that as we do this work,
4 we think about both contract language, service-level
5 agreements, and enforcement. I mean, I think that in all
6 of these areas, we should be looking at what does the
7 contract require a plan to do, how does a state know
8 whether the level of performance is meeting contract
9 expectations, and if there isn't the result that's expected
10 or the service level that's expected, what action is
11 available for the state to take.

12 I also think that it's useful to -- one of the
13 areas that I think we should pay some attention to is
14 people can have a lot of data, but it doesn't necessarily
15 trigger action. And I think that if we think about action,
16 then it's easier to trace back to the pieces of data that
17 you need in order to actually change something.

18 So instead of just saying, well, we need lots of
19 reports and we need lots of data, it is what would tell me
20 -- I think the key question for a state is what would tell
21 me that something has gone awry inside of a plan and I need
22 to intervene or I need to ask more questions or I need to

1 take some kind of action, and I need to have the tools
2 available to do that. But I also first need to know that
3 that's a level of concern that I need to be responding to.

4 And so I think the early warning -- Stacey has
5 talked about on the appeals and grievances, making sure
6 that we think about complaints as well, but it's not just
7 about looking at the results of that process, but also how
8 that gets looked at in terms of what level of concern do I
9 have with a certain kind of complaint or grievance or
10 appeal by a certain kind of beneficiary relating to a
11 certain kind of service, and when do I step in and start
12 asking questions of a plan, when do I start wondering
13 whether the plan is performing as required? I do think
14 there has been increasingly better information accumulation
15 by states, but I still think there's always this question
16 of what am I doing with that information and do I have an
17 idea in my head about why am I looking at a piece of
18 information and how I should be interpreting it and
19 responding to it.

20 All right. Let me open it up for other
21 commentary or questions.

22 Bill.

1 COMMISSIONER SCANLON: Thanks very much. That
2 was very helpful, and I agree that this is a very important
3 topic.

4 Let me start with your last slide where you
5 talked about the balance between flexibility and control,
6 and I actually think there's a precursor, which is
7 accountability. I'd be very happy to a grant flexibility
8 as long as I knew there was accountability for delivering
9 the services and the care that we are expecting, and I'm
10 not sure that that expectation is a control as much as it's
11 an expectation, "We're going to let you approach this the
12 way you choose as long as you deliver what is required sort
13 of for beneficiaries."

14 Part of that is -- a key part of that is
15 reporting, and from some of the examples that were in the
16 write-ups, we've got examples where the reporting has
17 turned out to be false or flawed, and so there's a real
18 important thing, I think, on the part of CMS to be looking
19 behind the information that they're getting, to feel
20 confident that this is reporting sort of what is actually
21 sort of happening on the ground because that's key in terms
22 of serving this population of people that in many cases are

1 sort of disadvantaged in terms of getting these services on
2 their own.

3 And that leads me to my second question, which is
4 maybe also could turn into another comment, and that goes
5 to the appeals and grievances and how good of a measure
6 that is in terms of performance.

7 What I am concerned about is the ability of
8 people and particularly people with disabilities to
9 actually take advantage of a grievance and appeals process,
10 to know what their rights are, and to be able to then
11 pursue them in a way that they're going to show up in these
12 statistics that we're going to use to monitor whether or
13 not there has been performance.

14 And this is a comment, and I'll put it in context
15 so that you don't think I'm criticizing managed care. This
16 is coming -- I've heard this many, many times from the fee-
17 for-service side. What beneficiaries will be told -- and
18 it's not just Medicaid, but it's also Medicare-only
19 beneficiaries. What they'll be told is "Medicare,
20 Medicaid, CMS won't let me do that. You cannot have that
21 service," and I can tell you that there are a number of --
22 many occasions when I know for a fact there is no

1 Medicare/Medicaid rule against that service being
2 delivered. It was a provider choice to not do that.

3 And so there's this issue that I think is
4 important of beneficiaries being given the information that
5 they know what they should be expecting, so that they can
6 act, before we can really rely on their filing a grievance
7 or a complaint even and use that as a sole measure. So I
8 think that's an important part to look at that.

9 So I guess the question part there is how much
10 has been done to look at sort of the education process for
11 people as they're enrolling sort of in managed care,
12 particularly people whose circumstances are exceptional? I
13 mean, people with disabilities, where it's not just "These
14 are your services. You're entitled to physician care.
15 You're entitled to sort of inpatient care," et cetera.
16 It's like we need to give them more information about the
17 kinds of services that they are both entitled to and need.

18 Thanks.

19 CHAIR THOMPSON: That's a good point, Bill, and I
20 think there are ombudsman requirements especially for long-
21 term services and supports.

22 Is that right, Moira?

1 MS. FORBES: There's a -- I don't know if it's
2 ombudsman. I mean, there is a requirement that there be an
3 independent enrollment broker.

4 CHAIR THOMPSON: No, I'm thinking of something
5 different.

6 I do think that this is a little bit back to
7 Stacey's question about complaints too, so in addition to
8 making sure that we're not overly defining the process as
9 the exercise of rights, that we're looking for pockets of
10 information that may exist in a variety of different places
11 that may be indicative of problems associated with
12 accessing services.

13 COMMISSIONER SCANLON: I'm not sure how exactly
14 the ombudsman relate to managed care in Medicaid, but in
15 looking at an ombudsman with respect to sort of nursing
16 home care, there are ombudsman in every state that perform
17 a function to provide oversight.

18 The reality is, though, the resources are so
19 sparse relative to the potential in terms of how much
20 oversight should be done that it's very thin protection.

21 CHAIR THOMPSON: Kathy, you want to jump in on
22 this point?

1 COMMISSIONER WENO: Yeah. I was a Medicaid
2 ombudsman for a number of years, and I would actually
3 confirm a lot of what you're saying, where about 90 percent
4 of the MCO appeals and fair hearings that I was involved
5 with would settle, and so none of the data that you would
6 be looking at would be reflective of what the true problems
7 were with Medicaid. I would see the same things again and
8 again that would never go to hearing or you could resolve
9 within the MCO.

10 CHAIR THOMPSON: So say a little bit more about
11 that again. That just may be something that we can ask the
12 staff to be looking for. It's almost like before you get
13 to an appeal?

14 COMMISSIONER WENO: Absolutely. Well, it's just
15 like any type of legal proceeding where you are trying your
16 best to resolve the problem for the individual beneficiary.
17 So a lot of the trends and things wouldn't show up in the
18 data because you could point out to an MCO that their
19 contract was X, and they were not meeting that, and they
20 would agree with you, whereas they would not probably say
21 the same thing to the beneficiary.

22 CHAIR THOMPSON: Stacey.

1 VICE CHAIR LAMPKIN: Yeah. And that's exactly
2 where I've raised the issue of complaints before. It's
3 been exactly that point, and maybe the question is better
4 more generalized: What are states doing to monitor at the
5 front end? What are their early warning signs that there's
6 an access problem? What are they doing for that? Maybe
7 it's an integrated complaint system. Maybe it's an
8 ombudsman process, but what are they doing, and is that
9 effective?

10 CHAIR THOMPSON: And I think to also give credit
11 to Bill's point, if we believe that one of the problems may
12 be beneficiaries don't even know they can argue the point,
13 then what are the other mechanisms to compensate for that
14 potential problem, and what are the kinds of systems that
15 you put in place, whether that is beneficiary, interviews,
16 or secret shopper? What are the other ways that you can
17 acknowledge the limits of that system to give you the
18 information that you're looking for, and how do you adjust
19 for that?

20 Okay. I think Martha was coming in. Then I've
21 got Chuck. Then I've got Brian.

22 COMMISSIONER CARTER: I think I'm coming from the

1 transparency issue, again, from the bottom up. As an
2 organization that contracts with managed care companies, I
3 think the transparency is lacking, in terms of how they're
4 taking care of our patients, you know. I can't really, at
5 this point, as far as I know, find out what sorts of
6 complaints our patients have had with MCOs. You know, we
7 can't steer patients to any particular MCO. But, at the
8 same time, in our contracting process we have some
9 flexibility in terms of what we're looking for and whether
10 we contract at all.

11 So I would like to hear more about what are the
12 transparency requirements and what's accessible to health
13 care providers and patients as far as those reports.

14 CHAIR THOMPSON: So Martha, you're suggesting
15 that in addition to thinking about how does a state oversee
16 a plan, how does the state make some of the information
17 available to create the right kind of market forces, if you
18 will, to reward the high-performing plans. Okay.

19 All right. We've got Chuck and Brian.

20 COMMISSIONER MILLIGAN: One of the other areas,
21 to me, is the federal oversight of the state. I mean, I
22 think we're focusing here on state oversight and state

1 readiness, and all of that, early warning signs. But as
2 you sort of introduced this, Moira, you were sort of
3 framing it as with waiver reform in our previous work. Do
4 we have the right balance in terms of oversight of states?
5 And I think that's part of this framework that we need to
6 talk about.

7 A couple of things come to mind about that. One
8 is, I think one of the major areas, and we've seen this
9 disruption in Iowa, as an example, is plan withdrawal, big
10 disruption to members, big risk to members. And I think
11 underlying that -- and people can have kind of different
12 opinions about it -- but kind of the adequacy of the way in
13 which the rate setting is done. So on the one hand, do
14 MCOs go in with their eyes open, that the rates are low,
15 but on the other hand, what is the state obligation in
16 terms of adequacy of the data book and rate bids and all of
17 that stuff. So I think part of the member protection here
18 is federal oversight of payment too.

19 And the second to me is whether or not it should
20 be phased in, how it should be phased in, do you need to
21 kind of walk your way in or can you go statewide with all
22 populations, all of that quickly?

1 So I think -- and others might have other ideas
2 about that, but I think, to me, part of the framing here is
3 if it's going to be simpler for states to get approval to
4 do managed care, what is the federal role in the oversight
5 of it, even if it's a SPA, waiver, or whatever.

6 The second thing, and I want to kind of come back
7 to the complaint comment. Let me give an example in my own
8 organization. We've got a vendor that was delivering a
9 service, and we were looking for complaint data related to
10 that service from that vendor. And what they were sending
11 us, we thought, was under-reported. And when we got
12 underneath it, what they were sending us was what they
13 perceived to be substantiated complaints, as opposed to all
14 complaints.

15 And there's another example, in terms of provider
16 network, which is providers sometimes don't realize they're
17 contracted for Medicaid and they will say, "No, I'm not a
18 provider of that service." Sometimes what that raises,
19 then, is an intervention is required to do education.

20 And so whatever form the feedback is coming in, I
21 would think the more raw the data is, in certain ways, I
22 think all complaints matter, substantiated or not, as an

1 indicator of not just is there a problem, in terms of the
2 underlying delivery of the service, but is there a problem
3 in terms of education and outreach and information.

4 And so if we get into the complaint area, I just
5 want to raise for you the nuance that folks might only
6 report so-called substantiated complaints, and I think that
7 that's insufficient to do oversight.

8 CHAIR THOMPSON: Brian and Sheldon.

9 COMMISSIONER BURWELL: I'm not sure where to go
10 with this, but I would like for our work in this area to
11 acknowledge the diversity of managed care types of
12 programs, and how oversight requirements may vary according
13 to managed care type. For example, behavioral health
14 managed care. How should oversight requirements vary for
15 managed care programs that just cover behavioral health
16 services? And the area of that is just emerging. In most
17 states, persons with intellectual disability have been
18 carved out of managed care initiatives. But I know a
19 number of states are considering having specialty plans for
20 that population, which, obviously, has very different needs
21 and very different oversight responsibilities.

22 I'm not sure how to bring this into our work, but

1 I think we just need to acknowledge that managed care is
2 not just medical managed care. There's a real diversity of
3 plan types that states need to oversee.

4 CHAIR THOMPSON: Sheldon, then Stacey.

5 COMMISSIONER RETCHIN: I think this is just a
6 terrific area, Moira. I'm really pleased that the
7 Commission is continuing to press on not just the MCO issue
8 but also just access in general. I continue to remind all
9 of us that that's in the name of the Commission.

10 So maybe you could help me out on this, and I
11 don't think that -- I think the MCOs are really a
12 bellwether. Like Bill, I don't know that there's that much
13 difference between the MCOs and fee-for-service. There may
14 be. But certainly in the area of transparency and being
15 able to follow actual delivery of care, it's much more
16 difficult to follow that within the MCOs.

17 So in the last, I guess, now, three years, the
18 Medicaid program has seen a growth of about 20 percent in
19 enrolled beneficiaries. I can't really figure out where
20 they all went for providers. So let me ask you, in terms
21 of the context of MCO oversight. Were there any changes in
22 expansion states, in terms of their network adequacy

1 standards, as a result of expansion?

2 Let me bring it slightly --

3 MS. FORBES: I mean, I don't know. It's
4 certainly something we can look into. I don't remember any
5 states expanding particularly, like expanding the number of
6 MCOs particularly because of the Medicaid expansion. I
7 don't know why they would have changed their standards.

8 COMMISSIONER RETCHIN: So I shouldn't -- maybe
9 there's a metaphor here that a surge in grocery stores,
10 unfortunately, in front of a hurricane, but the shelves
11 will be depleted very rapidly. But with a 20 percent
12 growth they use the same network and just said, "We assume
13 you have capacity." How do you measure that? I just don't
14 know how you administer that.

15 MS. FORBES: No, it's certainly a question we
16 could -- I mean, that's a -- it's a question we could look
17 into.

18 CHAIR THOMPSON: Stacey.

19 VICE CHAIR LAMPKIN: Yeah, thanks. I'll be
20 brief. Thanks, Moira. This is really helpful, I think.
21 These do feel like four very good areas for us to explore,
22 and the policy questions are interesting. The early

1 warning thing was a point of feedback that I had, that we
2 already talked about. And the other one, I think, is just
3 to echo Penny's comment about enforcement, because that's
4 part of the foundation that I think that we need to
5 understand to address some of these policy questions, is
6 just to understand to what extent states are enforcing
7 contract requirements with their MCOs and what are the
8 barriers to enforcement when they're not enforcing them,
9 would, I think, also be a useful question. Thanks.

10 CHAIR THOMPSON: Okay. All right. Toby.

11 COMMISSIONER DOUGLAS: The only other policy
12 question kind of relates back to our discussion yesterday,
13 is around administrative capacity and just how are states -
14 -

15 CHAIR THOMPSON: Thank you, yes.

16 COMMISSIONER DOUGLAS: -- developing the right
17 administrative capacity to react and appropriately enforce.

18 CHAIR THOMPSON: Yeah, Fred.

19 COMMISSIONER CERISE: Just one other quick one.
20 We talked about early signals and I'm not sure -- the
21 complaints is kind of late the game so just a plug for, you
22 know, testing of the attestations and the network adequacy,

1 and are they delivering what we say we're going to deliver
2 before we get to the complaint stage.

3 CHAIR THOMPSON: Okay. Good. So, Moira, I know
4 that, you know, part of this is we're trying to focus, and
5 we keep broadening, right, but that's what the Commission
6 does.

7 I just wanted to pick up on a couple of points
8 that have been made in this conversation. So whether or
9 not we call it focusing on appeals and grievances, maybe we
10 should be thinking about the data that is the early warning
11 system, you know. And so where does that data reside? Who
12 has it? Is it sufficient? Does it tell us what we want to
13 know? Maybe that's a way to think about that part of the
14 question that you're posing.

15 I do think that, then, on top of this is this
16 state administrative capacity. How is the state organizing
17 itself? Does it have the right resources? Does it have
18 the right approach to thinking about this as a delivery
19 system, as a contract, et cetera. And then, you know,
20 underneath all of this, I think, is a desire to especially
21 focus on beneficiaries with complex health care needs or
22 substantial health care needs. And so maybe that's a

1 window of how we look at these issues, in general, in terms
2 of oversight.

3 I want to also come back to Chuck's point. We
4 have been talking about trying to focus this just because
5 this is a big subject, but in terms of how are states
6 overseeing plans. But I think it is worthwhile to remember
7 that we do have a federal regulation that is under review,
8 that we will want to be commenting on. I think we should
9 keep our eye on that.

10 We should keep our eye on this question of
11 whether or not some of the kinds of problems that have
12 occurred in states with plan withdrawals or with particular
13 concerns being expressed by some families and beneficiaries
14 about the level of service that's been approved for them,
15 whether that is rooted in fundamental issues of rate
16 setting. And so I think we should be also conscious about
17 making sure that we believe that there is a regulatory
18 schema that helps ensure that underlying resources are
19 available for plans to be successful within the states.

20 Any final commentary on any of that?

21 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just
22 wanted to comment for Commissioners. You have a lot of

1 ideas and thoughts about things that we want to know. So I
2 think we are going to, at the staff level, have to go out
3 and figure out how we're going to learn those things. So
4 that will not be something we will come back to you with
5 the answers to these in October, December. It's going to
6 take us some time to go out and get this information.

7 So I would just say, I think we have enough now
8 to go write a scope of work, but then we'll have to let a
9 contract to do some of this. So just hang tight and, you
10 know, we'll deal with the NPRM when it comes out. But on
11 this I think it's going to take us a while to gather the
12 information, to have a next productive conversation about
13 it.

14 CHAIR THOMPSON: Yeah, and I just want to
15 encourage you to think about whether it splits into parts,
16 so that we're looking at different aspects of this in
17 pieces over time. I think there are some opportunities for
18 that here that I'm sure that you'll be able to take
19 advantage of.

20 I think it's clear from the Commission's
21 conversation that the idea that there needs to be a robust
22 system of collecting and using data for action around

1 beneficiary access is really an important part of success
2 for the program, and ensuring that there's an appropriate
3 set of levels of review and oversight by the state and the
4 federal government with respect to that, I think, is
5 certainly the case. And we just want to be sure that as
6 we're examining this, we're thinking always about what some
7 of those most efficient and most rewarding places for
8 investment are.

9 Okay. Thanks. Let's go ahead and move on.

10 CHAIR THOMPSON: And we have Rob back, because we
11 cannot get enough Rob, to talk about upper payment levels.

12 **#### OVERSIGHT OF UPPER PAYMENT LEVEL (UPL) PAYMENTS:**

13 **ADDITIONAL ANALYSIS AND POLICY OPTIONS**

14 * MR. NELB: Great, thanks. Yeah, just when you
15 thought you were done with hospital payment I'm back for
16 more.

17 Today I'll be focusing in on of oversight of UPL
18 payments, the upper payment limit.

19 For today's presentation I'll begin with some
20 background on UPL rules, and share some of our latest
21 findings from our review of hospital-specific UPL data that
22 CMS shared with us this summer. So this complements some

1 of the state-level data that I had presented in the spring
2 and allowed us to get a closer look at how the UPL is being
3 calculated in different states. And I'll focus on some of
4 the concerns that you raised in the spring meeting around
5 data completeness, UPL compliance, and the methods that
6 states use to calculate their Medicare payment estimates.

7 In addition to reviewing this hospital-specific
8 data, we spoke with CMS and state officials about barriers
9 for improving UPL reporting and compliance, and so I'll
10 share some of those findings, and finally conclude by
11 discussing some potential policy options to improve UPL
12 oversight.

13 So first some background. The UPL, as you will
14 recall, is an upper limit on aggregate fee-for-service
15 payments for a class of providers, and it's based on a
16 reasonable estimate of what Medicare would have paid for
17 the same service. If a state makes base fee-for-service
18 payments that are below the UPL, then the state can make
19 UPL supplemental payments to make up this difference.

20 States are allowed to make UPL payments for a
21 variety of providers, including hospitals, nursing
22 facilities, and physicians, but the vast majority of UPL

1 payments are for hospitals, so more than 75 percent. And
2 so we're going to focus our analysis today on hospital UPL
3 payments, which are also the only ones that we have
4 facility-specific data for.

5 In order to demonstrate compliance with UPL
6 requirements, states are required to submit UPL
7 demonstrations annually to CMS. These demonstrations
8 include hospital-specific data on base and supplemental
9 payments that states make as well as estimates of what
10 would have been paid according to Medicare payment
11 principles.

12 As I mentioned, earlier this year we had some
13 state-level data for '14, '15, and '16, and then in the
14 summer we were able to obtain hospital-level data for state
15 fiscal year '16 for 47 states and the District of Columbia.

16 We had, of course, initially collected this
17 information as part of our long-term hospital work plan,
18 just trying to better understand these payments and how
19 they were distributed, but as we were reviewing them we
20 identified some more urgent concerns around UPL oversight,
21 that I want to focus on today.

22 First, when we're doing the hospital-level data,

1 we identified several concerns with data completeness. In
2 several states there were missing payments, particularly
3 missing data on the UPL supplemental payments that states
4 make. We're not exactly sure why the data is missing but
5 one potential reason is that several states submit their
6 UPL demonstrates prospectively, and that may be before they
7 finalize their payments for the year under review. So a
8 state may kind of do the UPL calculations to figure out
9 what their UPL gap is and then later they use that to
10 figure out the UPL payments they make, but in several of
11 the states they never actually put the UPL payment data in
12 their UPL demonstration.

13 In addition, we identified several missing
14 hospitals in about half of states. Unfortunately, the
15 hospital-level data that we got didn't have the right
16 identifiers to sort of match it with other sources, so we
17 can't really say too much about the specific hospitals that
18 are missing. However, we do know that many of the missing
19 hospitals are government-owned hospitals, and we know that
20 CMS doesn't require states to submit UPL demonstrations for
21 hospitals that are paid on a cost basis. So that might
22 explain some of the discrepancy. However, when we matched

1 the data with our own compendium of sort of which states
2 pay hospitals on a cost basis, we found that there were --
3 it didn't really explain all the discrepancy, that there
4 were some states that didn't pay on a cost basis, that were
5 still missing a lot of hospitals.

6 So to better understand some of this data that's
7 missing and how the spending compared to actual spending,
8 we looked at the data on the UPL demonstrations and how it
9 compared with the CMS-64 expenditure reports, which were
10 the data on the actual spending that was made. Based on
11 your feedback at the April meeting, we made several
12 adjustments to the 64 data to try to make it as comparable
13 as possible. So looking at the same state fiscal year and
14 also making adjustments for various prior period
15 adjustments.

16 However, the data aren't perfectly comparable.
17 One key difference is that UPL demonstration data is based
18 on the date of service, while the expenditure reports are
19 based on the date that the payment was made.

20 And then there are some other technical issues.
21 For example, UPL demonstrations exclude crossover claims
22 for patients who are dually eligible for Medicare and

1 Medicaid. But on the 64 data, we can't exclude those
2 payments.

3 Overall, when we did -- I made these adjustments
4 and did the comparison, we found that actual spending on
5 the 64 exceeded UPL demonstration projections in most
6 states.

7 So this figure shows the spending reported on the
8 UPL demonstrations compared to the 64 spending in state
9 fiscal year 2016. You can see that there's quite a large
10 difference. So overall the 64 spending was \$10.8 billion
11 higher than what was reported on the UPL demonstrations.

12 The biggest discrepancy was for supplemental
13 payments. Part of this could be due to some of the missing
14 supplemental payments, but we also found large
15 discrepancies even in states that did report their
16 supplemental payments, that there were still -- the actual
17 spending was higher than what was reported.

18 In addition, we also observed large differences
19 in base payments. Some of this may be due to some of the
20 missing hospitals. But some of it could also be if actual
21 utilization was perhaps higher than what states projected.

22 Overall, these findings raised several concerns

1 about UPL compliance in several states. So in some states,
2 even though the actual spending was higher than what was
3 projected, it was still below the states' UPL that they
4 calculated. However, in 16 states that reported, UPL
5 spending exceeded the UPL gap on their demonstrations.
6 And, overall, the UPL spending in those states exceeded the
7 UPL gap by about \$1.5 billion in the aggregate.

8 When we then compared total base and supplemental
9 payment spending to the UPL, we found that even more states
10 exceeded the UPL, so 27 states in this case, when we did
11 this method, they exceeded the UPL by about \$4.7 billion in
12 the aggregate.

13 As I mentioned, because the base payment spending
14 we found was a bit higher than what states projected, that
15 could be due to increased utilization, and so we also
16 looked at this another way, kind of giving states the
17 benefit of the doubt and assuming that with increased base
18 payments that their UPL gap might increase as well. Doing
19 that method, we found that 12 states had base and
20 supplemental payments that exceeded the suggested UPL
21 amount, and the amount was -- they exceeded the UPL by
22 about \$2.1 billion in the aggregate.

1 Lastly, we also used the hospital-specific UPL
2 demonstration data to examine some of the methods that
3 states used to calculate the UPL. Currently, CMS provide
4 states with several methods that they can use, including
5 cost-based methods, which are higher than what Medicare
6 currently pays hospitals.

7 In 2016, about half of states used a cost-based
8 method for inpatient hospital UPLs, and most states used a
9 cost-based method for outpatient UPLs.

10 One other quirk of the cost-based method is that
11 states can increase their UPL to account for the provider
12 taxes that hospitals pay. Although most states do have
13 provider taxes for hospitals in place, we found that only a
14 few states actually reported these adjustments on their UPL
15 demonstrations. And in the aggregate, the amount of these
16 adjustments was less than 10 percent of the UPL amount.

17 So to better understand some of the barriers for
18 improving UPL reporting and compliance, we spoke with CMS
19 staff, and we also spoke with state officials in three
20 different states that used a variety of different methods
21 for calculating the UPL. From both state and CMS
22 officials, we heard some common challenges.

1 First is the fact that there are different
2 reporting processes used for the data that go into the UPL
3 demonstrations versus the data that go into the CMS-64. So
4 states get the UPL spending information from their Medicaid
5 Management Information Systems, MMIS systems, which, as I
6 mentioned, you know, record claims based on the date of
7 service rather than the date that the payment was made.
8 And there's little process to sort of reconcile the data
9 between these two sources.

10 Second, some state officials noted that there was
11 a bit of confusion about the UPL requirements, so this is a
12 new process that CMS has put in place, and there's been
13 sort of several revisions to the CMS guidance. And so that
14 in the earlier years, there was some confusion about what
15 to put on what line and different things.

16 There is a standardized template now in hopes
17 that this will get better as states have more experience
18 with it. But, you know, there's still more guidance that
19 probably could be helpful.

20 And, finally, states noticed that -- mentioned
21 that they really haven't received much feedback from CMS
22 about their UPL calculations, and CMS noted it doesn't

1 really have a process in place to certify the data that
2 states submit. So as a result, states, you know, they
3 submit these calculations and then make payments based on
4 them, sort of assuming that their calculations are correct.
5 But there isn't a process to sort of check it in any way.

6 CMS for its part noted that they don't feel they
7 have the resources necessary to fully audit all the state
8 data, and particularly don't have the information to verify
9 whether the state data is correct. And for their part,
10 they'd prefer if there was some sort of independent entity
11 or some other way to help them in their review.

12 So I've highlighted a number of concerns here
13 around oversight of UPL and wanted to outline a couple
14 policy options just to jump-start your conversation today.

15 First, to address some of the concerns that UPL
16 spending appears to exceed the state-calculated UPL gap,
17 CMS could monitor actual UPL spending relative to the UPL
18 gap calculated by states, and this could be done through a
19 change to the CMS-64, so the same way that DSH payments,
20 for example, are tracked in the 64 against state DSH
21 allotments, you could track state UPL spending relative to
22 their calculated UPL amount.

1 Second, to address some of the larger concerns
2 that overall base and supplemental payment spending exceeds
3 the UPL, CMS could review UPL compliance retrospectively
4 using actual data for the year rather than state
5 projections of what the utilization might be for the year.

6 And, finally, to address concerns about the cost-
7 based methods that states use, CMS could require that
8 states calculate the UPL based on actual Medicare payment
9 methods. If the UPL were calculated based on actual
10 Medicare payment rates, it could potentially be possible in
11 the future for CMS to calculate the UPL for states using
12 claims data from T-MSIS or others. But it's probably a bit
13 challenging to do that right up front.

14 So that concludes my presentation for today. I
15 look forward to your feedback on some of these options as
16 well as ideas for any other policy options we should
17 consider. If there is interest in Commission
18 recommendations in these areas, we can further develop
19 policies of interest and prepare specific recommendation
20 language for you later this fall. Thanks.

21 CHAIR THOMPSON: Thank you, Rob.

22 I'll kick things off. I'd like to separate two

1 things, one thing which is, is the calculation of the UPL
2 and the method for doing the UPL proper? Could it be
3 improved? Could it be simplified? Versus there is a UPL
4 but we don't use it, and it doesn't have any impact on
5 expenditure reporting.

6 So in that latter category, there's a couple of
7 things I want to ask about. One is states certify their
8 expenditures. How do states know -- so a lot of our
9 conversation is about the fact that CMS doesn't know
10 whether the expenditures are consistent with the UPL. How
11 does the state know whether the expenditures they're
12 claiming are consistent with their UPL?

13 MR. NELB: For what it's worth, the states we
14 have talked to had the perception that their payments were
15 consistent with the UPL, but these sort of calculations
16 sort of happen in a separate part from the people who
17 actually sort of make the payments.

18 I do think they use these calculations that they
19 submitted to CMS and then sort of base their payments on
20 it. But there is -- so states are responsible still for
21 compliance with UPL requirements, but, yeah, when we shared
22 some of the data that we had with states, they were

1 surprised as well.

2 CHAIR THOMPSON: So, I mean, I say that in part
3 to say this doesn't appear to be solely a federal issue. I
4 think there are issues at the state level, too, in terms of
5 people -- in both the state and the federal government, it
6 sounds like people who do the UPL demonstrations are over
7 here; people are claiming the expenditures are over there;
8 and there aren't necessarily processes to validate that
9 these are consistent with that, and I think we should keep
10 that in view. So that's one point I want to make.

11 The second point I want to make is that there's a
12 process by which CMS can ask a state questions. So even
13 appreciating that there may not be a specific crosswalk
14 between the UPL demonstrations and the CMS-64, and to do so
15 may, you know, require systems changes and programming and,
16 you know, et cetera, et cetera. But the people who are
17 reviewing state-claimed expenditures and approving those
18 should be making use of lots of different pieces of
19 information in order to assure themselves that the claims
20 for expenditures are proper. And there's a process by
21 which the CMS staff can ask questions of a state and say,
22 "I need more information or documentation to assure myself

1 that these claimed expenditures are proper." That's the
2 deferral process.

3 So as those expenditures are being claimed on the
4 64 and are being reviewed, questions can be asked of
5 states: Well, what does this mean? Why does this number
6 look like this? If CMS isn't satisfied, it can issue a
7 deferral. There's a process by which states submit
8 additional documentation.

9 So even if there isn't this, you know, more
10 elegant crosswalk that occurs on the 64 itself, there is
11 still a process of federal financial management that allows
12 people to ask questions and collect information. And so,
13 you know, I think there's also an opportunity to use that
14 process to say, you know, "As I'm reviewing your claimed
15 expenditures, I'm looking at your UPL demonstration, and
16 I'm missing some information." Or, "I'm not sure that this
17 is correct. Can you show me your calculations to ensure
18 that this is proper?"

19 So I just raise those points to say part of this
20 is a dual responsibility on the part of both the federal
21 and the state government to ensure that claimed
22 expenditures are proper. And I think in terms of any

1 advice that we might want to give both the states and CMS,
2 both of whom are within our mandate to be able to advise,
3 that each should be looking at ensuring that the proper
4 process is being used to comply with the requirements of
5 the UPL.

6 I think there's a different subject about, you
7 know, how the UPL is calculation and, you know, are there
8 places where that doesn't provide the kind of fiscal
9 protection that people want it to provide for federal
10 match. And that to me is a more complicated matter, and
11 maybe that's something that we should be taking into view
12 as we have this larger conversation about hospital payments
13 and know kind of what the UPL does and doesn't do in the
14 current system. But I think on these other aspects of just
15 process and operations and confidence about the appropriate
16 claiming and match for expenditures, there are some -- a
17 variety of different steps that both the federal and state
18 government can do to correct the situation in the shorter
19 term.

20 Stacey, were you trying to jump in and say
21 something?

22 VICE CHAIR LAMPKIN: At any point.

1 CHAIR THOMPSON: Go.

2 VICE CHAIR LAMPKIN: So thanks, Rob. This is
3 really helpful, kind of in line with our conversations
4 about hospital payment and financing transparency. A state
5 policymaker said something to me one time about this system
6 being something of a Rube Goldberg contraption, and it
7 certainly does look like that, of course. And situations
8 like this just make it worse and harder to understand.

9 And so from my perspective, I agree with Penny
10 about the bifurcation that she made on the first two policy
11 options on your slide. I personally would like to see us
12 develop those options a little bit and see some pros and
13 cons with the potential recommendations to come in those
14 areas. I think that does seem like an area we should look
15 at.

16 On the third one, with respect to how the UPL is
17 calculated, I'd like to understand a little bit more about
18 why it is the way it is, why there are the options that
19 there are, before we come to any conclusions there. I
20 mean, there are some strange-looking things about it, but
21 we also know that, at least historically, Medicare hasn't
22 done a lot of maternity and newborn kinds of claims, and so

1 there may have been systems developed to work around
2 inadequacies of Medicare pricing to be able to calculate a
3 Medicaid UPL. So I think we could use some more information
4 on that before knowing whether there's fertile ground there
5 for a recommendation. But thank you for doing this. This
6 was really helpful follow-up to the spring.

7 CHAIR THOMPSON: All right. We've got Toby,
8 Brian, Bill.

9 COMMISSIONER DOUGLAS: So more of a question,
10 just understanding the two different -- you know, from a
11 state perspective. There's the UPL, achieving the
12 compliance or getting approval for your UPL, and then the
13 payments. And it is kind of like the left and the right
14 hand are separate. And Penny's raising this idea of
15 bringing them together, and I just want to understand on
16 the current rules, is that really -- would that trigger a
17 deferral when CMS had approved the UPL and yet it wasn't in
18 line with the actual payment?

19 MR. NELB: Let's see. CMS, as part of the UPL
20 demonstrations, has made maybe just a handful of deferrals
21 for a couple states where they're -- on the calculations
22 that they've submitted to CMS, they exceeded the UPL. But

1 the UPL demonstrations are submitted prospectively, and
2 they're never like officially approved by CMS, and so there
3 is no process after the fact, if actual payments are above
4 or below, there's no process to go back and sort of
5 recalculate it or do any adjustments.

6 Part of it, it's a reasonable estimate, so it's
7 not -- sort of as long as it was close enough, there's no -
8 - it's never sort of a final number that's used to track,
9 unfortunately.

10 CHAIR THOMPSON: Well, let's talk about what the
11 deferral process -- what approval or deferral process or
12 disallowance process does, which is that if there is any
13 information indicative to CMS that the claims expenditures
14 are not proper, CMS has the opportunity to ask questions or
15 defer those expenditures and allow states to respond. So
16 any external information can be used -- a GAO report, an
17 OIG report, prior conversations or issues that occurred
18 between the federal and state governments -- to ask those
19 questions. That's the duty of the CMS officials who are
20 approving federal match for those expenditures.

21 And so the point is that say it's a state plan
22 amendment or a waiver, that state plan amendment may be

1 approved, that waiver may be approved, but you are unclear
2 how the expenditures are lining up to those authorities.
3 So this is the same kind of question in my mind. It
4 doesn't mean that you have some kind of systems-based,
5 code-based crosswalk that says, you know, oh, this is the
6 level of expenditures approved under, say, the state plan
7 amendment. But if you have a state plan amendment that
8 says we're doing these kinds of services and this kind of
9 geography, and the expenditures are far more than what
10 would have been expected or projected under that, you have
11 an opportunity to ask the question: Are these expenditures
12 correct? These look a little different than I would have
13 expected given the approvals that you're operating under.

14 So that's the process that I'm talking about, and
15 to the extent that there is a question in the federal
16 staff's mind about the appropriateness of those
17 expenditures, there are established processes that ensure
18 states have due process as those expenditures are being
19 matched or deferred from match.

20 COMMISSIONER DOUGLAS: I understand. Part of
21 this gets to the question of up front or retrospective, and
22 from a state's perspective, it is viewed as kind of we got

1 approval, we're going forward, and yes, the UPL. Then it
2 gets into utilization and all the different things, the
3 factors that play out.

4 It would give me pause that this would turn into
5 a retrospective and then giving back funding and states not
6 being able to deal with the impacts and having to take that
7 back from hospitals as well as their budgets. But there
8 needs to be more work on the front end on really improving,
9 if this is an issue going on, then it gets to the questions
10 on the front end, what are we doing to set the right
11 policies so that there is better accuracy.

12 CHAIR THOMPSON: Well, right. I think that we
13 would all agree better to have clarity and confidence up
14 front and then to be in a mode where expenditures have been
15 made but now are not being acceptable for match. I mean,
16 that's a bad situation.

17 COMMISSIONER DOUGLAS: Yeah.

18 CHAIR THOMPSON: And that's, again, why I'm
19 asking what steps are the states taking to ensure that the
20 expenditures they are making and then claiming are in fact
21 in accordance with the UPL, as they understand it.

22 There can always be a dispute between the federal

1 and the state governments as to whether or not we're all
2 interpreting the UPL in the same way, and the state can
3 say, "Well, I think I'm operating in accord with my
4 approved UPL," and the feds can say, "I don't think you
5 are." Then they've got to sort that out.

6 But it sounds like what we have now is a lot of
7 people -- here's a UPL, but then the expenditure claiming
8 happens without a nexus to that, and the expenditure review
9 and approval happens without a nexus to that. And that's
10 what I think -- this is not the only situation in which
11 there are necessary authorities in order to claim
12 expenditures. That happens all the time. All expenditures
13 operating under approved authorities.

14 So we should just not create a new -- I'm just
15 suggesting we shouldn't create a new process for this, and
16 it's not even a new question. It's the actual use and
17 relevance of the UPL demonstration to the expenditures.

18 So we have Brian and then Bill.

19 COMMISSIONER BURWELL: So I have a question. Can
20 you explain to me kind of conceptually the similarities or
21 differences between the concept of the Medicaid shortfall
22 and the UPL gap?

1 MR. NELB: So Medicaid shortfall that we talked
2 about with DSH is the difference between a hospital's cost
3 and the payment that it receives for Medicaid services.

4 In a state that does a cost-based UPL demo, the
5 upper payment limit is the hospital's cost. So it's sort
6 of the same thing, the difference between the payments and
7 the cost. The amount that they could make is a UPL
8 payment.

9 Some states do use actual Medicare payment
10 methods, which are below. Medicare doesn't fully pay
11 hospital's costs, so that level is a bit lower than cost.

12 COMMISSIONER BURWELL: I guess the bottom line is
13 they're double counting. Are they the same? Because they
14 overlap in those two definitions.

15 MR. NELB: No. So for DSH, Medicaid shortfall is
16 calculated after accounting for the base and supplemental
17 payments. So if there's anything left over after that,
18 then it counts as Medicaid shortfall for DSH.

19 For the UPL, we're just looking at the fee-for-
20 service payments.

21 COMMISSIONER BURWELL: Okay.

22 CHAIR THOMPSON: Bill.

1 COMMISSIONER SCANLON: Okay. This relates to
2 Brian's question as well as what Stacey was talking about
3 in terms of how Medicare pays and sort of how you might
4 sort of adjust, because when I was looking at the
5 materials, I was thinking to myself why would you have cost
6 be the basis when the principle is we're trying to have an
7 upper payment limit, which is what Medicare would have
8 paid, and there is the issue of case mix, which you have to
9 make that adjustment.

10 And I can imagine there was a time maybe about 10
11 years ago, where it was relatively convenient to say, well,
12 use cost because Medicare at that point was paying on
13 average sort of the cost of care across the country, that
14 Medicare margins were typically around zero. And that's
15 changed, and it's changed, very deliberate policy change,
16 but not in some respects what one might think of as a major
17 sort of shift in payment methods.

18 We still are using the prospective payment
19 system, DRGs. What we've done is we've changed the
20 updates. We changed the updates from being sort of
21 inflation to something less than inflation, to recognize --
22 and this has been a MedPAC position. MedPAC has been

1 reporting on this for a long time, continues to report on
2 it, that there's a difference between what are reported
3 costs, which are accounting costs, and what you might think
4 of as the necessary cost to deliver care. And they're
5 trying to encourage through policy that hospitals cost,
6 that the money they are actually spending comes closer to
7 those necessary costs.

8 And what MedPAC has demonstrated over and over
9 again is that hospitals -- and you shouldn't be surprised,
10 given they're nonprofits -- they spend the money they get.
11 You look at hospitals that have much stronger private
12 revenues, they spend more, and their spending grows faster
13 than hospitals that have more limited revenues.

14 And we don't detect big differences or any
15 differences, significant differences, in terms of quality
16 of care.

17 Admittedly, our measures of quality of care sort
18 of need to be improved, but the reality is we don't see
19 anything in terms of what we have sort of measured now.

20 This idea of using cost, over time it's going to
21 continue to increase what the upper payment limit cap is,
22 as opposed to if we were going to what Medicare's current

1 sort of payment methods are, which I would say is an effort
2 to try and make sort of our spending sort of on health care
3 more efficient, which would benefit Medicaid beneficiaries.

4 Part of the problem that Medicaid beneficiaries
5 have is care costs are growing too much, and states are not
6 ready or able to meet all those increases in cost, and this
7 ends up creating sort of access problems.

8 I'll go back to Brian's comment about the
9 Medicaid shortfall. I would like the word "necessary"
10 inserted in that sentence, which is "The Medicaid shortfall
11 is the difference between what Medicaid pays and the
12 necessary costs of delivering care." I understand that
13 there would be difficulties in terms of how to measure
14 that, but I think we need to have that focus if over time,
15 we're going to bring more rationality to the cost of care,
16 which is going to improve access and ultimately can also
17 probably improve quality if we can think about how do we
18 focus our attention on what good quality is and say we are
19 insisting on that as well as we're insisting on sort of
20 better access.

21 Thanks.

22 CHAIR THOMPSON: Fred, you wanted to jump in?

1 COMMISSIONER CERISE: Just a quick comment.

2 First, Rob, great work again, and I do think it's
3 important to put better structure and parameters around
4 this, just because as we talk about the other supplemental
5 payment methods you squeeze on one area, it's going to
6 balloon out in the other area. And so having some
7 parameters around this, more definition is going to be
8 important.

9 I agree with Bill's comments around the cost
10 issue. I think you're better of tagging to Medicare and in
11 those situations where Stacey references you don't have
12 good -- to figure out something that's not just strictly
13 based on cost.

14 Then your comment about the provider taxes being
15 included in there, if we're going to talk about the means
16 of financing as a perverse incentive to do these things, it
17 would not be unreasonable to not include those costs.

18 CHAIR THOMPSON: Okay. Any other commentary on
19 this?

20 [No response.]

21 CHAIR THOMPSON: So, Rob, let's separate out
22 these two questions. I think there's a lot of interest in

1 continuing to look at the underlying methodology, the
2 choices that states have about how they're going to
3 calculate the UPL, what's going to be included, et cetera.
4 And I think that is something we'd like to put on your
5 agenda to come back to us on.

6 The easier piece for me is this kind of just
7 administrative hygiene piece, where I think that we can
8 come up with some steps that we think both CMS and states
9 ought to be taking to give greater confidence. That to the
10 extent we're living under a UPL system today, with whatever
11 flaws it has, that at least it's being applied equitably
12 and correctly across states and across expenditures. So
13 maybe that's something that you can come back with as early
14 as next meeting, with some language and parameters around
15 what we ought to be saying to CMS and states about that.

16 Let me just pause and see if there's any public
17 comments on that subject or any others that we talked about
18 this morning.

19 [Pause.]

20 CHAIR THOMPSON: All right. Let's move on to
21 therapeutic foster care.

22 Thank you, Rob.

1 [Pause.]

2 CHAIR THOMPSON: All right. Martha. Thank you.

3 #### MANDATED REPORT: THERAPEUTIC FOSTER CARE

4 * MS. HEBERLEIN: Okay. So good morning.

5 As Penny said, we're going to conclude our
6 meeting today talking about a mandated report on
7 therapeutic foster care.

8 So I will begin by describing the congressional
9 request that has led to this work before explaining
10 Medicaid's role for children in child welfare. I will then
11 provide an overview of therapeutic foster care and state
12 practices before turning to some questions for your
13 consideration.

14 So, to begin, in the report accompanying the
15 fiscal year 2019, Labor, Health and Human Services, and
16 Education Funding bill, the U.S. House of Representatives
17 Committee on Appropriations requested that MACPAC examine
18 therapeutic foster care.

19 Specifically, the committee expressed concern
20 regarding the lack of a uniform definition of therapeutic
21 foster care in Medicaid and has requested that within 12
22 months of enactment that MACPAC conduct a review for the

1 development of an operational definition of therapeutic
2 foster care, examine the advantages of the universal
3 definition, and include a list of potential services to
4 treat mental illness and trauma that would be within the
5 scope of such a definition. So we will begin to address
6 this request today.

7 So, if you recall, we wrote a chapter on the
8 intersection of Medicaid and child welfare back in 2015, so
9 these findings sort of draw from that earlier work.

10 So the majority of child welfare-involved
11 children and youth are eligible for Medicaid either because
12 they receive child welfare assistance, because of their low
13 family incomes, or because of their disability status.

14 Children involved in the child welfare system
15 often have significant medical, behavioral, and other
16 social needs for which a range of Medicaid-covered services
17 may be necessary and appropriate.

18 For example, among children eligible for Medicaid
19 based on foster care assistance, 49 percent had diagnoses
20 of mental health disorders, and 3 percent had diagnoses of
21 substance use disorders.

22 For other children in Medicaid, the figures were

1 11 percent and less than 1 percent respectively.

2 Although it is not possible to identify the
3 entirety of the child welfare population enrolled in
4 Medicaid, about 1 million children were reported as ever
5 enrolled based upon their receipt of child welfare
6 assistance in fiscal year 2011. This accounted for about 3
7 percent of nondisabled child enrollees; however, due to
8 their high health needs and service use, Medicaid benefit
9 spending for these children totaled about 5.8 billion in
10 fiscal year 2010 or about 9 percent of spending for
11 nondisabled children.

12 So there is currently no uniform definition of
13 therapeutic foster care in either federal statute or
14 regulation; however, therapeutic foster care can be
15 described generally as the practice of serving children and
16 youth with serious conditions in a family-based setting.

17 Children receiving therapeutic foster care most
18 often have serious emotional or behavioral health needs,
19 but may also have serious medical conditions. Given their
20 high needs, these children and youth would typically be
21 placed in a group or institutional setting, often referred
22 to congregate care.

1 Therapeutic foster care provides a less-
2 restrictive environment and allows the needs of these
3 children to be met in the community.

4 All states provide some form of therapeutic
5 foster care, although the programs vary widely in a number
6 of dimensions, including which children they serve, what
7 services are provided, and whether the services are paid
8 for by Medicaid.

9 Even though the definition of therapeutic foster
10 care is not uniform, there are certain common elements.
11 For example, the services provided within therapeutic
12 foster care typically include crisis support, behavior
13 management, medication monitoring, counseling, and case
14 management services.

15 Children in therapeutic foster care receive an
16 individualized treatment plan, and their treatment team
17 typically meets on a more frequent basis than children in
18 more standard foster care arrangements.

19 Foster parents serving these children typically
20 receive higher levels of training, payment, and case worker
21 support, and are considered part of the treatment team.

22 Many states have multiple levels of therapeutic

1 foster care with higher payment levels to families,
2 depending on the child's needs, and states can also pay
3 higher rates for more intensive Medicaid services.

4 So similar to how states provide other health
5 services to the child welfare population, they often use
6 Medicaid funds to pay for the clinical aspects of
7 therapeutic foster care, such as behavioral health
8 treatment, and child welfare funds under Title IV-E to pay
9 for living expenses, such as room and board, administrative
10 costs, and recruitment and training of foster parents.

11 Therapeutic foster care is not currently included
12 in the list of optional or mandatory Medicaid benefits. As
13 such, states have used a variety of approaches to finance
14 the treatment component of therapeutic foster care using
15 Medicaid funds.

16 For example, many states define therapeutic
17 foster care as a rehabilitative service, which includes a
18 variety of services to treat mental and physical health
19 conditions, designed to return children to function at age-
20 appropriate levels.

21 Of the 38 states that responded to questions
22 regarding Medicaid billing for therapeutic foster care

1 services for children in foster care, 31 reported having
2 specific billing codes for therapeutic foster care under
3 rehabilitative services. Twenty-two reported specific
4 billing codes under targeted case management options,
5 including a large number that also reported using the
6 rehabilitation option.

7 Other states consider therapeutic foster care a
8 behavioral health service, and some states report that
9 therapeutic foster care services are provided under
10 waivers.

11 So as the Commission considers the merits of a
12 universal definition of therapeutic foster care, some
13 questions come to mind. For example, would a uniform
14 definition result in consistency across states, and how
15 would that change state flexibility?

16 As just discussed, all states provide some form
17 of therapeutic foster care, but the specifics vary. As in
18 the case of many other Medicaid policies, this variation
19 likely reflects both the needs of the enrollees and state
20 decisions regarding available resources. It is not clear
21 how much this variation would change with the adoption of a
22 universal definition, as states do not always adopt the

1 options provided to them and may view their current
2 approach as the most appropriate for their circumstances.

3 Furthermore, the effects would likely depend upon
4 whether the definition is operationalized through guidance
5 or added to the statute as a mandatory or optional benefit,
6 as well as how prescriptive that definition is.

7 Operationalizing a universal definition of
8 therapeutic foster care may be done through the issuance of
9 sub-regulatory guidance. This guidance could describe how
10 therapeutic foster care can be provided under existing law.

11 Further direction from the Secretary could help
12 clarify which benefits should be included in therapeutic
13 foster care, appropriate billing practices for such
14 services, steps to ensure participation from qualified
15 providers, and ways to effectively coordinate with other
16 agencies serving these same high-need children and youth,
17 including child welfare, juvenile justice, and behavioral
18 health agencies.

19 Such an approach would not add a new benefit to
20 Medicaid but merely clarify how states can use the existing
21 benefit design flexibility to provide therapeutic foster
22 care services.

1 Alternatively, therapeutic foster care could be
2 added as a statutory benefit. Designating therapeutic
3 foster care as a mandatory benefit would require all states
4 to cover the service, but would limit a state's ability to
5 pick and choose which benefits to offer under a therapeutic
6 foster care umbrella.

7 Adding therapeutic foster care as an optional
8 benefit, would not require states to provide therapeutic
9 foster care, but may allow them to more easily cover a
10 consistent package of services as opposed to piecing
11 therapeutic foster care together from available benefits,
12 such as rehab and targeted case management.

13 In this case, states could choose to add
14 therapeutic foster care to their state plan, choose not to
15 offer the benefit, or continue their current state
16 practice.

17 Unlike operationalizing a definition through
18 guidance, adding therapeutic foster care as a statutory
19 benefit could potentially limit state flexibility. On the
20 one hand, states would continue to have the flexibility to
21 define medical necessity and the amount, duration, and
22 scope of the benefit; however, the Secretary could still

1 put parameters around this flexibility if he chose to
2 further define the benefit through regulation or guidance.

3 Furthermore, designating therapeutic foster care
4 as an optional benefit under Section 1905(a), has
5 implications for the early and periodic screening,
6 diagnostic, and treatment, also known as EPSDT, benefit,
7 which requires states to provide any medically necessary
8 service named in the Medicaid statute, including optional
9 services not otherwise covered by the state, without caps
10 or limits. This could potentially result in states
11 providing therapeutic foster care to a broader population
12 of children and youth.

13 States face a number of difficulties in providing
14 therapeutic foster care, including recruitment and training
15 of caregivers, ensuring delivery of quality, evidence-based
16 services, and securing adequate funding. A universal
17 definition of therapeutic foster care may assist in easing
18 some of these concerns, but may not eliminate them.

19 For example, therapeutic foster care requires
20 highly skilled and committed caregivers, and while these
21 programs provide additional training, support, and payment
22 to these families, recruitment is a challenge in most

1 states.

2 Concerns have also been raised regarding the
3 quality of TFC providers and agency screening of foster
4 parents.

5 To address some of these concerns, advocates have
6 promoted coupling a universal definition with requirements
7 for specialized training and accreditation. Provider
8 requirements are typically the purview of states, although
9 federal standards have been established in some
10 circumstances, such as for nursing facilities.

11 In addition, while a uniform definition may
12 provide some consistency in the children served and
13 services provided across states, it may not increase the
14 adoption of evidence-based practices. There are two
15 evidence-based therapeutic foster care approaches that are
16 discussed in your materials, yet most states have not
17 adopted these approaches, given the difficulty of
18 implementation and caregiver capacity.

19 So, finally, therapeutic foster care is less
20 costly than congregate care, it is more expensive than
21 standard foster care. Many states are interested in
22 shifting from congregate care settings and expanding their

1 use of therapeutic foster care, but child welfare funding
2 limitations may impeded their ability to do so.

3 So, with that as background, I will turn it over
4 to you for discussion. Our plan to fulfill this
5 congressional request is to come back to you at a later
6 date with a draft response for your comments and review
7 that draws on your discussion today and any additional
8 research you request from us.

9 CHAIR THOMPSON: Thank you, Martha.

10 I just want to clarify one point about -- as I
11 read the request, talking about a universal definition does
12 not necessarily mean that we get into a conversation about
13 coverage or benefits as opposed to -- and this goes back to
14 kind of, I think, your first point, which is there's an
15 ability to kind of construct, this is like the preferred
16 model for therapeutic foster care and here's how you put
17 together IV-E and Medicaid in support of that model as
18 something states take and use and say, okay, I will either
19 do that because that gives me kind of a standard to
20 reference, or I'll just keep doing something else that
21 makes more sense in my state, versus, well, are we
22 constructing a new benefit. Help me understand your

1 thinking about how a universal definition of what this is,
2 which has to do with delivery of care and thinking about
3 the professionalization and the standardization of these
4 services as against constructing a new benefit or a way of
5 producing federal match for something that we don't
6 currently match.

7 MS. HEBERLEIN: Oh, I think there are a number of
8 approaches you could take. I think you could say this is
9 sort of the state of practice and these are the things that
10 we think are good about that practice and that we should
11 encourage among states. And that could be, you know, how
12 you frame your response.

13 The Secretary could provide additional guidance
14 that sort of supports that, or it could go as far as a new
15 definition. I think from what I've read, all the states
16 are currently figuring out some way to do this and have
17 pieced together something from already available benefits.
18 And so then the question becomes, you know, if they're
19 already sort of doing this, what's sort of the best way to
20 encourage -- if you think there should be more uniformity,
21 what's the best way to encourage uniformity across the
22 states? And I think you have different options as to how

1 you would want to do that.

2 CHAIR THOMPSON: Thank you. Okay.

3 Kit?

4 COMMISSIONER GORTON: Okay. Well, nice to be
5 asked to do work. So I want to disclose that my response
6 to this is not from my typical perch but from a different
7 perch, so I'm going to answer this -- I'm going to provide
8 feedback as a pediatrician who worked in federally
9 qualified health centers for 17 years and as a person who
10 has done therapeutic foster care for two children, one of
11 whom had profound physical disabilities and one of whom had
12 behavioral health issues.

13 So it's an important service, and while I have
14 been a frequent critic over the years of expanded EPSDT in
15 OBRA '89. In my view, this is a service which clearly
16 should fall into that rubric and clearly should be
17 available. So while I think it's great that states have
18 figured out a number of piecemeal and partial responses to
19 delivering this service, my personal experience in a fairly
20 well-put-together large state was that it was a struggle
21 with both of our kids just because of the system lines and
22 children, youth, and Medicaid and mental health and

1 substance use -- so it's a morass from a bureaucratic and
2 administrative point of view trying to take care of these
3 children, and it's certainly hard on parents, and hard on
4 the kids. So I do think that there is value in
5 regularizing this, and my personal view would be that it
6 probably should be added -- I don't know that it needs to
7 be added as a statutory definition. I mean, there's an
8 awful lot covered under what is medically necessary care
9 for children before their 21st birthday. But we ought to
10 push it into that realm so that -- because I don't think --
11 you know, typically I stand here and I say states need
12 flexibility and blah, blah, blah. This is a place where
13 these are some of the most vulnerable children and some of
14 the neediest children we have, and if we don't want them in
15 congregate settings, which is not good for them, then we
16 need some other option for it.

17 And so I would encourage us to end up being in a
18 place where this is not seen as, no, we don't want to do
19 that here. And if the only way to do that is to add it to
20 the standard benefit, then that's fine. If there are other
21 ways to do that, I don't know the benefit rules well enough
22 to know, but I don't think this should be optional. That's

1 my personal opinion. This is as important to these
2 children as ambulances are to people having heart attacks
3 and as medicine is to people who need medicine. And it can
4 be life-altering if done properly. So that's one thing I
5 want to say.

6 The other thing I wanted to say is I was alarmed
7 in reading the materials to see some states saying, oh,
8 this is a behavioral health service, or this is a rehab
9 service, because in some ways it's a habilitative service,
10 not a rehab service. These are people gaining stuff that
11 they didn't have before. And, you know, my thought's
12 heavily covered by my son, who, you know, yeah, he had some
13 cognitive and intellectual stuff, but his overarching issue
14 was his spinal muscular atrophy, and so it was his physical
15 disability. And if we think about serving kids with those
16 kind of complex needs, it makes me anxious to be siloing
17 and bucketing because --

18 CHAIR THOMPSON: You're afraid it distorts the
19 service --

20 COMMISSIONER GORTON: It distorts, yes.

21 CHAIR THOMPSON: -- because of fitting it into
22 some category that really isn't -- doesn't have the right

1 parameters.

2 COMMISSIONER GORTON: Exactly. So, you know,
3 expanded EPSDT gives us the opportunity to serve these
4 kids, not in congregate settings, in ways which meet their
5 needs and give support to families. And so I'm glad we got
6 asked to do this, and that would be the direction that I
7 would hope we would take moving forward.

8 CHAIR THOMPSON: Toby, Chuck.

9 COMMISSIONER DOUGLAS: Well, I have a follow-up
10 on just this definition of EPSDT from -- so California,
11 when I was there, we were litigated over -- a litigation
12 called Katie A. And my understanding is that we covered --
13 and we worked a lot with CMS to try to fit -- there were
14 multiple components to it, therapeutic foster care being
15 one of the three major pieces. But I thought it was an
16 EPSDT benefit, and that was through working with CMS. So I
17 am a little confused on the definition.

18 MS. HEBERLEIN: So if you have adopted a service,
19 or not, but a service that is listed in 1905(a) is covered
20 under EPSDT, and so in California's case, you had provided
21 some of these services. And so EPSDT applies to anything
22 that's in 1905(a). And to Kit's point, the services that

1 many of these kids need may already be services listed in
2 1905(a). So the question then is: Is there enough there
3 to sort of cover the services these children need? Or are
4 we adding sort of a new 1905(a) service, which would then
5 have its own EPSDT requirement with it.

6 COMMISSIONER DOUGLAS: Meaning the way California
7 implemented it, it was by taking the services that were
8 already in 1905(a) --

9 MS. HEBERLEIN: Yes.

10 COMMISSIONER DOUGLAS: -- and turning into the
11 definition of therapeutic --

12 MS. HEBERLEIN: That's my understanding of Katie
13 A., not reading the full --

14 COMMISSIONER DOUGLAS: Okay. Yeah, if you could
15 talk with us offline about --

16 MS. HEBERLEIN: That would be great. Thank you.

17 CHAIR THOMPSON: Chuck.

18 COMMISSIONER MILLIGAN: A question, and I want to
19 make a comparison to opioid conversations we've had before
20 where there's emerging through a lot of work a kind of -- a
21 sort of standard of practice based on kind of
22 characteristics of individuals who need the service kind of

1 working up a range all the way to kind of inpatient, but,
2 you know, a variety of outpatient treatments and so on.

3 And so using that as an analogy, with respect to
4 therapeutic foster care, is there a body, a professional
5 body that is developing clinical criteria, accreditation,
6 licensure, that kind of rubric, or not in terms of kind of
7 what work is out there that could be leveraged?

8 MS. HEBERLEIN: So there is an association of the
9 providers, and it's FFTA -- and I'm not going to remember
10 the acronym correctly, and I apologize for that -- and they
11 have done a toolkit that sort of talks about what the
12 practices should be. And I think, you know, sort of the
13 idea is that these kids need a lot more services and can
14 receive those services in family-based settings as opposed
15 to congregate care. And I think to Kit's point that the
16 services they need are very dependent upon the children,
17 and in some cases they might need more medical services,
18 and in other cases they might need more behavioral health
19 services. They might need more social skills training. I
20 think it depends upon the kids themselves. But there is a
21 body that has focused on sort of what the providers should
22 provide and the provider training and that sort of stuff.

1 CHAIR THOMPSON: I'm wondering, Leanna, is there
2 anything that you want to add to this conversation?

3 COMMISSIONER GEORGE: I think my biggest question
4 is: How is this different than alternate family living?
5 That is one of the residential models that are out there,
6 where an individual can go and live with another family.
7 I'm just trying to figure out what is the difference
8 between these two items.

9 MS. HEBERLEIN: Well, I'm not familiar with that
10 model, so I will try to answer the question.

11 COMMISSIONER GEORGE: I stumped her [off
12 microphone].

13 [Laughter.]

14 MS. HEBERLEIN: I know, stumped. I'm the first
15 one. I will go down and say that with honor that I have
16 been stumped by Leanna today.

17 So I think the -- so most of these kids are child
18 welfare-involved, and so Title IV-E funds, if they are
19 Title IV-E eligible, would pay for their room and board and
20 those other services. And so that might be what is
21 slightly different in this model, is that, you know, in
22 some states they are not all child welfare-involved youth,

1 but for the most part they are child welfare-involved, and
2 so you have a different agency that's sort of paying for
3 part of their services and is responsible for, you know,
4 their physical well-being and trying to establish
5 permanency for them. And then you have Medicaid that sort
6 of comes in and fills in the medical piece of it. So I
7 think that's part of the issue here, is that there's also
8 at least two agencies, if not more, sort of responsible for
9 the child's well-being.

10 CHAIR THOMPSON: But it does raise the question
11 of making sure that we take into view similarly situated
12 children with similar needs and how they're being served
13 and how that does or does not line up to something that
14 people might be interested in for foster kids.

15 Chuck?

16 COMMISSIONER MILLIGAN: And I'm sorry. It took
17 me a little while to kind of formulate a follow-up to my
18 earlier questioning. Going back to Kit's example with his
19 two kids, what I'm struggling with here, Martha, is: Is
20 this a service or is it a constellation of services under
21 the name therapeutic foster care? Because if it's really -
22 - it's almost like saying HCBS is a service when it's a

1 modality of delivering an array of services. And so I
2 think that's what I'm struggling with in terms of how we
3 define whether this is a service or this is kind of an
4 overarching umbrella name we give to an array of services
5 underneath that are customized to kids.

6 MS. HEBERLEIN: My personal opinion -- and there
7 may be others who disagree with me -- is I think it's the
8 latter. I think there are -- it's whatever this child
9 needs, they're sort of piecing together what they can for
10 this child under the Medicaid covered services. And then
11 where the services are not Medicaid covered, they may be
12 paying for them with IV-E funds or something else.

13 I think there's also the idea that this takes
14 place in a particular setting, similar to what you're
15 saying about HCBS, is that these services are typically
16 provided in a therapeutic foster home, and so this is the
17 setting and you can sort of think of them as a
18 constellation of services that are provided within this
19 particular setting.

20 CHAIR THOMPSON: Any other comments or questions?

21 [No response.]

22 CHAIR THOMPSON: Martha, first of all, very

1 useful materials, very informative, good discussion. I
2 think that you're on the right track. I think you're
3 asking the right questions. We'll be very interested to
4 see some of the different options that you're coming back
5 with.

6 I think, you know, the question for us is: How
7 far do we want to go in making particular recommendations
8 or suggesting new benefits? I think at minimum, to the
9 extent that we can record and reflect the state of practice
10 and how to make this work, even under the current
11 authorities, I think that'll be a big contribution and
12 help. And then I think, you know, bringing some light to
13 some of the issues that you've identified will be helpful
14 to the Congress as they contemplate what additional steps
15 they might want to take on this subject. So we'll look
16 forward to that conversation.

17 Okay. Any final comments from the Commissioners
18 on this topic or others?

19 [No response.]

20 CHAIR THOMPSON: Any final comments from the
21 public?

22 #### PUBLIC COMMENT

1 * [No response.]

2 CHAIR THOMPSON: All right. We are adjourned.

3 [Whereupon, at 11:19 a.m., the Public Session was

4 adjourned.]

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20