



PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

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[9:30 a.m.]

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

[Pause.]

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

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

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

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

9 **### PANEL ON STATE APPROACHES TO FINANCING SOCIAL**
10 **INTERVENTIONS THROUGH MEDICAID**

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

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

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

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

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

21 Our final panelist will be Kevin Moore, Vice
22 President for Policy with UnitedHealthcare Community and

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

9 And with that I will turn it over to Jocelyn.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the same model that our team built decades ago for CMS, the
2 HCC relative risk score. So we basically take age, sex,
3 and all the medical problems observed during a year on
4 medical claims and create a summary measure of expected
5 health care costs, and then it's relativized -- that's the
6 first R in relative risk score -- so that a 1 means
7 average, and if the state is planning to spend \$5,000 on
8 average per person in the Medicaid program, then a 1 means
9 the provider who agrees to care for that person will get
10 \$5,000. It's a little more complicated than that. There's
11 adjustments for geography, et cetera, but that's the idea.

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

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

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

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

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

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

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

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

1 We also, in this exercise of asking people who
2 they were worried about, people with serious mental
3 illness, people with substance use disorders, they were a
4 special concern, and when we built the model the first time
5 around we noticed that unless we put in separate markers
6 for those problems we were not getting the payment high
7 enough. I will tell you that for reasons we don't
8 understand in Version 2 we no longer need those extra
9 markers. So they're not just there because, ideologically,
10 we think they should be there. They were there in Version
11 1 because they proved needed to get the payments right.
12 They are not there in Version 2 because the other
13 information that's in the model already captures their
14 costs and gets it right.

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

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

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

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

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

22 Anyway, the details here are we did not model

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

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

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

16 Oh, got one minute. All right.

17 [Laughter.]

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

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

3 So we believe that these new dollars could
4 support interventions. We'll be looking to see if they do
5 support interventions. We do know that putting an extra
6 \$600 for coded homeless into the model is changing the
7 interest of organizations in seeing that it gets coded when
8 it's present, and we'll be looking to see if the changes
9 that we made actually do lead to innovative ways to address
10 these problems.

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

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

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

18 MR. VAN BUREN: Go for it.

19 [Laughter.]

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

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

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

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

12 Thank you very much.

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

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

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

17 [Laughter.]

18 MR. MOORE: So it's fantastic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 I've got two minutes left.

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

13 [Laughter.]

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

22 I hope that those numbers may be a little bit

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

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

16 I've got one minute. Okay.

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

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

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

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

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

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

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

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

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

19 Let me just first ask a couple of quick
20 questions.

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

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

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

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

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

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

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

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

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

1 don't get infections from their wounds.

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

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

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

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

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

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

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

1 the best interest of the member.

2 CHAIR THOMPSON: Martha.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 COMMISSIONER GORDON: And it's a very important

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

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

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

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

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

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

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

3 CHAIR THOMPSON: Peter?

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

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

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

1 program.

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

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

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

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

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

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

4 MR. MOORE: I think the -- I want to echo
5 especially North Carolina as they've done not only looking
6 at a statewide -- just coming up with a statewide screening
7 tool so that you have -- you don't have kind of the
8 hodgepodge of different screening tools, or at least if you
9 do, that you're tethering them back to some core domains
10 that we at least know, you know, food insecurity,
11 interpersonal violence is the other one that really kind of
12 came up through both the CMMI grant as well as the -- in
13 North Carolina. But there I think that one part about
14 North Carolina that's very unique is that -- and correct me
15 if I'm wrong on this, but almost every state talks about
16 SDOH. I think North Carolina has also gone and with their
17 1115 they've asked for resources to be able to support
18 efforts within the state. And then they're also looking to
19 build data platforms to be able to allow providers to bring
20 that information in, and then for the community to be able
21 to push that out. I would concur, the paper that they put
22 out -- not that I may have read it on the way here, but it

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

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

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

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

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

9 CHAIR THOMPSON: Fred, Chuck, Stacey.

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

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

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

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

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

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

7 [Laughter.]

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

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

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

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

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

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

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

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

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

12 So I think that's another ongoing struggle, on
13 the Medicaid-izing side of it, but also just what is that
14 long-term return on investment. I pick on Evicted, but a
15 \$50 ability to pay rent has a huge trajectory in terms of
16 keeping people off of Medicaid, maybe keeping them in work,
17 keeping the kids in school. How do you measure that? And
18 again, I'm not saying that I know the answer to that, but
19 the fact that we're asking the question, I think it allows
20 us to continue to propel that line of thought.

21 CHAIR THOMPSON: Chuck.

22 MR. MILLIGAN: Great panel. Thank you for coming

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

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

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

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

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

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

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

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

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

6 MS. GUYER: Yeah.

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

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

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

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

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

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

10 [Laughter.]

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

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

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

1 their SMI population in Medicaid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 We have a little bit of a recognition of this

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

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

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

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

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

5 So I have Stacey, Martha, and Toby.

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

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

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

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

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

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

19 CHAIR THOMPSON: Martha.

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

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

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

7 CHAIR THOMPSON: Toby.

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

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

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

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

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

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

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

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

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

1 are cutting those monies down.

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

9 DR. ASH: Yes.

10 [Laughter.]

11 CHAIR THOMPSON: Kit.

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

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

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

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

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

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

7 CHAIR THOMPSON: Hear, hear.

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

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

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

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

1 day out.

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

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

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

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

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

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

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

3 Thank you very much.

4 * [Recess.]

5 **### FURTHER DISCUSSION ON STATE APPROACHES TO**
6 **FINANCING SOCIAL INTERVENTIONS THROUGH MEDICAID**

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

9 Okay. Commissioners, I thought that was a really
10 productive conversation and a really good panel, Rick.

11 Thank you very much for organizing that for us.

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

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

22 So one is the area of rate setting and MCO

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

11 Any reactions to those topics or different topics
12 or thoughts?

13 Sheldon.

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

20 [Laughter.]

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

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

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

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

18 CHAIR THOMPSON: Bill.

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

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

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

14 COMMISSIONER RETCHIN: Oh, I get the concept.

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

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

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

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

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

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

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

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

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

8 COMMISSIONER SCANLON: Well, cost effective is
9 different.

10 CHAIR THOMPSON: All right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 CHAIR THOMPSON: Alan?

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

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

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

1 the investment role.

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

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

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

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

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

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

19 CHAIR THOMPSON: Thank you.

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

1 almost immediately.

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

13 Okay. Darin and then Chuck and then Brian.

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

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

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

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

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

16 [No response.]

17 CHAIR THOMPSON: Okay.

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

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

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

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

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

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

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

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

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

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

1 CHAIR THOMPSON: Right, right.

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

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

6 [Laughter.]

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

9 Brian, do you want to jump in?

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

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

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

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

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

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

1 So I just -- that's my uneasiness.

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

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

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

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

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

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

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

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

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

1 specifically because they are outside of that Medicaid box.

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

6 Toby, you can get the last word.

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

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

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

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

4 CHAIR THOMPSON: Done.

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

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

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

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

22 The chapter opens by summarizing Medicaid's

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 Our analysis of state coverage doesn't include
14 which states do have arrangements where residential
15 substance use treatment is being paid for as an in-lieu-of
16 service, but it does include a discussion of how the states
17 are using substance use disorder waivers under the Section
18 1115 authority.

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

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

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

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

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

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

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

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

1 facilities than others.

2 And then providers offering medication-assisted
3 treatment is also limited. A recent study found that only
4 2.7 percent of specialty substance use facilities do offer
5 all three forms of medication-assisted treatment. And then
6 OTPs are also generally located mostly in urban areas and
7 require patients to visit pretty close to daily to get
8 their medication administered. This creates, you know,
9 limited access for patients that do live in rural areas or
10 places where transportation is a challenge.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And a hypothesis that we might look into there is

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

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

16 But nice job. Thank you.

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

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

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

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

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

7 CHAIR THOMPSON: Okay.

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

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

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

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

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

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

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

22 EXECUTIVE DIRECTOR SCHWARTZ: Can I --

1 CHAIR THOMPSON: Go ahead.

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

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

1 things could be, you know --

2 EXECUTIVE DIRECTOR SCHWARTZ: Okay.

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

10 So we have Toby and then Martha.

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

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

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

11 CHAIR THOMPSON: Martha.

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

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

1 2017 and 2018 have dropped dramatically. So I think we
2 need to understand what is going on. Is that problem -- is
3 that causing a problem with access? Is it because of
4 payments? Is it because of additional regulatory
5 requirements or compliance requirements that are putting up
6 barriers to providers to provide these services? Maybe we
7 had an oversupply to begin with. That's hard to believe,
8 but, you know, just -- it's something to think about.

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

13 CHAIR THOMPSON: Brian.

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

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

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

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

14 [Laughter.]

15 CHAIR THOMPSON: What's that?

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

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

20 [Laughter.]

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

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

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

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

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

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

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

11 [No response.]

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

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

17 **### PUBLIC COMMENT**

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

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

8 Thank you.

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

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

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

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1 AFTERNOON SESSION

2 [2:03 p.m.]

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

6 [Pause.]

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

13 **### REVIEW OF PROPOSED RULE: METHODS FOR ASSURING**
14 **ACCESS TO COVERED MEDICAID SERVICES - EXEMPTIONS**
15 **FOR STATES WITH HIGH MANAGED CARE PENETRATION**
16 **RATES AND RATE REDUCTION THRESHOLD**

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

19 [Laughter.]

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

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

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

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

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

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

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

22 In addition to the program accountability

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

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

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

22 Until 2015, there was no federal regulations that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Under the proposed 85 percent threshold, 17

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

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

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

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

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

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

14 The Commission may wish to comment on whether the
15 4 and 6 percent thresholds seem reasonable, which may in
16 part depend on the payment rates that currently exist in
17 states. For example, a 4 percent reduction in a state with
18 already low payment rates could have different implications
19 for access than in a state with higher payment rates.

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

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

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

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

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

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

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

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

9 Another area for potential comment could be the
10 exceptions noted in the earlier guidance. In a November
11 2017 letter, CMS clarified particular circumstances that
12 are unlikely to diminish access and would therefore not
13 invoke the monitoring requirements.

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

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

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

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

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

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

1 And with that, I look forward to your thoughts.

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

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

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

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

18 [Laughter.]

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

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

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

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

14 MS. HEBERLEIN: Yeah.

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

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

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

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

10 CHAIR THOMPSON: I just want to clarify this
11 point.

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

1 COMMISSIONER RETCHIN: It's the Armstrong
2 decision.

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

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

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

20 So Bill, Darin, Peter, Chuck.

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

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

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

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

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

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

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

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

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

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

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

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

8 CHAIR THOMPSON: Darin.

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

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

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

22 The issue was you had that plus you had this come

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

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

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

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

2 CHAIR THOMPSON: Peter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 CHAIR THOMPSON: Okay. Alan?

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

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

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

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

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

9 COMMISSIONER WEIL: So it wouldn't be --

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

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

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

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

6 [Laughter.]

7 COMMISSIONER WEIL: That was an inside joke.
8 But, really, in the end I'm where Peter is. You know, 75,
9 85, 4, 6, all of these to me are completely arbitrary. And
10 I couldn't defend them, and I'm not really sure how CMS
11 intends to do so. I do think, Chuck, despite agreeing with
12 you that I don't think we can agree to 95 or I don't think
13 we can agree to 2, I wonder if we couldn't agree that 75,
14 85, 4 and 6, and particularly when 85 is aggregated across
15 the board, that the arbitrariness does not give us a lot of
16 comfort. I mean, I actually think that's worth saying. I
17 would say it. I'm not sure you all would. That's what I
18 would say.

19 CHAIR THOMPSON: Okay. Kit.

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

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

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

1 then the states beat up on the --

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

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

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

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

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

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

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

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

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

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

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

22 CHAIR THOMPSON: So it seems central to the

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

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

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

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

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

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

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

6 CHAIR THOMPSON: Marsha?

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

12

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

21 We also did a separate piece of work that was a
22 50-state survey, although we didn't get all responding, so

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

10 VICE CHAIR GOLD: Good.

11 MS. HEBERLEIN: In comparison to managed care.

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

19 [Laughter.]

20 CHAIR THOMPSON: I'm not the only one.

21 COMMISSIONER GORDON: I'm flattered.

22 VICE CHAIR GOLD: Yeah, about that managed care

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

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

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

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

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

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

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

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

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

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

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

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

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

22 CHAIR THOMPSON: Toby.

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

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

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

9 CHAIR THOMPSON: Alan.

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

20 CHAIR THOMPSON: Oh.

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

22 MR. DOUGLAS: The Ninth Circuit believed the same

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

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

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

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

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

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

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

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

21 Bill and then Chuck.

22 DR. SCANLON: I mean, I think this happens

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

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

22 CHAIR THOMPSON: Chuck, do you want to have the

1 final word here?

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

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

9 [Laughter.]

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

13 **### PUBLIC COMMENT**

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

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

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

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

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

20 CHAIR THOMPSON: Thank you. Any other public
21 comments?

22 [No response.]

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

4 * [Recess.]

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

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

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

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

19 Just to set up some background, in fiscal year
20 2015, long-term services and supports, or LTSS, accounted
21 for \$158 billion of Medicaid benefit spending, which was
22 approximately 18 percent of this was delivered through

1 managed care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Next in this section as we go on to talk more

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

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

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

1 that may differ from other populations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 Thank you.

15 CHAIR THOMPSON: Great.

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

1 feedback.

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

4 Toby.

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

9 CHAIR THOMPSON: Marsha, then Bill.

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

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

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

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

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

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

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

22 Finally, almost finally, when you talk about the

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

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

20 CHAIR THOMPSON: Bill.

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

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

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

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

1 outcomes gets to that in part.

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

9 We haven't come to grips I think with this whole
10 question of what's the public sector role. When we talk
11 about rebalancing, we're talking about people not being in
12 a nursing home where care is to be available, according to
13 the rules, 24/7 to being at home, and we're not giving them
14 24/7 care when they're at home. The balance comes in by
15 the fact that they have family members almost always to
16 provide the care that hopefully meets needs. But what's
17 the balance between families and this public sector
18 investment? We don't have a sense of that.

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

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

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

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

18 CHAIR THOMPSON: Chuck and then Brian.

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

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

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

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

22 CHAIR THOMPSON: Brian.

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

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

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

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

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

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

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

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

20 Kit, do you want to jump in?

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

1 CHAIR THOMPSON: Oh, yes, thank you.

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

4 CHAIR THOMPSON: Yes, excellent.

5 Any final thoughts?

6 [No response.]

7 CHAIR THOMPSON: Thank you, Kristal. Wonderful
8 job.

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

12 **### PUBLIC COMMENT**

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

22 I think that MACPAC can play in this June report

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

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

21 Thank you.

22 CHAIR THOMPSON: Thank you.

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

4 * [Whereupon, at 3:43 p.m., the meeting was
5 recessed, to reconvene at 9:00 a.m. on Friday, April 20,
6 2018.]



PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

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

ANNE L. SCHWARTZ, PhD, Executive Director

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

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

PANEL ON SECTION 1115 WAIVER EVALUATIONS

* MS. BUDERI: Thanks.

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

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

1 improve the evaluation process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 We also had a recommendation in this space that

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

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

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

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

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

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

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

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

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

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

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

1 thought might be useful for you.

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

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

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

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

1 response to the recommendations of the GAO.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So just a couple of other points about some

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

1 working on that technical assistance.

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

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

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

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

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

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

16 MS. CASH: Thank you.

17 CHAIR THOMPSON: We're delighted to see that.

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

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

3 So I'm going to ask Marsha to kick us off with
4 questions.

5 VICE CHAIR GOLD: Thank you. This is a topic
6 that is both central to our Commission's discussion often
7 as we look to understand what we're learning from a
8 demonstration, since that's the point of the demonstration,
9 and also mine personally because I've been involved in a
10 number of these evaluations and, you know, not the ones
11 discussed here but earlier. And this is not an issue
12 specific to any one administration, but it has been an
13 issue, especially in an increasingly polarized environment
14 the last several years. And as a taxpayer, I just get
15 annoyed because, you know, there's a lot of good work out
16 there, and it doesn't get shared.

17 So I had two questions, one focusing on the
18 material you presented on the federal side and the other on
19 the future. So the first area is I just wonder -- I mean,
20 it's important to get the data out. I see you're committed
21 to do that. I don't know -- I know there are lots of ways
22 it could not come out or it could get delayed and lots of

1 reasons that can be provided there. I don't know if GAO
2 came across anything that was relevant as to how you do it.
3 I don't know if you just have transparency, you list all
4 the reports that are coming on with when they're due and
5 whether they get delivered and when they get out, or I
6 don't know what. But I guess the question I have is it's
7 an important issue and how do we make sure that the
8 information gets out.

9 The second question that I wanted to get to was
10 just if you -- I don't know, Judith, if you're the right
11 one to answer this, but, you know, getting report
12 information out depends on having there be studies. And
13 I'm not sure what the current policy is on doing evaluation
14 of state initiatives, which ones will be done. In our
15 material we had an article from Modern Healthcare on
16 scaling back plans for the Indiana demonstration, leaving
17 out a survey which it seems is critical to getting things
18 done. And so if you can clarify a little what the current
19 policy is on evaluations, that would be great.

20 MS. CASH: Sure. Happy to do that. Thanks for
21 the question. So to your first point about making sure the
22 data get out, I will tell you that we agree with that goal,

1 and the administration is committed to getting the data
2 out. So there are a number of reasons why the reports that
3 the GAO mentioned and some of which were released yesterday
4 have taken a long time, and mostly that is our just need to
5 understand them and to ensure that everyone has the
6 opportunity to review them.

7 These were independent evaluations, so they are
8 not evaluations that CMS edited or changed, but, in fact,
9 just needed to make sure that we understood and were able
10 to fully share with all of our federal partners. And so
11 that continues to be the case.

12 One of the things that you will see, I'm sure, if
13 you haven't already, in those evaluation reports is that
14 they are preliminary. They are an interim evaluation, and
15 there are data limitations consistent with any significant
16 health services research. And they are in the early phases
17 of the programs that they were evaluating. And so, again,
18 we wanted to make sure that we understood those limitations
19 and really what we could and should be doing with that
20 information.

21 That said, we take responsibility for the fact
22 that we need to get them out more quickly, and so the

1 process that we've put in place we hope will do that. And
2 I would tell you that the administration is committed to
3 that as well.

4 In terms of the specific question, sort of where
5 we're going with evaluation, and then I'll get to the
6 Indiana question, I think that, as I think was noted
7 somewhere along the way, there is, in fact, a commitment in
8 this administration to more flexibility for states, and
9 along with that more flexibility comes a requirement for
10 accountability. And so we are interested in continuing to
11 have states provide information to us and for us to then
12 put that information out.

13 So the federal evaluation that we have been doing
14 that actually began under the previous administration is
15 continuing, and as I noted in my slides, we are looking to
16 the future to be able to do additional federal evaluation,
17 cost data evaluation. Those decisions have not yet been
18 made, but we're still working through those. But, again,
19 our expectation is not that federal evaluation would
20 replace the state evaluation. States are still required to
21 do an evaluation. And what we do not want is to put
22 ourselves in a place where we have competing evaluations.

1 What we want is to learn from both of them. And so where
2 we can learn across states in what we are doing with the
3 work now and could do in the future is some meta-analysis
4 of the state evaluation as well as looking at them from a
5 variety of perspectives. So that is still very much a goal
6 and one that we anticipate continuing to work through.

7 The Indiana one in particular, I can certainly
8 tell you that we still feel like that is and will be a
9 robust evaluation. That evaluation design is also posted
10 on Medicaid.gov, and so you can see all of the different
11 data sources that will be in that Indiana evaluation.

12 Not quite clear in the press article that came
13 out last week, but the decision about the survey was not a
14 new decision. That actually was a decision that was made
15 over a year ago. And that really was a decision that we
16 made, recognizing we wanted to make good use of our limited
17 resources. And given that at that time we were not able to
18 get the data that we needed from Indiana and there were
19 other sources of data that we knew we would have, which
20 I'll talk about in a minute, we decided to apply those
21 resources to another state -- Montana, in fact --
22 evaluation and then to increase the number of focus groups

1 that we'd be using in Indiana to be able to get more
2 information from those focus groups to have more of them.

3 But that is not the only thing that that Indiana
4 evaluation is being informed by. We also are using or the
5 contractors are using American Community Survey and
6 Behavioral Risk Factor Surveillance System data, so there
7 are a number of different data sources that we'll have to
8 get what we think will still be a good picture and a robust
9 evaluation of the Indiana demonstration.

10 CHAIR THOMPSON: Thank you. Very helpful.

11 We have Darin and then Fred.

12 COMMISSIONER GORDON: Thank you both for your
13 presentation. I really appreciate it.

14 First, a comment. I was glad to hear from a CMS
15 perspective that you are focusing the evaluations on things
16 that are not the -- well, I'd say it this way. You said
17 uncomplex or unchanged policy, you're setting those aside,
18 and that's appreciated from a state perspective, I'm sure.

19 One thing that has come up in both of your
20 comments and I'd like both your perspectives on this
21 because they may be different, data limitations constantly
22 comes us, and I'd just like a little bit more detail on

1 some of the things you saw in that respect. Is it
2 inability to provide it, the data that was being sought
3 after for an ideal evaluation just didn't exist? Is it a
4 combination of those things? Is it the transferring of
5 data, the quality of the data? Just every time I hear
6 "data limitations," there's like a thousand things under
7 it, and from our perspective I think it's helpful to
8 understand what some of those issues are. And then as a
9 follow-up -- and, Judith, this is more for you -- what is
10 CMS doing to help states to try to address some of those
11 things? Thank you.

12 MS. BARNIDGE: I appreciate the question. I
13 think, you know, we raised some of the data limitations
14 particularly that were affecting the federal evaluations,
15 and those -- a big part of that was the switch to T-MSIS,
16 and there was sort of a period of time where states were no
17 longer required to submit data to the legacy system, but
18 they weren't all submitting data to T-MSIS, so I think the
19 evaluators had planned to be able to mine that to get this
20 data, and it just wasn't there, so they were going to --
21 states were scaling back the evaluations to deal with that.

22 I think, you know, some of the methodological

1 limitations probably also related to data, and I know that
2 Arizona, there were some delays in submitting final reports
3 due to data limitations. I don't know all the details of
4 that, but it does seem that what we saw was that CMS was
5 more actively engaging states early in the evaluation
6 process to try to anticipate those data challenges and
7 think through how to design around them.

8 MS. CASH: Yeah, and I think -- thanks for the
9 question, Darin. I think from CMS' perspective, we
10 recognized that there are data limitations both on the
11 state side and on the CMS side. And there are some
12 similarities and differences to those limitations, but I
13 think, you know, including the fact that state
14 administrative data varies from state to state, I would
15 venture to say that your data dictionary in Tennessee
16 probably looked different from Toby's data dictionary in
17 California, and across states there is some variability
18 there. So yours was better than his, I'm sure.

19 [Laughter.]

20 MS. CASH: But I think that, you know, we learned
21 that there are differences from state to state across the
22 data.

1 You know, I think recognizing the issues related
2 to T-MSIS data, we at CMS have spent a lot of time and
3 energy with states over the last couple of years in helping
4 them to get the data in, and that transition period was a
5 really challenging one for both states and us. And now we
6 really are realigning those resources to focus on that data
7 quality, and I think our friends in the data systems group
8 will be happy to talk with you some about how we're doing
9 that. But there's a real focus on, again, getting some
10 consistency across definitions and making sure that people
11 are clearer that when, you know, we count this way, we mean
12 it.

13 And, clearly, at the state level, that's a
14 difficult thing to do, recognizing that the inputs for
15 those data also come from, well, providers and certainly
16 the eligibility systems and the multiple systems that feed
17 into those data are in varying stages of development of
18 interoperability. And so the chance to be able to really
19 use those data I think continues to evolve.

20 CHAIR THOMPSON: Fred.

21 DR. CERISE: Thank you, and thank you for the
22 presentation. Good information.

1 I have two questions and just a comment at the
2 outset. So as we look at the issues that you're raising
3 and describing, evaluation, design, comparison groups, lack
4 of data, problems with protecting privacy, these sound
5 pretty fundamental, right, and we've been doing the waivers
6 for a long time and so we're talking about these things.
7 So kind of going forward, my concern is as we go forward,
8 how do we intend to have the rigor there around some of the
9 important issues that we're talking about?

10 So yesterday we talked about social determinants.
11 So my two questions. One, I want to understand what we're
12 doing around social determinants, as you look at national
13 quality metrics and how are you building those into
14 evaluations, things like homelessness and serious mental
15 illness, substance use, distressed neighborhoods, and those
16 types of things. And then the second one is specifically
17 around DSRIP. I know the agency is sort of moving away
18 from DSRIP as a permanent part of waivers. As you look at
19 DSRIP and look at the outcomes that are measured, many of
20 those outcomes depend on ongoing activity, you know,
21 reducing hospital-acquired infections, readmissions,
22 managing chronic disease, immunizations, things like that.

1 And so as you look at the evaluation around
2 DSRIP, or other programs, looking at the inputs, and are
3 those issues, problems that are corrected and then you can
4 move on or that require ongoing resources to maintain those
5 outcomes? Maybe you can tell me the current thinking
6 around DSRIP and particularly around those outcomes that
7 will need ongoing support or effort to maintain.

8 MS. CASH: Sure. Okay. So to your first point,
9 yes, we've been doing 1115 demonstrations for a long time,
10 and identifying the kinds of limitations in our evaluation
11 that we're identifying are, in fact, pretty foundational.
12 And I think that that is why, at this point, we are really
13 looking at the specific changes that need to be made in our
14 approach to evaluation, and we've been doing that now for a
15 couple of years. And I would say that the work that we
16 started, probably two or so years ago, really is the first
17 focused effort on improving evaluation that we've done in
18 probably 15 years, in 1115 demonstrations.

19 And so I think, you know, it's not surprising,
20 however, that what we're identifying is foundational,
21 because they are the kinds of problems that we're seeing
22 both in our own federal evaluations, in this early stage of

1 what we're doing, and in state evaluations, and it tells us
2 that we need to provide the really focused technical
3 assistance that we're providing to states.

4 And I will tell you that we've really seen some
5 significant change already in how states are engaging in
6 the evaluation process. They, too, are committed to
7 improving the rigor of their evaluations. It benefits them
8 to learn about their evaluations as much as it benefits us
9 and the rest of our stakeholders. So we're actually seeing
10 some change there. But I agree with you that these are
11 foundational issues that we need to work on.

12 So relative to social determinants, we do have a
13 number of existing demonstrations that are looking at
14 social determinants of health and really beginning to
15 address them, certainly in Washington, in California, in
16 New York and a few other states. We've got states now that
17 are continuing to express interest in that, and so the
18 administration is looking at that overall policy approach
19 and determining how and where Medicaid demonstrations
20 really should play in that arena, recognizing that, you
21 know, there are multiple determinants of an individual's
22 health and Medicaid has a role in supporting those in order

1 to achieve positive health outcomes.

2 And so those are things that we are evaluating.
3 As I said, we have existing demonstrations now. We have
4 states that have expressed interest in them and the
5 administration is looking at those and really developing
6 its policy around those areas.

7 So in reference to comment about DSRIP and
8 whether or not those are continuing, again, at this stage,
9 we have a number of continuing DSRIPs that are working.
10 The reports that were posted yesterday I think indicate
11 some very preliminary data around DSRIP and we're looking
12 forward to continuing to learn from those evaluations.

13 So, you know, we look at DSRIP as a one-time
14 federal investment and we are working with states now, all
15 of the states now that DSRIP is an investment that we are
16 interested in making with them, and that we expect the
17 states to also identify for us a plan for the state's
18 sustainability of those efforts, once the federal
19 investment is no longer there. And so some of the recent
20 DSRIPs that we have approved include a phase-down of the
21 DSRIP payments over time and a clearer plan for the states
22 to sustain those programs, which will include continuing to

1 evaluate the sustainability of the change that is being
2 made. So, you know, looking at what those inputs are now,
3 what we're evaluating now, and how we expect states to
4 continue to measure those changes, you know, at the -- sort
5 of on the other side, if you will, of the DSRIP.

6 CHAIR THOMPSON: And, Fred, I took your question
7 about social determinants to be, in part, at least, about
8 reflecting the conversation that we had yesterday that as
9 we look at our program interventions and determine what's
10 working or not working, we should take social determinants
11 into account.

12 DR. CERISE: In addition to those specific --

13 CHAIR THOMPSON: Right. So just think about that
14 in terms of -- I think part of what we were discussing
15 yesterday was the idea that social determinants may be
16 complicating the success of different interventions --

17 MS. CASH: Oh, absolutely. For sure.

18 CHAIR THOMPSON: -- and, therefore, in the
19 evaluation design maybe that's something that should
20 deserve some specific attention, to see if that helps
21 explain or account for --

22 MS. CASH: Right.

1 CHAIR THOMPSON: -- some of the results.

2 MS. CASH: So that may or may not be a variable -

3 -

4 CHAIR THOMPSON: Yeah.

5 MS. CASH: -- that we're actually evaluating as

6 part of it, but it certainly may be a factor in -- our

7 review of the findings. Absolutely.

8 CHAIR THOMPSON: Right. Okay.

9 So we have Brian, Alan, Kit, Toby, and then
10 Chuck.

11 MR. BURWELL: I also very much want to thank you
12 for taking the time to come and talk to us today.

13 One of the responsibilities of MACPAC is to make
14 recommendations to Congress about Medicaid issues, and this
15 is a topic that's of very large interest to us and we may
16 end up making some recommendations at some point.

17 I have two questions in that regard. One is
18 good, objective, robust evaluations cost money, and I just
19 want to ask a general question. Do you feel that CMCS has
20 the requisite resources to do the kinds of evaluations of
21 1115s that are going on, and there are a lot of them and
22 there's a lot of experimentation going on, and there's a

1 lot of demand for information, like what are these changes
2 all about and are they improvements to serving Medicaid
3 beneficiaries?

4 The second has to do with kind of dissemination
5 and ownership of the results. The dissemination strategy
6 of CMS is often posted to Medicaid.gov. That is not
7 exactly a broad dissemination strategy. There are
8 limitations on your travel, in terms of attendance at
9 conferences, et cetera. A lot of contractors who work on
10 these have a desire to publish the results of these
11 evaluations in referee journals. I guess this is also a
12 question of Susan. Are there ways in which these results
13 can get out into the academic community and to the broader
14 community more generally than happens currently?

15 MS. CASH: So I'll take the resources question
16 first and say that I would venture to say that resources
17 are limited. We feel like we're making the best use of the
18 resources that we have available, but, you know, I think
19 that it would be -- it would not be an understatement to
20 say that resources are limited and we do the best with what
21 we have. Additional resources would help us across the
22 board in our ability to do our work, and I think that's

1 something that we continue to look at, and we are looking
2 at ways we can use the resources that we have in the way
3 that it's most efficient. In fact, that was one of the
4 things that informed our decision last year around the
5 Indiana evaluation, was about how can we make the best use
6 of the federal resources to get the best we can, the best
7 evaluation we can, given the limitations. So, you know,
8 that's sort of what we can say.

9 The dissemination and ownership, I would say we
10 support broad dissemination. At this point, Medicaid.gov
11 is the mechanism that we use, although I will tell you that
12 we have, on occasion, some of the evaluators that work with
13 us and have done some of these evaluations, have had the
14 opportunity to share some of the information across a wider
15 audience, and we would support that. I think that we
16 recognize that, you know, the more light that is shed on
17 any information you have, the better the information gets.
18 And so we would support that broad dissemination of these -
19 - of the results and would appreciate any sort of
20 suggestions or recommendations you would have about how we
21 would be able to do that better.

22 CHAIR THOMPSON: Alan.

1 I'm sorry. Susan, were you jumping in?

2 MS. BARNIDGE: Well, I wasn't actually going to
3 add anything particularly useful other than to say we
4 didn't sort of envision what dissemination might look like,
5 but that sounds like a great space for MACPAC to consider
6 whether there are best practices.

7 MR. WEIL: Thank you for these presentations and
8 the work. This is a very important area.

9 I want to focus for a minute on sort of the meta-
10 analysis or the multistate evaluation, as the term was used
11 by GAO. This feels particularly important as we have
12 potentially major policy changes or initiatives being
13 considered and often adopted simultaneously by multiple
14 states before there are any results from the early
15 adopters.

16 From a GAO perspective, I'm trying to remember
17 anything prior to the recent report that sort of talks
18 about multistate. I can't remember but that doesn't mean I
19 would, and would be interested. My sense, from your
20 presentation and the report is that this is really sort of
21 a data issue, but it seems to me there would be other
22 relevant considerations in trying to understand the effects

1 of a policy adopted across states.

2 I guess what I'm trying to get at is I think the
3 whole is more than the sum of the parts, and so if you look
4 at sort of the individual state evaluations, that's not the
5 whole way to understanding whether we can reach any
6 conclusions about a policy across states. And I guess
7 that's sort of my question for CMS. When you say a meta-
8 analysis, and we talk about the duration of these
9 evaluations, often our understanding of a policy change
10 actually occurs long after, and it requires consistency in
11 data elements and the like, and it requires some
12 willingness to make judgments about the relative quality of
13 each individual study. That's what a meta-analysis does.

14 So I'd just like to get a little more sense of
15 where we might go in being able to draw more clear
16 conclusions of initiatives that are adopted across states.

17 MS. CASH: Do you want to just talk about any
18 previous multistate, if there were any?

19 MS. Barnidge: I mean, I think that -- I'm not
20 remembering the details, but the last evaluations done by
21 CMS, that I believe were multistate, were early 2000s. We
22 didn't sort of look more broadly to see if the research

1 community had done more. So, yeah, not a whole lot.

2 MS. CASH: But, you know, to the point about the
3 research community, I'd just have to say I do know that
4 there are a number of, you know, really strong research
5 folks out there who are doing a lot of good work in this
6 space, and I think we continue to learn from them as well.

7 I have to say that I did a presentation a few
8 months ago to a group that was convened by the Robert Wood
9 Johnson Foundation, and I was looking out like this at the
10 group of people, and I said, "So, you know, I'm a little
11 nervous here because this is probably the first time I've
12 been surrounded by people who know more about the work that
13 I'm supposed to be overseeing than I do." But there's good
14 work that's being done out there, and we have a
15 responsibility to do our own good work as well.

16 So I think you're right, Alan, that, you know,
17 there are some significant policy changes that are
18 happening now that we care a lot about, and care a lot
19 about understanding, and we take seriously the
20 acknowledgment that, again, we are talking about 1115
21 demonstrations, and we really want to know what is it that
22 the state is demonstrating and what are the outcomes of

1 those demonstrations, and the ability to learn not just
2 from individual states about that state experience and
3 experience of beneficiaries and other stakeholders in those
4 states, but what we can learn across those patterns is
5 critically important.

6 And part of our acknowledgment of the need to be
7 able to do that, and the need for consistency across those
8 analyses, is what drives us now to come up with some
9 consistent metrics and measures that we are requiring all
10 states that are implementing, for example, a community
11 engagement demonstration. There is a specific set of
12 metrics and measures that we are developing that all states
13 that are doing community engagement demonstrations will be
14 required to monitor and ultimately to evaluate. The
15 purpose of those demonstrations is to determine whether
16 requiring working community engagement as a condition of
17 Medicaid eligibility leads to sustained employment and
18 leads to improved health outcomes.

19 And so we really are looking to states to be able
20 to really take that thread all the way through and to
21 collect and report on data to answer those questions. And
22 so we know that we have to really monitor those closely,

1 and I think that will contribute to the quality of any
2 study, of any results that we might get in the future. But
3 our attempt to do a meta-analysis, if we are to do that,
4 and, as I said, that is still a work in progress, but it
5 depends upon our ability to identify some of those
6 consistent threads across demonstrations that we can then
7 reasonably and rigorously compare one to another.

8 CHAIR THOMPSON: So we are coming to the end of
9 the time, but we have three more folks with questions. So
10 Kit, Toby, Chuck, and then we'll bring it to a close.

11 DR. GORTON: So I just want to join everybody in
12 thanking you for taking time to come and talk with us. We
13 understand that's a big commitment on your part, both the
14 preparation and actually showing up.

15 Following up on Brian's question, for Judith, in
16 your slides you talked about, you know, developing a
17 learning diffusion plan, and I guess beyond just posting
18 more stuff on Medicaid.gov, if you could give us a little
19 more color about what that learning diffusion plan might
20 look like, recognizing it's in its early days, it's
21 developing so it doesn't exist yet, but just sort of what
22 are the things you're thinking about.

1 The second piece of that question is, would you
2 view MACPAC as a targeted consumer of the outputs of that
3 plan and what do you think that might look like, other than
4 just having Kacey click on Medicaid.gov once a week and see
5 what's there.

6 And then the last piece is, in this context, once
7 you come up with this and get it right, what's the goal of
8 this? What does success look like? How will we know
9 whether, you know, from a federal accountability point of
10 view, how will we know whether the agency did this well or
11 not? What is that target that you're shooting for,
12 recognizing, again, that this is Version 1.0 and it's not
13 going to be, you know, fully formed from the head of Zeus,
14 you know, in any short period of time. But just a little
15 more color and any detail you can provide about where
16 that's going.

17 MS. CASH: Sure. So, yes, to start with your
18 bookends, which is it is very much developing, a work in
19 progress, and it will take time. You know, this is a
20 significant -- it's very important and it's a huge amount
21 of work, and it's going to take time to get from where we
22 are now to where we ultimately can answer the question, how

1 will we know we've been successful, but some of the things
2 we've been thinking about already, as we're in the
3 developing stages.

4 So in terms of what the learning diffusion looks
5 like and how we're doing that, besides just posting on
6 Medicaid.gov, one of the things that we are doing is
7 bringing together groups of states to have them have the
8 opportunity to share their experiences, their learning with
9 each other, to be able to ask questions of each other. You
10 know, there are a number of opportunities for states to do
11 that. We feel like we have a responsibility to be one of
12 those opportunities, to give states a forum to be able to
13 share the information that they're getting, as well as the
14 information that we're getting, to do that.

15 Specific to the latest approach that some states
16 are interested in taking with the community engagement
17 demonstrations, we're actually creating what we're
18 referring to as the Community Engagement Learning
19 Collaborative, which is going to bring together some states
20 that are interested in doing it and beginning to learn from
21 each other, even right now in the planning and envisioning
22 stages and then sort of carry that through over time.

1 We're doing the same thing with some of our DSRIP programs,
2 to kind of bring those states together to have the
3 opportunity to learn from each other and what they're
4 experiencing.

5 So those are some of the ways that we hope to
6 diffuse the learning across the states. And then, beyond
7 that, I think, absolutely, MACPAC is an audience that we
8 think is a really valuable one, and would be happy to
9 continue a dialogue with you all as we learn from this
10 process.

11 I think we'll know we've been successful when we
12 actually have, you know, a similar approach that GAO took,
13 to say here are the things that are happening in the 1115
14 evaluation space, and that some of the findings include
15 states are using rigorous data-driven evaluation designs,
16 and CMS is using the information and the findings from
17 those rigorous evaluation designs to make decisions about
18 1115 demonstrations going forward.

19 CHAIR THOMPSON: Toby.

20 MR. DOUGLAS: Thank you both for your
21 presentations, and congratulations, Judith, on your
22 position.

1 A big area of concern is state administrative
2 capacity, and you've talked a lot about TA and all the
3 learning. But the question, you know, when I think of
4 administrative capacity, it's both the breadth as well as
5 the depth, and when we talk about a lot of these rigorous
6 evaluations it takes, you know, very complex and a staff
7 with a lot of different backgrounds. And the question is
8 what are you seeing in terms of the change, the ability for
9 states to react, to be able to take on these new
10 requirements, and are there any recommendations in these
11 areas that we should be looking or thinking about? You
12 mentioned concerns at the federal level. Well, what about
13 states?

14 MS. CASH: Yeah. Thanks for the question, Toby.

15 And I think what we're seeing is why variability,
16 as you would imagine, from state to state in terms of both
17 their current capacity and capability to do the kind of
18 evaluation that we're requiring and that they want to do
19 and in their ability to kind of come along with us on this
20 journey.

21 And I think that we've got states that have
22 existing relationships with evaluation contractors that

1 engage on their behalf in this work and are able to bring
2 some of those resources to bear, and we have states that
3 have state staff that are doing it as part of their other
4 jobs and everything in between.

5 Recognizing that it is costly, we also -- that's
6 part of why we're also trying to provide some of the tools
7 that we're providing. So guidance in how to develop an
8 evaluation design that is for us informed by experts in the
9 field of evaluation that we can then share with states so
10 that they can sort of understand, as I said, earlier the
11 kinds of things we're looking for in terms of that rigor,
12 evaluation and methodologies and data indicators and
13 development of hypotheses and questions, all of those
14 things that really states just in some cases need somebody
15 to help them understand what it is that really makes up a
16 rigorous evaluation design.

17 But it really is all over the map in states, and
18 we are trying to states where they are with that evaluation
19 approach and try to provide as many tools and as much
20 technical assistance as we can provide to get them to that
21 place because for the most part, as I said, states really
22 are just as interested in a rigorous design of their

1 evaluation as we are and have varying levels of resources
2 to bring to bear on that, and we're trying to provide some
3 support to that.

4 CHAIR THOMPSON: Chuck, you can take us out.

5 COMMISSIONER MILLIGAN: Good morning, Judith.

6 I have a question for you with a couple of
7 elements to it. I'm trying to learn a little bit about
8 kind of the inner workings at CMS about how this is
9 integrated with maybe some other groups or other parts of
10 CMS.

11 MS. CASH: Okay.

12 COMMISSIONER MILLIGAN: So sort of two parts to
13 the question. One is, to what extent, when states are
14 pursuing advanced planning documents or other IT-related
15 funding -- to what extent does the evaluation design for a
16 waiver play into the funding decisions or feedback to
17 states about their data management strategy, their data
18 reporting strategy? So that's how you're working with kind
19 of the system side.

20 MS. CASH: Mm-hmm.

21 COMMISSIONER MILLIGAN: I'm tempted to ask Penny
22 this question too.

1 The second part of the question, though, is when
2 new states -- and it's kind of following up on Alan's.
3 When new states are pursuing an 1115 waiver, where there
4 maybe isn't a whole lot of results yet from an early
5 adopter of the same concept, to what extent do you all look
6 internally are preliminary data, preliminary evaluations in
7 how you inform the development of terms and conditions,
8 questions that CMS and states go back and forth with about
9 kind of the waiver approval process? So I'm interested in
10 that element as well.

11 MS. CASH: Okay. So to your first question, this
12 is also a work in progress, but we do work in fact pretty
13 closely with our colleagues on the systems side of the
14 house, if you will, to ensure that not only the evaluation
15 requirements of the proposed 1115 demonstration, but all of
16 the systems-related requirements for an 1115 demonstration
17 are synced up with what's happening and what's described
18 and what's funded in those -- via those against planning
19 documents.

20 So where a state comes to us with a demonstration
21 that includes a need to actually make changes to their
22 eligibility system or their Medicaid Management Information

1 System as well as ultimately to then have systems
2 capability to draw in data that will inform the evaluation,
3 we work with a state, and we connect with our colleagues on
4 the system side to ensure that those changes are
5 identified, that they are costed out, and they are included
6 in the budget that's laid out in the Advanced Planning
7 Document.

8 So we've been doing that. We are continuing to
9 do that, and we recognize that we've got work to do in that
10 area in really syncing those things up, but it's very much
11 part of the conversation.

12 The other thing -- you didn't ask this, but the
13 other thing in terms of sort of inner workings is that we
14 also know that 1115 demonstrations are connected sometimes
15 to other things. So if there is a state plan amendment or
16 a 1915 waiver, all of those things have to come together.
17 So we work closely with our colleagues in all of those
18 areas to make sure the states kind of got all the pieces of
19 the mosaic together.

20 And then a state that's proposing a new
21 demonstration that might be something another state is
22 doing or has started doing, but it's still early and we

1 don't have data around, what we do, though, often is have
2 at least some preliminary information about implementation
3 and the kinds of road blocks or really lessons learned from
4 that implementation.

5 And so we do share that information with states
6 if we have them. We connect those states together to learn
7 from each other.

8 The rapid cycle reports that Susan referenced and
9 a few of which were posted yesterday also serve some of
10 that purpose in that because they are rapid cycle, they're
11 more implementation-specific than they are outcome-
12 specific. They can tell us some of those early lessons
13 that states are seeing, what are the things we need to know
14 about eligibility or provider engagement or planning with
15 the APD some of those things that come early that we can
16 share with states. And we try to do that wherever we can.

17 CHAIR THOMPSON: I know we're a little bit past
18 our time, but I wonder if you could indulge me to allow me
19 to ask a final question. Just hearing this conversation,
20 first of all, I think the GAO report is very useful, and I
21 think the work that's going on at CMS is very promising.
22 But I'm just wondering whether our paradigm about this is

1 itself fundamentally correct.

2 Judith, you mentioned that, for example, the
3 discussion about the evaluation approach and design follows
4 the approval of the waiver, and we're having a discussion
5 as though in every case, which I think is more the
6 exception than the rule, a state is genuinely unsure about
7 what it's doing and why it's doing and what it's going to
8 produce. In fact, most states who come forward asking for
9 an 1115 have a point of view. They believe that what they
10 are going to do is promoting the objectives of the program
11 and is going to create certain kinds of outcomes that
12 they're prioritizing.

13 So they're not exactly neutral in the
14 proposition. They are advocates of the proposition, and so
15 I just wonder if you can talk a little bit about the idea
16 of should there be more up-front agreement within the STCs
17 themselves about what constitutes success and what would
18 generate a decision on the part of a state to abandon an
19 approach or to refine an approach in order to affect the
20 outcomes that they're trying to seek.

21 I think that we're in a world where the desire
22 for rigor, which is understandable, the administrative

1 capacity issues, the data issues, et cetera, sometimes
2 confound us and cause us to have a long period of time
3 before we accumulate the knowledge and then the wisdom from
4 the knowledge in order to make use of it, and so I'm trying
5 to think about if there are ways in which we should be
6 altering the approach differently so that we are focusing
7 on specific measures, the data that we know exists in order
8 to be able to inform whether we're accomplishing what we
9 are accomplishing so that we have a better sense as
10 decisions are made on an ongoing basis about whether or not
11 we're achieving what we hope to achieve.

12 MS. CASH: Yes. So I would say that is in fact a
13 lot of what we're thinking about.

14 Let me just make sure that I am clear. That
15 while CMS generally approves the evaluation design after
16 the approval of the demonstration itself for reasons I
17 described earlier, that is not to imply by any means that
18 we are not engaged in conversation, in negotiation, and
19 that there are in fact terms and conditions in the
20 demonstration about evaluation.

21 We do in fact require that states identify ahead
22 of time before we approve what their hypotheses are, what

1 their evaluation questions are, and we begin to identify
2 both some monitoring metrics and anticipated outcomes
3 within the negotiation of the demonstration, and those are
4 reflected in the terms and conditions.

5 Ultimately, the design is done after, but that
6 foundational work happens during the negotiations.

7 And expect states to tell us what is it that they
8 anticipate is going to be the outcome and how does it
9 promote the effectiveness of Medicaid, and it is exactly,
10 Penny, as you said that states most of the time are coming
11 to us with a demonstration that they believe is going to
12 work, and they believe it's going to achieve the state's
13 desired outcomes. And I think it's incumbent upon us at
14 CMS in part of our negotiation with them to ensure that not
15 only are we looking with them at those outcomes but also
16 what are other outcomes that may result from the
17 demonstrations.

18 And so I think we do in fact have a
19 responsibility and have been engaging with states on what
20 some of those other outcomes might be besides the ones that
21 you identified in your proposal, and that is part of the --
22 where we end with that is often very much a part of the

1 negotiation itself prior to approval.

2 And I think it's work that we continue -- that we
3 have -- I think we have continued work to do, and we should
4 continue to hold ourselves, have others hold us to those
5 standards and expectations, that that's what we're looking
6 for because we should be measuring not just what the state
7 sort of thinks is going to be its outcome, but other
8 outcomes that we care about that may or may not have been
9 those that were part of the state's initial proposal.

10 CHAIR THOMPSON: Thank you very much.

11 Well, again, a terrific conversation and a
12 subject of great and continuing interest from us, so we'll
13 look forward to a continuing dialogue with you on this
14 subject. Thank you both very much for coming and spending
15 time with us this morning.

16 MS. CASH: Thank you.

17 CHAIR THOMPSON: We'll take a short break and
18 father back together in 10 minutes. My watch says that
19 will be 10:20 we will reconvene.

20 * [Recess.]

21 **### FURTHER DISCUSSION ON SECTION 1115 WAIVERS**

22 **EVALUATIONS**

1 * CHAIR THOMPSON: Okay. Why don't we try to
2 reconvene here and pick back up on the conversation.

3 Okay. Let me open it up for Commissioners to
4 reflect on what we heard and if there are some additional
5 areas that we should be exploring in ongoing work with the
6 staff.

7 I wanted to open up the conversation around the
8 data limitations issue to kick us off maybe. You know,
9 we've heard this before, and I think it was Brian, you made
10 the point when we were talking about the money follows the
11 person report about -- where we similarly had an issue
12 where there were delays that I think were accounted for by
13 T-MSIS that caused us to suggest that we actually needed
14 some supplemental reporting as a consequence of not having
15 data available. And so while I appreciate the idea that
16 you might have federal evaluators who assumed that they
17 would have T-MSIS data available, it's the states who are
18 submitting some of this data to the federal government, and
19 they certainly have MMIS data that they're processing and
20 are available that would be transformed into T-MSIS data.
21 And so certainly at least the states would have access to
22 some of the data.

1 So I want to talk a little bit about whether or
2 not we should be looking more about the extent to which
3 federal data sets versus state data sets should be relied
4 upon in some of these circumstances so that we don't find
5 ourselves confounded by an expectation that we would have
6 had certain data and now we don't have it. What do we do
7 now that we don't? And the issue that came up with respect
8 to Indiana not providing the data because they were
9 concerned that a CMS contractor didn't have the proper
10 protections in place seemed to me to be something that
11 ought not to ever occur. That should be something that
12 should be resolved by either the federal government making
13 that assurance as opposed to a state simply deciding that
14 it doesn't meet certain of their requirements.

15 So I'm wondering if we can talk a little bit
16 about that and whether the Commissioners are interested in
17 trying to think through some of those data issues which
18 seemed to stymie us in a number of circumstances, both in
19 terms of the availability and the timeliness of the data.
20 Alan?

21 COMMISSIONER WEIL: Far be it for me to say no to
22 a data conversation, but I'm going to say no to a data

1 conversation. I mean, I -- let me come at it from a
2 different perspective. It's not where I would start in
3 MACPAC's discussion about 1115s and what we're hearing and
4 responding to. I think that's really my reaction, is that
5 I think we -- there's a -- where do I go with this? I
6 think there's a lot of desire to maximize the value of
7 these. I think that if it were me, I would probably start
8 more at the design level than at the data level. That's, I
9 guess, what I'm...

10 CHAIR THOMPSON: And, Alan, can you say more
11 about that then in terms of thinking about the design level
12 in terms of establishing more consistent design parameters,
13 more rigorous design parameters, more design parameters
14 that produce insight earlier into the process?

15 COMMISSIONER WEIL: Yes, yes, and yes. And I
16 just think that -- I mean, I'm trying to figure out where
17 we have impact. It goes sort of to Brian's comment and a
18 little bit to what Chuck said yesterday. You know, I don't
19 want us to be just saying the generic, "We need to learn
20 more," because that's not helpful to anyone. I guess I'm
21 looking -- to me it's sort of middle, because I don't want
22 to -- and, again, my view is only one view. I worry about

1 the data issue sort of being the endpoint of some of the
2 examples you just gave. And if we could move up and fix --
3 or help guide on some of those, I think we'd be less likely
4 to be doing sort of the cleanup on the back end. That's
5 more where I was coming at it.

6 CHAIR THOMPSON: Brian?

7 COMMISSIONER BURWELL: I am thinking about
8 recommendations and where we want to go with this. We all
9 know that there is a very strong connection between 1115s
10 and evaluations and political agendas, and it's not just
11 true of this administration. It's been true of all
12 administrations. So I'm wondering if we should think about
13 some kind of more institutional independence from the
14 administration around this type of research and advisory
15 panels and designs, et cetera. If we could separate the
16 evaluation and research part from the political agendas a
17 little, you know, and get the control outside the
18 administration a little more, we might see more
19 responsiveness to the general health policy community about
20 what these demonstrations are really doing in the -- I
21 don't know. I'm just throwing out ideas.

22 CHAIR THOMPSON: Yeah.

1 COMMISSIONER BURWELL: I mean, part of the
2 problem is that these things are owned by the people who
3 want the results to show a certain result.

4 CHAIR THOMPSON: Bill and then Toby.

5 COMMISSIONER SCANLON: Brian, I guess we do have
6 a problem. We only have three branches of government, so
7 there's a question of kind of where it's going to go.

8 [Laughter.]

9 COMMISSIONER SCANLON: But I do think that, I
10 mean, in part of this discussion that we need to be clear
11 about what we're dealing with. And if we take the ordinary
12 sort of reaction to the term "demonstration," we think of
13 something where I'm testing a concept to see whether it
14 should be adopted more widely or more permanently, and if
15 we look at this, we're often using the word "demonstration"
16 to mean I'm operating a Medicaid program that is contrary
17 to current law on an ongoing basis, and it will be renewed
18 periodically. And for the latter, I think there's a
19 question of, we have for the regular Medicaid program, so
20 to speak, put into place certain monitoring requirements to
21 assure sort of that it's operating appropriately. And I
22 think we have to ask sort of whether using an evaluation

1 framework accomplishes the same thing.

2 One of the things that struck me was that some of
3 the changes that were referenced, we're going to first see
4 them in 2022, 2023. This idea that if something -- if we
5 discover in 2019 or '20 that there's a need for
6 modification, do we have the flexibility to have that
7 modification occur? So there's that aspect of it.

8 Then I think there is -- I'll go back to your
9 data question, because I think that there is a need to
10 identify what should be routine, and T-MSIS should be
11 routine. It was an aberration that -- hopefully an
12 aberration that we had sort of a discontinuity there and
13 that it was not available. But in terms of ordinary
14 administration, claims data and encounter data should be
15 routine, and we should be able to, without sort of great
16 sort of expenditures, be able to use them to monitor
17 something. But we have to recognize the limits on those in
18 terms of what we learn, and that's where evaluations may
19 get complicated and expensive in terms of thinking about
20 surveys, thinking about sort of other kinds of data that
21 may be essential to a demonstration that's being tested,
22 but they are going to represent a significant expenditure.

1 You wouldn't want to continue them forever if you renew
2 this program, but you have to identify sort of what it is
3 that is important and then make the commitment, I think, to
4 get that essential information.

5 COMMISSIONER DOUGLAS: When I think through the
6 lens of states, when they go forward with 1115s, both from
7 the governor, legislature, and policymakers, they're really
8 viewing the 1115 through the policy as well as, you know,
9 in many cases around federal -- you know, as we talked
10 about Medicaid-ization or any type of revenue maximization.
11 Evaluation frankly from those people is not top of mind.
12 It's not even in some cases on the agenda. And so this
13 gets to the -- you know, as we think through this construct
14 and these additional expectations, the question always
15 comes back to me as how this is then driven back to a state
16 level of built into the infrastructure as well as fabric of
17 how they're going to do an 1115. And right now it's not
18 there in most cases. I can't, obviously, say for all.

19 And so, you know, going to Alan's point, starting
20 with the data to the left, I think we really need just the
21 overall what are the levers to make sure states -- not just
22 the federal government but states are actually able to

1 execute on very complex evaluations and that doing 1115
2 isn't just about policy and federal maximization of
3 resources but about the expectation that there is going to
4 be a rigorous evaluation.

5 CHAIR THOMPSON: I guess, you know, my suggesting
6 talking about data in part is about trying to bring it home
7 to a kind of practical level, to kind of say, sort of
8 picking up on all of your points, that engaging in a
9 significant change that affects potentially beneficiaries,
10 providers, expenditures, all aspects of the program without
11 an idea about how I'm going to know whether what my
12 intention is being -- even if I get agreement, yes, this
13 policy makes sense to try, this is why I'm trying it, this
14 is what I hope to achieve, and to have some ability to
15 provide evidence and data underneath of that, that helps
16 you monitor -- maybe it's more -- maybe I'm saying I'm more
17 interested in monitoring than evaluation. If evaluation is
18 something that comes five or six years later, that's great,
19 and we should care about that because we should care about
20 accumulating knowledge and gaining insight as a whole
21 community. But the idea of really understanding how is
22 this demonstration performing is it performing as expected?

1 If it's not performing as expected, are there elements of
2 the policy or the implementation that are associated with
3 that result? Maybe I'm saying I'm more interested in that
4 question in general.

5 Marsha?

6 VICE CHAIR GOLD: Yeah, I actually was going to
7 suggest -- this isn't an either/or, but given how long it
8 takes to show outcomes for some of these, I mean, I've done
9 a lot of evaluations, and they always take longer, cost
10 more, and don't get implemented in exactly the way people
11 intended. And so I think formative feedback -- and that's
12 where a lot of the contracts are going. That's what a lot
13 of these reports are that are there -- is important, but
14 not just to CMS. I mean, if you're approving others states
15 and we've already learned from some existing states that
16 it's really hard to implement a certain aspect of work
17 requirements or whatever else, that's important information
18 to get out there. And so I think figuring out how to --
19 you know, I think CMS probably does get that information
20 now more, at least from the national studies, because you
21 have to go and talk to the states to find out what's going
22 on. The states probably don't tell you that themselves.

1 But how to make sure that's happening and make sure that
2 gets disseminated in a way beyond just to CMS, but to the
3 broader world in terms of what we're learning about
4 implementation is important, I think.

5 Now, one of the things -- I don't know, you
6 didn't mention it, Brian. I mean, it used to be an issue
7 of what the contracts allow in the way of -- you know,
8 you're a contractor at will or you end up -- they have
9 total control over what you say and whether you're allowed
10 to change anything, whether they even accept what you say,
11 and looking at how those contract requirements are written
12 now and what flexibility the -- maybe this is what you were
13 getting at, Brian. The research community has to
14 disseminate even if the results aren't as the people want
15 is also important. But I certainly think we should be --
16 promote more -- you know, the continuation of national
17 evaluations and the focus on the formative feedback and
18 getting that out broadly, rapidly.

19 COMMISSIONER BURWELL: And the issue of control
20 over the results is an important issue. I don't know if we
21 can deal with it, but, you know, they own the results, they
22 can bury reports, they can change reports. They can do

1 anything they want. And there are certain contractors,
2 RAND being one of them, that will not sign an evaluation
3 contract with CMS unless it has total independence over the
4 control of results. And often they disqualify -- they're
5 disqualified from bidding or they don't win because CMS
6 won't budge on that, and neither will RAND. So, you know,
7 it's an important issue.

8 CHAIR THOMPSON: Kit, then Chuck.

9 COMMISSIONER GORTON: So, I mean, the question
10 I'm thinking about is we've been doing these demonstrations
11 since the '80s. Has one ever failed? You know, when have
12 we ever seen somebody -- and maybe I'm just ignorant and I
13 don't know. But, you know, it just seems -- and one has to
14 wonder, to Brian's point, whether the failures are simply
15 not talked about, they get tweaked in a renewal cycle,
16 somebody tried -- you know, sort of the demonstration ad
17 infinitum without ever getting to evaluation.

18 You know, it might be useful for the Commission
19 to look at the history of the 1115 program. You know, you
20 would assume that if rigorous evaluations were being done
21 of truly innovative program designs, at least once in a
22 while you would have a massive fail, which we could all

1 learn from. And I don't know -- and, again, maybe it's
2 just I'm uninformed and I don't read the right journals or
3 click on Medicaid.gov often enough -- which is to say that
4 I very rarely click on Medicaid.gov. But --

5 CHAIR THOMPSON: It's a really good website. You
6 should go there.

7 [Laughter.]

8 COMMISSIONER GORTON: I'll think about that.
9 Thank you.

10 But I just wonder if there's some perspective
11 that -- and it gets to the question you were asking, Penny,
12 about fundamentally what are we about here. And is this
13 really about health policy research? My personal view
14 being it is not now and has not ever been about health
15 policy research. Or is it, in fact, a facile mechanism to
16 allow states some flexibility to get around the basic SPA
17 rules and the other accreted controls? And, you know,
18 maybe it ought to be thought about in a different way, and
19 that's to your point of let's stop putting all of our eggs
20 in the final evaluation or the now interim evaluation at
21 the end of each waiver cycle piece of it, and let's talk
22 about ongoing monitoring of important things. Let's talk

1 about where we spent extra money, whether it's DSRIP or
2 money follows the person or any of these other things, and
3 did we get value from the additional federal share that got
4 pulled down there?

5 You know, I just wonder if there's a role for
6 MACPAC to say, look, here's the history of this tool, this
7 1115 tool, and here's how it's been used, and maybe that's
8 good and maybe it's not, but at least here's what's
9 happened, and to pose the question: Should we be
10 fundamentally rethinking how this authority is shaped. Not
11 to say that states shouldn't have some authority that lets
12 them do exactly what they're doing, but maybe we oughtn't
13 call it "demonstration authority" and be wrapping a flag of
14 research around its shoulders when I think precious little
15 research ever sees the light of day in terms of rigorous
16 outcomes and results.

17 CHAIR THOMPSON: Chuck and then Darin.

18 COMMISSIONER MILLIGAN: As I'm listening to the
19 conversation, where my thoughts take me is in terms of the
20 waiver framework that we kind of brought this through and
21 our role as advisory to Congress, and where that takes me
22 is there's a lot of discussions in the waiver space around

1 streamlining 1115s for State B to adopt what State A
2 already did, and what are the criteria for something to
3 have been proven successful enough that it should be easier
4 for the second state to do something that is successful?
5 So that's -- one is kind of the waiver simplification for
6 dissemination of an approach.

7 Second is for a state to have a simpler renewal
8 process for something that's successful, which Judith
9 touched on today.

10 Third is when should the Social Security Act
11 itself be changed because something is successful enough
12 that it shouldn't require a waiver anymore at all in ways,
13 for example, like the PACE program became successful enough
14 that it just became much more just of an option.

15 And so, to me, where that all takes me in terms
16 of MACPAC's role is what would our criteria be to recommend
17 to Congress that this is the evaluation rigor or the
18 dissemination or the whatever that would lead to
19 streamlining any of those three things, something becoming
20 permanently part of the Social Security Act, something
21 becoming easier for a second state to adopt after a first
22 state has proven it to work, and third, for a state to have

1 a streamlined renewal path. And absent whatever criteria
2 that might be, an 1115 would be contained, if you will,
3 within a given state with no streamlining, no
4 dissemination, no statutory permanence. So what helps me
5 get oriented in this topic is how to inform Congress about
6 1115 as an authority.

7 CHAIR THOMPSON: Darin.

8 COMMISSIONER GORDON: My comments somewhat
9 dovetail with what Toby was talking about.

10 I don't think there has been a lot of priority in
11 thinking about an 1115 waiver route, about the resources
12 that would be necessary on the evaluation side, and quite
13 frankly, in many cases, not thinking about the resources
14 that would be necessary to actually implement the
15 demonstration for what you're asking for authority.

16 And so to some degree -- and it's not because of
17 lack of will or lack of knowledge and needing to do so.
18 It's just because of some of the limitations that occur
19 from state to state and time frames that legislatures
20 sometimes put on the executive to keep something in a time
21 frame that doesn't allow for a build-up and building on the
22 capabilities.

1 But when we think about the evaluations, the one
2 thing -- and this gets a little bit to Kit's comments about
3 have things failed. Yeah, I've seen some of them fail, but
4 then I've also seen them kind of regroup and recover as
5 well. So do you abandon that path because it failed, or
6 did you learn and did you iterate off of that? And that's
7 one of these things through these programs that even
8 through a waiver cycle, there is a lot of iteration that
9 goes on throughout a waiver demonstration, and that doesn't
10 always get captured.

11 But just trying to bring in those other elements
12 when they do these evaluations -- I was asking to Judith to
13 ask her where this comes into play. Where do you capture
14 the fact that when you evaluate a particular situation that
15 there were some dynamics that weren't part of the
16 evaluation design that need to be considered to increase
17 the odds of a different outcome and primarily about
18 investments in human capital, investments in data
19 infrastructure, regulatory oversight mechanisms that are
20 needed?

21 The evaluation itself could be helpful. I think
22 those other things, from a state learning perspective, are

1 critical from taking evaluation to transferring that into a
2 learning that has the operational significance that's
3 needed and know how that's needed before you go down a
4 similar path.

5 CHAIR THOMPSON: I mean, as you say that, Darin,
6 what occurs to me is that what you're describing is good
7 program management, which is, however I'm managing my
8 program, whether or not I'm operating under an 1115 program
9 or I'm not, I should be understanding what I'm trying to
10 achieve, and I should be collecting data and evidence. And
11 I should be refining my approaches, and I should be
12 acknowledging what isn't working and trying to solve those
13 problems. So in that sense, is 1115 really a different
14 animal in a significant way from just operating the general
15 state plan authorities?

16 And sort of this gets to Kit's point too. In
17 some cases, these longstanding 1115s have just evolved over
18 time, and how much of this is really testing something
19 really new, creating a level of risk to the program, to the
20 beneficiary, to the providers that we're doing business
21 with in the program and so forth.

22 What I did like -- there were many things I liked

1 about what Judith was talking about in terms of their
2 progress -- this desire to distinguish -- and I think this
3 is a little bit to your point too, Chuck, about what is the
4 sort of ongoing, continual improvement. The program has
5 been operating for a period of time doing what it's doing
6 versus something really complex and different, and can we
7 define those in some fashion and then establish a certain
8 degree of scrutiny and rigor to the scrutiny over that
9 second group of program approaches?

10 Alan.

11 COMMISSIONER WEIL: I can't help but note that I
12 wrote about this 20 years ago, and I haven't worked for a
13 state in 25 years. And when I worked for the chair of the
14 National Governors Association, it was the policy of the
15 NGA that when one state had a successful waiver, other
16 states should be able to adopt it. It should be renewed
17 with -- I mean, these are not new issues.

18 So to me, the question is how to move -- again,
19 what's our role? I don't think we can resolve that.

20 Kit, I just have to say I -- my answer is it's
21 both. I mean, it is clearly a political safety valve and
22 an opportunity, but we have learned a huge amount of 1115

1 evaluation. And to suggest otherwise, I think it is
2 overemphasizing the limitations relative to what we have
3 learned.

4 I also think that even the word "evaluation"
5 means something different now. People have this sort of
6 retrospective view, and now there's formative evaluations
7 that are more akin to the program management tool that
8 you've described.

9 We kind of need to catch up, but what I was
10 trying to do -- now I worry maybe I started us off the
11 rails. I won't say I took us the whole way. When you
12 started down here at data, I was trying to move us up. I
13 do worry if we move too far up to the abstractions of what
14 waivers are for and the like, that frankly it's all been
15 said, and I'm not sure we need to say it again.

16 CHAIR THOMPSON: Marsha.

17 VICE CHAIR GOLD: Yeah. I think amidst the
18 worrying about the waivers that have been there forever and
19 what to do about them, I'm more concerned with making sure
20 that the new stuff -- I don't want to lose sight of --
21 there's new stuff being tested that is very controversial
22 that may have big effects on people, that may be hard to

1 implement.

2 In any case, the kind of things I was talking
3 about I think, Darin, were just the ones that the formative
4 evaluation does in these rapid feedback cycles.

5 I mean, you have to, if you're going to do some
6 of these, and I've worked with people doing demonstrations,
7 lay in a logic model of what you're trying to do and what
8 has to happen to implement it, and you have to have metrics
9 that tell you where you've gotten with those. Those are
10 not easy to get ahead of time. They're not easy to create.
11 You have to think it through.

12 When evaluators do it, they have to spend a fair
13 amount of money going out and talking to people. Your
14 existing management systems may provide some of that, but I
15 think it's vital that on some of these new demonstrations
16 that are controversial as to how they fit Medicaid even at
17 all, that we have that rigorous formative evaluation as
18 well as the outcomes evaluation eventually. And so I'd
19 hate for us to get on track of these are all just a waste
20 of time and burden on states. There are things we need to
21 figure out about those ongoing whatever, but I do think a
22 priority needs to be holding people's feet to the fire to

1 look at the current stuff.

2 COMMISSIONER GORDON: Yeah. I wasn't implying
3 that you think about them as just needless burdens on
4 states, my point being when you go down a path and the
5 legislature says you have to get this implemented by July 1
6 and you just finished up April 15th, and that your mindset
7 typically isn't going to -- how do I build out and how am I
8 going to support a rigorous evaluation design and/or
9 thinking about what are the things I need, the components I
10 need to actually lead to a successful implementation, and
11 how will I measure a successful implementation.

12 It's a little bit back to Toby's point. These
13 are things that I think would be helpful that as they're
14 going through that process that there is given some time
15 and attention and thought and support and doing that
16 because in the absence of it, it's going to be -- they're
17 running as fast as they can to get the things implemented.
18 So it wasn't saying that they don't add value as much as
19 how do you recognize the reality that you're also
20 implementing typically very complex programs in a very
21 quick period of time.

22 And in some of these cases -- I mean, we saw

1 this. We had some third-party evaluators that we ended up
2 having to take people that were responsible for
3 implementing programs, and they had to educate some of
4 these third-party evaluators about some basic things about
5 the program and what we were trying to accomplish.

6 So I know we all like to think of the perfect
7 scenario in how these things work, but when you're tasked
8 with actually running the programs and doing this, I just
9 think there's got to be that space on the front end when
10 you're helping states and CMS to think through how they're
11 going to do that, how they're going to support that, and
12 ask those questions there because in the absence of that
13 conversation, it isn't going to get the attention that I
14 think people are expecting to end up with a good evaluation
15 and good end product.

16 COMMISSIONER DOUGLAS: And even if a state or
17 official were to raise it, the response in most cases, the
18 government is going to figure it out with existing
19 resources. You know, there isn't a desire when you look at
20 1115s to build large administrative infrastructures, but
21 rather how you're effectuating policy. And so we just need
22 to think through what are the carrots, what are the

1 approaches.

2 And this gets again to our discussion yesterday.
3 This isn't the only thing that's coming down. We have
4 access monitoring requirements, multiple layers, and it is
5 -- you're right, Penny, about overall program management
6 and structure and gets to what is MACPAC's role in terms of
7 thinking through the evolution of Medicaid and the
8 expectations on overall program management and outcomes and
9 continuous quality improvement on a state agency that may
10 not have the resources or has not kept pace with the
11 evolution of the change in the program.

12 CHAIR THOMPSON: Okay. Brian.

13 COMMISSIONER BURWELL: What I find difficult to
14 get my head around is this idea of 1115s as a demo or
15 testing something new, whereas it's -- I mean, the way it's
16 evolved in many states, it's just another program design
17 mechanism, like a state plan amendment almost. So there
18 are various states that have used 1115s to just design
19 their Medicaid program and the way they want, whether it be
20 Tennessee, Arizona, Vermont, Rhode Island. So I have
21 difficulty conceptualizing what's the role of evaluation in
22 this kind of -- the reality of how 1115s operate in the

1 Medicaid program, and why should we be evaluating 1115s any
2 more than just regular SPA, regular changes in Medicaid or
3 other program design tools.

4 CHAIR THOMPSON: So I don't know exactly where to
5 take this conversation. You guys are very challenging in
6 this meeting, trying to pull it together.

7 COMMISSIONER WEIL: Maybe we need a thorough-some
8 subcommittee.

9 [Laughter.]

10 CHAIR THOMPSON: Go ahead.

11 EXECUTIVE DIRECTOR SCHWARTZ: I think we need --
12 I would like to sort of regroup with the staff and think
13 about sort of what our capabilities are.

14 I get a little nervous hearing about some of
15 these threads because I think our discussion of them could
16 not be helpful from either a federal or a state policy
17 perspective. So I think we should think a little bit more
18 about what our role might be.

19 I know we have staff here who read the special
20 terms and the conditions of these new waivers and know them
21 really, really well, and so we learn some things in our
22 implementation work over the last series of expansion

1 waivers about things that change, things that didn't happen
2 that I would like to think about in terms of like what we
3 might go next with and then maybe come back to you all with
4 some ideas about some work that we could do.

5 CHAIR THOMPSON: All right. I will take
6 advantage of that offer.

7 [Laughter.]

8 CHAIR THOMPSON: But obviously an important
9 subject and one that we'll continue to grapple with. So
10 I'm glad, Kacey, that you arranged for us to have this
11 conversation this morning. Thank you.

12 Okay. So, Anne, you're up next with a quick
13 update on general MACPAC activities before we go into our
14 final session on upper payment limit supplemental payments.

15 **### UPDATE ON MACPAC ACTIVITIES**

16 * EXECUTIVE DIRECTOR SCHWARTZ: It would be ironic
17 if I did not actually print out what I was going to say,
18 but it actually seems to be extremely possible because I
19 remember doing it on my computer at home.

20 I think the points that I wanted to make, I can
21 make fairly quickly. One is just to make sure the public
22 understands where we are with our June report. The June

1 report comes out on June 15th, as per the statute. The
2 report has four chapters in it.

3 The first two were the ones that we talked about
4 at our March meeting, both of which include
5 recommendations. Those are -- the one on changes to the
6 drug rebate program, and the other on clarifying the 42 CFR
7 Part 2 regulations that affect privacy for folks with
8 substance use disorder.

9 The other two chapters of the report were the
10 ones we talked about yesterday on the review of managed
11 long-term services and supports and our assessment of
12 access to substance use disorder treatment, and neither of
13 those have recommendations. And those will be out in June.

14 We have been doing a ton of publishing, and so if
15 you are not aware of the various issue briefs and fact
16 sheets we've been doing, I would direct you to our website.
17 We have had issue briefs come out on DSRIP, on work and
18 community engagement requirements, on Medicaid and schools.
19 We've updated all our fact sheets on the duals demos. So
20 every single state fact sheet is up to date. We've updated
21 our brief on the 1115s expanding to the new adult group and
22 have updated the state fact sheets to reflect the new

1 waiver approvals for Arkansas, Kentucky, and Indiana, so
2 all of those are up to date.

3 We have updated the background information on our
4 website to reflect changes in the Balanced Budget Act. All
5 of our CHIP pages have been updated and our CHIP fact
6 sheet.

7 I also want to call your attention to MACStats
8 because even though we published the book in December --
9 and I'm very old school. I like a book, and as someone
10 pointed out to me, if you look at the book online, you have
11 to tilt your head. It's much easier to tilt your book than
12 to tilt your screen. But MACStats, we update continually
13 as the data are available, and I think in the past week to
14 10 days, we've updated about 10 data tables. And those are
15 all up. We announced all of those on Twitter. We don't
16 tweet a lot, but if you ever want to look at our Twitter
17 feed, that will give you the latest in terms of what's up
18 to date.

19 We had another issue brief on Medicaid and public
20 health emergencies.

21 We have a new compendium on state policies, on
22 appeals policies that will be up on Tuesday. It's a

1 massive spreadsheet, not easy to print out, but behind
2 that, we have a summary spreadsheet and also a spreadsheet
3 for all of the 51, I think, state policies, so the 50
4 states and the District of Columbia, and that will be up to
5 add.

6 We are about ready to update our compendium on
7 state policies for paying for inpatient hospital services
8 and have a schedule for updating our other state compendia.

9 So I think that's the main thing that I want to
10 report on. Our next public meeting will be in September,
11 and I also just want to let folks know in the public know
12 that staff of MACPAC meet at the request of various
13 associations and others. If you have something that you
14 would like to discuss with us, we have an open-door policy.
15 My only request would be that you have something specific
16 that you want to come talk about, and we are available to
17 do that. We will be doing planning over the summer,
18 although some of the work that we've been doing over the
19 course of this session, it's obvious we've already signaled
20 where we'll be doing more work on hospital payment, and we
21 assume on around opioids and around prescription drug
22 spending and the like.

1 So that's my update about what's been going on.

2 CHAIR THOMPSON: Thank you.

3 All right. Rob.

4 **### USES AND OVERSIGHT OF UPPER PAYMENT LIMIT (UPL)**
5 **SUPPLEMENTAL PAYMENTS TO HOSPITALS**

6 * MR. NELB: Thanks. All right. So last but not
7 least I will be talking about the uses and oversight of
8 upper payment limit supplemental payments, also known as
9 UPL payments.

10 I'll begin this presentation with some brief
11 background about UPL payments and about how they fit into
12 our larger hospital payment work plan. Then I'll review
13 findings about how states are currently using UPL payments,
14 based on our review of Medicaid state plans. And, finally,
15 I'll spend most of our time talking about CMS's process for
16 overseeing UPL payments. Specifically, I'll describe CMS's
17 new annual UPL review process, and I'll share findings from
18 our review of the first round of data that states
19 submitted.

20 This new review process was intended to address
21 some of the transparency and accountability concerns that
22 were previously raised by MACPAC, GAO, and OIG. However,

1 as I'll discuss, we find that many of these prior
2 recommendations have not yet been fully implemented.

3 The information today will hopefully jump-start
4 some conversation around several policy questions,
5 including questions about specific improvements to UPL
6 policy, by itself, as well as larger questions about how
7 this work fits into our work on hospital payment, more
8 broadly.

9 So as you recall, at our January meeting we
10 outlined a long-term work plan that aims to broadly
11 consider all types of Medicaid payments to hospitals, and
12 at our last public meeting in March we began our work in
13 this area by discussing the different types of base and
14 supplemental payments that states make. We found that
15 although the majority of Medicaid enrollees are in managed
16 care, the majority of Medicaid payments to hospitals are
17 still in fee-for-service.

18 Second, we found that about half of fee-for-
19 service payments were supplemental payments in 2016. There
20 are a variety of different types of supplemental payments
21 that states make. As you know, we've spent a lot of time
22 talking about disproportionate share hospital payments, or

1 DSH payments. But UPL payments are also a large source of
2 supplemental payments, the second largest, and the rules
3 for UPL payments are a lot different from DSH, so we'll be
4 diving into UPL today.

5 As we move forward, this summer we're going to
6 plan to kind of round out our analysis of payment methods
7 by interviewing states and other stakeholders about how
8 they develop their hospital payment methods, and also
9 talking about how some of the fee-for-service payment
10 policies affect managed care payments to hospitals. And
11 then, in the fall, with this better understanding of
12 payment methods, we'll continue to examine some of the
13 other questions in our work plan around payment amounts and
14 outcomes related to payments.

15 Okay. So UPL payments, as you know, are lump sum
16 payments to providers that are intended to offset low fee-
17 for-service based payment rates. The UPL stands for Upper
18 Payment Limit, which is the limit established in regulation
19 that applies to all fee-for-service payments, including
20 base and supplemental payments. And, in short, if base
21 payments to hospitals are below the UPL in the aggregate,
22 then states can make UPL supplemental payments to make up

1 the difference.

2 States are also allowed to make UPL payments to a
3 variety of other types of providers, including nursing
4 facilities and physicians, but in today's presentation I'm
5 just going to focus on UPL payments to hospitals, which we
6 see the majority of UPL payments.

7 So, of course, like most things in Medicaid, the
8 specifics of the UPL requirements are a little more
9 complicated than they sound, at first. Here are just some
10 important details that I think are useful to be aware of
11 for the conversation today.

12 So the regulations that establish the UPL state
13 that, in the aggregate for a class of providers, fee-for-
14 service based payments and UPL payments cannot exceed a
15 reasonable estimate of what providers would have been paid
16 according to Medicaid payment principles. There are a
17 couple of important things to unpack there. First of all,
18 classes of providers are defined based on ownership, so
19 there's different UPL limits for public and private
20 providers.

21 And second, the fact that the UPL is an estimate
22 means that states do not use actual Medicare payment rates

1 when calculating the UPL. Instead, they have the
2 flexibility to choose from a variety of different methods
3 for estimating what Medicare would have paid, according to
4 Medicare payment principles. And finally, since UPLs are
5 established in the aggregate, some hospitals may receive
6 payments that are higher than what Medicare would have
7 paid, as long as total payments for the class of providers
8 is below the UPL in the aggregate.

9 States have been allowed to make UPL payments
10 since 1981, when Medicaid payments were delinked from
11 Medicare. However, when we look at the historical data, we
12 see that the use of UPL payments started to grow, really,
13 in the 2000s. It's hard to say exactly why but in the '90s
14 Congress enacted several limits on DSH payments, and so we
15 see DSH payments going down while UPL payments were going
16 up.

17 In 2000, OIG reported that 15 states were making
18 \$4.5 billion in UPL payments to hospitals, and in 2016, we
19 found that 36 states were making \$16.4 billion in UPL
20 payments to hospitals, so there's been a big increase.

21 In recent years, some large states, such as
22 Texas, have transitioned their UPL programs to Section 1115

1 waivers in order to preserve these payments when they've
2 expanded managed care. However, we continue to find that a
3 number of states still use UPL payments, and these are a
4 large source of payments to hospitals.

5 Based on our review of Medicaid state plans, we
6 find that states often target UPL payments to specific
7 provider types, including some of the ones listed here.
8 These are often the same types of providers that states
9 target for DSH payments: government-owned hospitals,
10 safety-net hospitals, rural hospitals, and specialty
11 hospitals, such as children's hospitals.

12 We've also found, in our review, that most states
13 allocate UPL payments among providers in ways that are not
14 really tied to particular services. So, for example, a lot
15 of states allocate UPL payments based on the relative
16 number of Medicaid days at a hospital, or as an equal share
17 of a fixed amount. In our review, we found very few
18 examples of states that use UPL payments to incentivize
19 delivery system reform or in other ways tie the UPL
20 payments to achievement of any quality metrics.

21 So in addition to looking at how states use UPL,
22 let's look at how they're overseen by CMS. In 2013, CMS

1 issued new guidance establishing a process for states to
2 demonstrate compliance with the UPL annually. Previously,
3 states only had to demonstrate compliance with the UPL when
4 they made changes to their hospital payment rates. As part
5 of this new review process, CMS has required states to
6 submit hospital-specific data in a standard format,
7 including data on Medicaid payments and on the estimates of
8 what would have been paid according to Medicare payment
9 principles.

10 In general, states are supposed to include all
11 hospitals in the state. However, in practice, states do
12 tend to exclude some hospitals that are paid on a cost
13 basis, typically the critical access hospitals.

14 To date, we have obtained state-level data from
15 CMS for state fiscal years 2014, 2015, and 2016, and this
16 will be the basis of our presentation today. Actually,
17 good news. We are hoping to work with CMS to get some of
18 that hospital-level data, hopefully this summer, and so as
19 we continue work in this area we may be able to share some
20 findings at the hospital level as well.

21 When a state submits these what are called UPL
22 demonstrations, which are different from 1115

1 demonstrations -- this is the term that they use, anyway --
2 the first piece is they indicate what method that they're
3 using to estimate what Medicare would have paid, and CMS
4 guidelines have outlined four methods that states can use
5 for hospitals. First is a cost-based method, which is an
6 estimate of facility costs based on services provided to
7 Medicaid patients. It's important to note -- so Medicare
8 no longer pays on a cost basis for most hospitals, but this
9 option is still permitted because costs are calculated
10 according to Medicare payment principles, so that's the key
11 term there.

12 Second, states can choose a payment-based method.
13 Generally, this is based on a facility's aggregate Medicare
14 payments relative to its charges, and then that payment-to-
15 charge ratio is multiplied by a total Medicaid charges to
16 establish the UPL estimate. And then for inpatient
17 services, states can use a price-based method, based on
18 what Medicare actually pays for specific DRGs. But even in
19 this method there are adjustments to account for the
20 different acuity between a Medicaid and a Medicare patient,
21 different use of services that they have. And finally, for
22 inpatient services, states can also establish the UPL on a

1 per diem basis, based on average Medicare payments per
2 hospital day.

3 Based on our review states' 2014 submissions, we
4 found that about half the states use cost-based methods for
5 inpatient hospital services and about half used one of the
6 payment-based methods listed here. For outpatient hospital
7 services, most states used a cost-based method.

8 When states pick that overall UPL method they
9 then apply a variety of adjustments to the baseline data
10 used in the UPL calculation, for example, if they adjust
11 older data for inflation and may make adjustments for
12 changes in the volume of services provided. It's important
13 to note that states that use the cost-based method can add
14 in the cost of provider taxes that are used to finance UPL
15 payments. However, states are not allowed to add the cost
16 of other types of provider contributions to the non-federal
17 share, such as IGT payments from public hospitals.

18 This adjusted Medicare estimate is ultimately
19 compared to Medicaid spending in order to demonstrate
20 compliance with the UPL, and states have the option to
21 report Medicaid spending in one of two ways. They can
22 project Medicaid spending for the future year or they can

1 report on actual Medicaid spending. Unfortunately, we
2 don't know how many states use which method. In our
3 conversations with CMS staff, however, we understand that
4 what states submit in the UPL demonstrations is ultimately
5 not reconciled with what they submit on their CMS-64
6 expenditure reports. There are some technical reasons to
7 this about the timing and sort of definitions about how
8 data is reported in both sources.

9 So as part of our review we looked at the state-
10 submitted data in the aggregate for 2015, which was the
11 latest year for which we had complete data. We found that
12 most states reported compliance with the UPL requirements
13 in their state-submitted data. And so, specifically, total
14 Medicaid payments that states reported were below the UPL
15 by about \$12.4 billion, meaning that states, based on the
16 data they provided, it looked like they could have made
17 \$12.4 billion more in UPL payments in 2015.

18 However, when we compared the state-submitted
19 data to actual expenditures reported on the CMS-64, we
20 found some big discrepancies, and we particularly found
21 that most states appeared to underreport UPL payments in
22 their submissions to CMS. Specifically, we found that UPL

1 spending reported on the expenditure reports was actually
2 about \$11 billion higher than what states reported in their
3 UPL demos. Some of these discrepancies may be due to data
4 lag or some of the technical issues I mentioned earlier.
5 It's important to note that some states would still have
6 been in compliance with UPL even if their spending was
7 higher.

8 However, we did find that if UPL spending was
9 actually as high as what was reported on expenditure
10 reports, it appeared that about 15 states may have had fee-
11 for-service hospital payments that exceeded the UPL in
12 2015, and in the aggregate, these payments may have
13 exceeded the UPL by a large amount, several billion
14 dollars.

15 In addition to finding discrepancies in the
16 Medicaid spending side, we also found examples of large
17 adjustments on the Medicare side of the calculation, which
18 may result in UPLs that are larger than what Medicare may
19 have paid and may also have implications for whether or not
20 states are in compliance with UPL requirements.

21 So just for example, we found an example of a
22 state that was out of compliance with the UPL one year but

1 then was in compliance with the UPL in the later year,
2 after they increased the adjustment factor that they
3 applied to the Medicare baseline. So the state applied an
4 8 percent increase in one year and then a 54 percent
5 increase in a future year. And so with a higher adjustment
6 factor, the state was then in compliance with the UPL, even
7 though it was actually making more UPL payments.

8 Okay. So just linking this back to some of the
9 prior recommendations, as you know, MACPAC and other
10 stakeholders have made a variety of recommendations to CMS
11 to improve its oversight of UPL payments. This table
12 summarizes some of the major recommendations that have been
13 made since 2001. First, as you know, MACPAC has
14 recommended that CMS collect and report hospital-specific
15 data on Medicaid payments, including data on the sources of
16 non-federal share. GAO has made a similar recommendation,
17 but MACPAC is actually unique in sort of recommending that
18 this data be publicly available.

19 The second to address concerns about the accuracy
20 of the underlying data, both GAO and OIG have recommended
21 that UPL data be audited. And finally, UPL has -- OIG has
22 recommended that UPL limits be established at a facility-

1 specific level rather than the aggregate, since, as I
2 mentioned, some hospitals may receive fee-for-service
3 payments that are above what Medicare would have paid.

4 So CMS has taken some actions to address some of
5 these recommendations and more changes may be forthcoming.
6 But, as I noted at the outset, many of these
7 recommendations still remain unimplemented. For example,
8 CMS is now collecting hospital-level data but these data
9 are not publicly available and, in some cases, appear to be
10 incomplete. Second, although CMS has issued more guidance
11 to states about how to calculate UPLs, the UPL calculations
12 are not audited and are not reconciled with other sources
13 of data, such as expenditure reports.

14 CMS has indicated that it is currently planning
15 to release a supplemental payment regulation this fall to
16 codify some of its prior guidance, but at this point we
17 don't yet know the exact content of the rule or even the
18 timing, to be frank.

19 And finally, it's just worth noting that the
20 President's budget includes a legislative proposal to limit
21 Medicaid payments to public providers to provider-specific
22 costs. This proposal would, in some ways, be a step

1 towards establishing that hospital-specific UPL limit that
2 OIG has commented on, but it's hard to say since this
3 legislation has not yet been introduced and there's a
4 variety of important details still need to be worked out.

5 So that concludes my presentation for today. I
6 look forward to your feedback and discussion, again, both
7 about what this means for looking at UPL payments
8 individually but also how it can help inform our larger
9 hospital payment work plan. Thank you.

10 CHAIR THOMPSON: Okay. Let's see. We have
11 Stacey, Brian, Bill, Sheldon. Let me start off for a
12 second here.

13 I find this extremely concerning. You know, if
14 we go back to the slide where we talk about the various
15 recommendations that have been made by MACPAC, GAO, and
16 OIG, and appreciating that CMS may be considering
17 additional action in the realm of supplementals, all of
18 these recommendations make certain assumptions that
19 collecting the data, making it available, and auditing it,
20 and establishing limits, that the data is actually used.
21 None of this matters if the actual expenditures that are
22 claimed are unrelated to any limits or the demonstration of

1 compliance with any limits.

2 And I want to distinguish between consideration
3 and reconciliation. I can totally understand that it isn't
4 always possible to reconcile, if we think of reconciliation
5 as being a financial term in which there are two ledgers
6 and they match. But the differences ought to be
7 understandable and accounted for.

8 And when we're talking about a demonstration
9 being supplied, about how we're ensuring that we're under
10 the limit, and then when the expenditures are claimed no
11 one is even looking at those demonstrations, no one is
12 asking questions about why what we're seeing in the claim
13 for the expenditures diverges from the information or the
14 expectation established in the UPL demonstration, then
15 that, to me, is a significant issue and a significant
16 concern as a matter of procedure and process.

17 The fact that we are identifying potentially
18 billions of dollars in discrepancies between those two data
19 sources elevates our concern beyond the simple, you know,
20 this is bad hygiene, into this is a real significant
21 vulnerability that we ought to be understanding and
22 addressing. You know, it's something I think we ought to

1 be highlighting to the Congress and highlighting to CMS as
2 needing some immediate action.

3 I think there are various other issues that
4 you've identified here about methodologies that others
5 might want to jump in on, but I will just say that, you
6 know, there's, as you mentioned, a tremendous amount of
7 flexibility in how states can use methodologies and create
8 these demonstrations, but you've also identified that there
9 are very large adjustments. Even with all those
10 flexibilities there are very large adjustments that are
11 being used by states, and I don't think that we understand
12 what those adjustments represent.

13 And so we have the UPL demonstrations. They,
14 themselves, may have issues associated with these
15 adjustments or some of these other methodological issues,
16 and then we have a huge discrepancy between what those
17 would suggest would be the appropriate level of
18 expenditures and what's actually being claimed.

19 And so I think before we can even get into a
20 conversation about more reporting or more availability of
21 the reporting or more applications of additional limits, we
22 have to make sure that we're using the data that we

1 currently have and applying the limits that are currently
2 in place as a basic condition of ensuring the integrity of
3 the program.

4 CHAIR THOMPSON: Stacey.

5 COMMISSIONER LAMPKIN: Thank you. I just have a
6 few, I suppose, technical questions to help --

7 VICE CHAIR GOLD: Stacey, could you pull the mic
8 closer?

9 COMMISSIONER LAMPKIN: Sorry. A few technical
10 questions just to make sure that we have the right context
11 for some of this interpretation.

12 Can you tell us just a little -- a few more
13 basics around the demonstrations themselves? For example,
14 are they retrospective? Are they looking at expenditures
15 on a paid basis or an incurred basis? How much later after
16 the close of the reporting period are those calculations
17 made? Just some basics about that. And then when you
18 compare them to the 64s, you're comparing what the
19 demonstration says are actual supplemental payments for
20 that time period? Or are you looking at the gap? Just
21 kind of walk us through that in a little bit more detail.

22 And then the second piece of my question is: So

1 this is a very complicated demonstration to prepare,
2 clearly. Do we know whether states are doing this in-house
3 versus using consultants or which states are doing that?

4 Those are my questions.

5 MR. NELB: Sure. So, actually, I can't answer
6 much of the second question about who at the state is kind
7 of compiling the data. I would imagine there would be some
8 different consultants, and as we interview some states this
9 summer, we can sort of talk more about how they actually
10 operationalize it. But to get at your point and some
11 context for understanding this large discrepancy we see
12 between what states report on the UPL demonstration versus
13 what's in the 64, the points that you make about time
14 periods -- are important to keep in mind.

15 So the UPL demos, again, they have sort of two
16 options to report the Medicaid spending. So some states do
17 report it prospectively, so, you know, where state fiscal
18 year '19 might start in July, and so they're going to
19 submit a demonstration, you know, in June to say this is
20 how much I'm going to spend on UPL the next year. Some
21 states submit the UPL demonstrations sort of
22 retrospectively using their own internal state data. And,

1 again, we don't exactly know the timing of that and, you
2 know, so let's imagine a state fiscal year ends in June of
3 2018 or something, they might sort of report the UPL
4 spending as of that date, but then it is possible, you
5 know, you have a two-year claiming period in Medicaid, so a
6 state could potentially make future UPL payments that apply
7 to that year but they make them sort of after that year has
8 actually passed. So there are some different timing
9 issues.

10 The CMS 64 data that we report is sort of the
11 same that we have in MACStats and things. They're net
12 expenditures as of that period, and so there could be some
13 cases where there are sort of prior period adjustments and
14 sort of the claiming for prior years where the timing could
15 get off by a little bit. But the other challenge, though,
16 is -- in the 64, we have the date that they sort of
17 submitted the claim, but we don't have the date that the
18 claim was actually for. This is unlike a DSH payment. When
19 a state puts in a DSH payment, they apply it against an
20 allotment for a particular year, we can see what year it
21 applies to. With UPL, we just know that the amount was
22 spent. We don't know whether it was spent for '16 or '17

1 or '18, and so that's another reason why there might be
2 some of these gaps.

3 That being said, you know, we have seen this
4 discrepancy between the 64 and the UPL demos in all three
5 years that we looked at. So there does seem to be
6 something going on that's beyond just the time period.
7 But, yeah, to make those apples-to-apples comparisons,
8 understanding the differences between the sources is an
9 important context.

10 CHAIR THOMPSON: Brian.

11 COMMISSIONER BURWELL: So I have to say I am
12 starting to feel left out. I think we should seek
13 redesignation as the MACPAC demonstration.

14 [Laughter.]

15 COMMISSIONER BURWELL: More in the spirit of
16 what's going on.

17 Secondly, I also enjoy very much watching Darin's
18 facial expressions when Rob was talking about the
19 discrepancies in these demonstrations.

20 I do have a technical question around the impact
21 of managed care on supplemental payments, and the story
22 that -- this is not my area, but I remember hearing that

1 Texas wanted to expand the Texas STAR+PLUS program into the
2 Dallas area, but there was great resistance to doing that
3 from a number of hospitals in the Dallas area because they
4 would lose their UPL payments as a result of the shift to
5 managed care. I think it was eventually worked out. So I
6 wonder if Stacey and Fred can shed more light on that. Is
7 that an ongoing issue, or is that only resolved through an
8 1115? Or how are those two things interrelated?

9 COMMISSIONER LAMPKIN: I'm sorry. I'm going to
10 confess I was sidebarring with Toby, and I missed kind of
11 the --

12 [Laughter.]

13 COMMISSIONER BURWELL: Is there a risk to
14 hospitals of losing their supplemental payments if states
15 shift from fee-for-service to managed care?

16 COMMISSIONER LAMPKIN: So, yes, definitely so.
17 If the state doesn't go out of its way to try to do
18 something to restore those dollars through various
19 mechanisms -- and there are now some regulatory allowed
20 mechanisms that are relatively recent that states can
21 employ. But there is a risk there.

22 COMMISSIONER BURWELL: Regulatory mechanisms

1 other than other authorities like 1115s or -- I mean --

2 COMMISSIONER LAMPKIN: Right, so the new managed
3 care -- relatively new managed care regulation actually
4 explicitly gave states some options of ways that they could
5 direct payments that would allow them to deal with former
6 supplemental payments in a particular way. Now, the
7 authorities that are specific to those -- and I may be
8 getting out over my skis and need some help here, but
9 states have to submit in advance of making those directed
10 payments plans to CMS and get approval for that before they
11 can actually deploy them and actuaries can build them into
12 capitation rates or whatever the mechanism is. BP is one
13 of the ways, and there are some pass-through options that
14 are time-limited that states can use.

15 CHAIR THOMPSON: Bill.

16 COMMISSIONER SCANLON: I think this is very
17 useful information, and the questions you're going to be
18 pursuing are very important. I want to share Penny's
19 concern. I might raise the level to alarm over sort of
20 what you found to date. And I think part of that, to sort
21 of reinforce this, would be to in some respects change the
22 context and stop -- and not think about UPL payments as

1 filling in a shortfall, but actually thinking of them as
2 something that was created as a limit to try and avoid
3 excessive payments.

4 As you mentioned, they began sort of after some
5 limits were put on DSH, and those limits on DSH were put
6 there for a reason, because money wasn't necessarily going
7 for care. We know that quite graphically, when the DSH
8 limits first went into place, it was so dramatic that when
9 one state had to live with their DSH limit, Medicaid
10 spending nationwide went down one percentage point. Okay?
11 So there was considerable money that was what I used to
12 characterize as "making round trips," arriving at a
13 provider and then sort of going out. And with upper
14 payment limits, we had the same kind of situation. And
15 part of it goes to the question of that we're making the
16 test sort of in the aggregate, not necessarily sort of by
17 individual hospital. And the proposal in the budget maybe
18 sort of will deal with that by putting a limit on the basis
19 of cost. But that wasn't historically the case.

20 Now, I don't know what has happened to deal with
21 intergovernmental transfers because that was the mechanism
22 that was causing most of the abuse. And I could be dated

1 in terms of that we have sort of mechanisms now that handle
2 that well enough and so that some of when we investigate
3 this will disappear, and I'm perfectly open to sort of
4 learning that, because that would be very sort of welcome
5 information to know that we have stopped some of that.

6 But I think at the same time, you know, we
7 shouldn't think about this as we're making up a shortfall,
8 because what was keeping the base rates from being the
9 appropriate rate to begin with? Why are we doing this in
10 sort of two buckets as opposed to sort of one which would
11 be tied to the care that's being delivered and sort of an
12 appropriate amount of payment?

13 CHAIR THOMPSON: And that is somewhat not a UPL
14 issue but a supplemental payment issue, which are somewhat
15 related by different, you know, in terms of how payments
16 are being made and why we've seen this increase, which
17 we've talked about in the Commission before, the increase
18 in the level of supplemental payments and the amount of the
19 total payments accounted for by supplementals which has
20 occurred over time.

21 I have Sheldon and then Fred and then Toby.

22 COMMISSIONER RETCHIN: Well, let's see. How do I

1 provide any commentary here without seeming to be an
2 outcast or an outlier in terms of my own feeling about what
3 I'll call the "ecology of safety net payment and care."

4 We've raised this issue about supplemental
5 payments numerous times, and I think we always come up with
6 a discrepancy in terms of the identification of how the
7 payments are made and perhaps the abuses of the system that
8 we believe are present, and particularly having mentioned
9 the whole issue of the provider tax and the threshold for
10 provider tax as a percent of total revenues.

11 That said, it seems to me here, Rob, that the
12 discrepancy is so large that -- I mean, I don't know if you
13 want to hypothesize -- it can't be timing. So let me just
14 be sure I understand. In both of these, the provider tax
15 is embedded as a cost. There's no discrepancy there on how
16 64s are filed or the UPL demonstrations. Provider taxes
17 are used as a cost on both. Is that right?

18 MR. NELB: Not quite. So the UPL -- provider
19 taxes are a cost when calculating the Medicare side of the
20 equation for the UPL, but what I was presenting is the
21 discrepancies on the Medicaid side of the equation. And,
22 theoretically, that is supposed to be total computable

1 cost, so the federal and state, and is -- you know, even
2 if, as we've -- even if the provider receives lower
3 payments after making the provider tax or an IGT
4 contribution, they're theoretically supposed to be
5 reporting the full payment that they receive that's matched
6 by the federal government.

7 COMMISSIONER RETCHIN: So could that explain --
8 or not?

9 MR. NELB: I'd be cautious to make any
10 predictions now without taking a closer look, and maybe
11 once we get this hospital level data, we can help. But,
12 obviously, as we've talked about just in general the
13 difference between the gross payment that the hospital
14 receives and the net payment, after you subtract out the
15 taxes and the IGTs, it's a lot less. So there is some
16 difference there.

17 COMMISSIONER RETCHIN: So that difference could
18 be large, 32 percent I think you estimated in terms of the
19 provider tax. Is that right?

20 MR. NELB: So I think it's something like, yeah,
21 30 percent of the non-federal share for UPL payments is
22 provided by provider taxes. Another larger portion is

1 provided by IGTs.

2 CHAIR THOMPSON: But that would not account for
3 the difference that you're reporting here between the 64
4 and the UPL demonstration.

5 MR. NELB: Right, correct. Well, first of all,
6 they're supposed to be reporting it the same in both ways,
7 so there -- so yeah, that's -- we can take a look into it
8 and explore more, but we'll -- yeah, they're supposed to be
9 reporting total Medicaid spending and in both sources.

10 COMMISSIONER RETCHIN: So the provider tax would
11 have been on both sides undoubtedly.

12 MR. NELB: Right, so the provider tax is a cost;
13 it's not part of the spending.

14 COMMISSIONER RETCHIN: I'm confused, but I
15 started my question and comments confused, so I feel that
16 I'm pretty balanced on that.

17 [Laughter.]

18 COMMISSIONER RETCHIN: Let me just make a
19 qualitative judgment on this. Listen, I know that there is
20 a lot of concern on how supplemental payments are made, and
21 there are some that are quite pejorative about it. My only
22 cautionary note is before a rush to judgment and trying to

1 determine why there is such a discrepancy is appropriate,
2 that the ecology of safety net payment and care and the
3 delivery of care is fragile. And that said, my only lament
4 about supplemental payments is that we have not used those
5 to leverage delivery system reform. That's where I would
6 go with this, and also to understand the fragility on the
7 side -- and I've mentioned this many times -- about
8 physician payments. While hospital payments are on average
9 at a cost of about, I think, 60 percent of Medicare, 70
10 percent, and the supplemental payments make up some of the
11 shortfall, even though they're not designed for that for
12 the UPL, on the physician side it's not true. On the
13 physician side, they are on average something like 60
14 percent of Medicare, and while there is a thin veneer of
15 UPL, there is no DSH, obviously. The "H" stands for
16 hospital. So I continue to come back to that and wish that
17 we would focus on the delivery system reform that we could
18 be able to leverage these for.

19 CHAIR THOMPSON: Fred and then Toby.

20 COMMISSIONER CERISE: Thanks, and these guys have
21 made much of my comments, but I'll say a couple of things.

22 One, Brian, the Texas thing, exactly what

1 happened is they shifted those UPL payments to waiver
2 payments, and that's why it's worked out. So now those are
3 coming through UC payments and DSH payments. So, anyhow.

4 You know, Bill, you said the rates -- I mean,
5 there's a way to deal with this, and it's rates. You can
6 get to the UPL through rates, and generally, you know,
7 states use the supplemental payment programs to sort of get
8 closer to rates, but without putting up state share, and
9 it's easier because you can use other sources of -- you
10 know, it's easier to use IGTs and provider taxes and things
11 like that. And so I think then states become less lax
12 about how broadly to make the payments, because the state's
13 share is coming free to the state, and so you can see how
14 these things will grow.

15 And so, you know, I would, Sheldon, take issue
16 with one way you described it, because I agree with your
17 point, but these I don't believe are safety net payments.
18 I mean, they become very broad payments. And if you looked
19 at who's getting UPL payments, it's gone way beyond
20 somebody that may have a 30 percent Medicaid utilization
21 and 30 percent uninsured population. But it's kind of the
22 general -- it's gotten to be a much broader general

1 population. And so I do think, you know, you could address
2 rates through rates and not through supplemental payments,
3 and then use supplemental payments to drive delivery system
4 reform, to drive some policies that you want to look at.
5 And there's a lot of opportunity -- there's a lot of
6 opportunity to do that. You could start with looking at
7 the source of the state share and what's allowed to go into
8 that. And then when you make these supplemental payments,
9 tie them to explicit delivery system reforms that you want
10 to see.

11 CHAIR THOMPSON: Yeah, and I would just say
12 regardless of how you mix and match the rates and
13 supplementals, all of it has to live under the UPL. So you
14 can have a debate about how much should be in the rate and
15 how much should be in the supplemental and what the
16 supplemental are for, but all of it is still subject to the
17 upper payment limit. So I think that's the distinction
18 that I would drive between that conversation and the
19 conversation of whether or not you're enforcing the limits
20 and whether or not we have an issue in which people may be
21 exceeding the limits by a significant amount above the
22 level that they have demonstrated in these demonstrations

1 to the federal government that they're living within.

2 So that's just the distinction that I would want
3 to make sure that we keep in mind as we have the
4 conversation.

5 COMMISSIONER RETCHIN: Can I ask for one
6 clarification? Fred, at your hospital are you able -- you
7 must make payments to -- well, I already know you make
8 payments to physician groups. Are you able to put that on
9 your 64?

10 COMMISSIONER CERISE: I don't know. For --

11 CHAIR THOMPSON: Well, a hospital doesn't have a
12 64. We're talking about the states.

13 COMMISSIONER RETCHIN: Oh, I'm sorry. For
14 hospital --

15 COMMISSIONER CERISE: But I think what you're
16 asking is do I -- those are not costs I can claim for DSH,
17 unless they're for admin or things like that. But they
18 would be covered in my UC, uncompensated care, you know,
19 eligible for match to other -- through UPL or through UC.

20 CHAIR THOMPSON: Toby.

21 COMMISSIONER DOUGLAS: Well, first I just want to
22 -- one thing that Fred said, you know, they are permissible

1 -- they are state share, IGT provider taxes, so I want to
2 make sure we're on record and clear, those are all
3 permissible state share, and it's just another source of
4 the other. I mean, that brings up bigger issues of
5 financing.

6 The question I have for you, Rob, before we raise
7 alarms, I'm still questioning if there's more work that
8 needs to be done on making sure the reporting is -- you
9 know, there are issues at the state level or at CMS on the
10 reporting, because these discrepancies and just looking at
11 the data on a state-by-state -- just truly I'm concerned
12 we're raising alarms before we dig a little bit deeper.
13 And if there's more -- and a question to you is: Is there
14 more we can be doing before we take that step?

15 MR. NELB: Sure. So we will continue to take a
16 closer look at state level. We've been talking with CMS
17 staff about some of our preliminary findings, but yeah, the
18 hope is as we get more of the hospital-level data this
19 summer, we can take a closer look. And then the states
20 that we're interviewing, we can learn more. We can also
21 just even reach out to some other states that we're not
22 doing the full interview but just to better understand some

1 of these really big discrepancies.

2 So we'll continue to look into it and agree it's
3 important. This is just a preliminary analysis, seeing
4 some of these big disconnects, and so now as we continue
5 our work, we're going to really want to dive in and
6 understand it more so we can help inform ways to improve
7 the process.

8 CHAIR THOMPSON: Yeah. And, Toby, I mean, I
9 guess it is possible that there is an explanation and we
10 can account for it. My concern is that we don't have a
11 process under way to account for that. We don't have the
12 information that supports accounting for it. So we don't
13 know what it represents, and that's concerning, the fact
14 that we don't know the answer to that. And I think we've
15 tried to see if there is any process that's under way to
16 account for it.

17 So I'm not expressing serious concern because I
18 absolutely know that we have a bunch of states that really
19 exceeded the UPL. I'm concerned that we have information
20 that isn't being used and that we don't have explanations
21 for, which could mean a variety of things.

22 COMMISSIONER DOUGLAS: I'm not up on that, and

1 I'm concerned about that too.

2 CHAIR THOMPSON: Right.

3 COMMISSIONER DOUGLAS: I just don't want us to
4 jump to the next --

5 CHAIR THOMPSON: Yes, that's right.

6 COMMISSIONER DOUGLAS: To the next step.

7 EXECUTIVE DIRECTOR SCHWARTZ: And it is not for
8 lack of asking. I think there's also a question about sort
9 of the disconnect between folks who are tasked with the
10 mechanical exercise of compliance versus the meaning that's
11 found, to that compliance for a broader policy
12 consideration.

13 CHAIR THOMPSON: And just in terms of our own
14 continuing work, because I don't think that we actually
15 started to dive into this because we were interested in
16 looking at compliance with UPL. That wasn't kind of what
17 our focus was initially. We just kind of have identified
18 this.

19 But in terms of being able to put these pieces
20 together in the way that we want to put together, we're
21 trying to complete an entire picture, the theory of
22 everything, of how all these payments are lining up and if

1 the data is causing us concern in terms of do we have a
2 data problem, do we have a reporting problem, do we have a
3 compliance problem. We need to understand that just as a
4 matter of program management, but we also need to
5 understand that in order to make use of some of this
6 information, especially at the hospital level. Are we
7 going to encounter some of the similar kinds of questions
8 or concerns about that as we try to put it together?

9 So I would like to suggest that we try to put
10 this information together and send this off to CMS and ask
11 them for some additional information or explanation -- I
12 know that we've done that informally -- and then as well
13 make the Congress aware of this ongoing inquiry.

14 All right. Any other final comments or
15 questions?

16 [No response.]

17 CHAIR THOMPSON: Okay. Can we open it up for
18 public comment on this or any other issues that we've been
19 discussing this morning?

20 **### PUBLIC COMMENT**

21 * MR. BADARACCO: Hi. My name is Andrew Badaracco.
22 I'm a technical director in the Financial Management Group

1 at CMS that actually works on UPLs. Rob has been working
2 with a lot of my colleagues over the last several months --
3 I dare say years on this.

4 One of the areas that the templates are -- the
5 adjustment factor, first of all, one of the areas that the
6 templates is intended to figure out is -- and kind of
7 streamline is kind of remove the ability of states to make
8 those adjustments. It's just a straight presentation of
9 data.

10 In the first few years, we're trying to figure
11 out what do we have, where does it belong and all that
12 stuff. I think we're finally getting to a place where the
13 next couple years should be result in better data.

14 I would say as far as the gap is concerned, one
15 of the things that states do and don't do in terms of their
16 state plan as it relates to the UPLs is they put
17 methodologies in the plan that say, "We pay up to whatever
18 the gap is in the UPL," so that delta between what they
19 have paid and what the UPL represents, they just pay it
20 out.

21 In many cases, they don't report that on the UPL.
22 They probably should, but they just say this is how we pay,

1 and this is where the top line will be, whatever the UPL
2 results in.

3 So, in large part, you have a lot of states that
4 have UPL gaps on the demonstration itself, but as far as
5 the actual payments are concerned, they're paying up to
6 that gap. So that might help explain that delta. I mean,
7 we'd have to look back and see. Maybe that's a reporting
8 mechanism through the UPL demonstrations, but I think that
9 in terms of listening to the discussion today, in actual
10 practice, there is some of that that's going on, and that
11 might help explain the large gap.

12 But, anyway, thank you, guys, for the discussion
13 today.

14 CHAIR THOMPSON: Thank you, Andrew.

15 Okay. We are adjourned. Thank you very much.

16 * [Whereupon, at 11:47 a.m., the meeting was
17 adjourned.]