PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

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KATHERINE WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director
AGENDA

Session 1: Multistate Collaboration: Panel on State Perspectives

Moira Forbes, Policy Director.........................4

Panelists:

Elena Nicollela, Executive Director, New England States Consortium Systems Organization..........6

Rhonda Anderson, Director of Pharmacy/Director of the Drug Effectiveness Review Project (DERP), Oregon Health and Science University......................14

Public Comment/Recess..................................57

Session 2: Further Discussion on Multistate Collaboration

Moira Forbes, Policy Director.......................57

Session 3: Changes to MACPAC Conflict of Interest Policy

Anne Schwartz, Executive Director...............94

Public Comment/Lunch.................................98

Session 4: Themes from Interviews on the Development
Of Hospital Payment Policies

Robert Nelb, Principal Analyst.................................99

Session 5: Disproportionate Share Hospital (DSH) Payments: Policy Changes and Policy Options

Robert Nelb, Principal Analyst.................................129

Public Comment...................................................164
Recess..........................................................166

Session 6: Operational Considerations for Work and Community Engagement Requirements

Kacey Buderi, Senior Analyst.................................166

Public Comment...................................................206

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

Rick Van Buren, Senior Analyst.............................218
Chris Park, Principal Analyst.................................225

Public Comment/Adjourn Day 1..............................249
CHAIR THOMPSON: Okay. Why don't we go ahead and get started. First of all, welcome, everyone, to the 2018-19 report cycle for MACPAC. We are very happy to kick off our meeting today with the folks that are going to be presenting on this topic.

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

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

As we have been doing in the past, we're going to have some expert conversation, led by Moira, to discuss some successful efforts and also some ongoing challenges in
this area. I'm going to encourage the Commissioners, if there are subjects that the panel touches on that you want more exploration of or clarification around, you should jump into the flow of the conversation at those moments. Don't feel like you need to hold back your questions for the end of the presentation.

There will be time, at the end, to go around and see if people have particular questions or issues that they'd like to ask of Elena and Rhonda, and then we will have, then, time for Commissioner-only conversation and discussion about where we want to next take this topic. So, Moira, let me go ahead and hand it off to you for introductions.

##### MULTISTATE COLLABORATION: PANEL ON STATE PERSPECTIVES

* MS. FORBES: All right. Thanks, Penny, and welcome back, everyone. This session is a follow-up to prior Commission discussions on state administrative capacity, including a session last fall where I presented findings from a literature view on multistate action. You had asked for more information, particularly about the differences between state efforts to collaborate around
information-sharing issues and those focused on ongoing operational initiatives, and you had also asked us to provide more of a typology of state partnerships. Commissioners also asked us to find out more about how changes in federal policy, particularly in federal financial participation, could be used to incentivize states to work together more.

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

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

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

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

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

And I think Elena is going to begin.

* MS. NICOLLELA: Good morning. Thank you very much for the opportunity to talk to you about the
organization I work for, New England States Consortium Systems Organization. We're thinking about a name change but not yet. I have been with the organization for a little bit over two years, and I wanted to give you some history and then talk about some of our current projects.

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

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

The organization, as was mentioned, is a private, not-for-profit organization. The board is made up of the commissioners and secretaries of the New England health and human service agencies. Often they will delegate their board responsibilities to their Medicaid directors, but this year Jeff Meyers, who is the commissioner in New Hampshire, he is the chair of the board, and Al Gobeille,
in Vermont, serves on it, and then we have some of the
Medicaid directors in New England.

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

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

We derive our revenue from the annual dues that
the member states pay. They each pay $28,500 a year.

Excuse me. I should mention, the University of
Massachusetts Medical School is also a member of the board
and a NESCSO partner.

So the $28,500 that each state pays, when they
pay it to the organization they do not seek any federal
financial match for that payment, so it is straight general
revenue funding. What happens then is we accept that money
and then we spend it on initiatives that support the member
states, and at that time, because of our relationship to
UMass Medical School, we are able to access some federal
financial participation. And I can go into the details of
that later, if you have questions, but suffice it to say
that is one advantage, unique, again, advantage of the
organization, its board membership, its mission, and also
its linkage to UMass Medical School, a public entity that
enables it to access federal financial match.

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

Our overall mission, as dictated by the board, is
to promote person-centered, effective delivery of health
and human services. So we have a focus on Medicaid, but
it's really Medicaid as a tool to finance HHS services and
Medicaid as a policy lever to, again, bring about person-
centered health and human service delivery.
So just to clarify, what I mean by that, because I know those terms are thrown around quite a bit, as an example, if a family is receiving services from a child welfare entity and a behavioral health entity in the state, as well as receiving Medicaid-funded health care services, our goal is that within the state there is collaboration across those agencies.

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

So in the area of strengthening administrative capacity -- oh, and I forgot to put my timer on, so I'll look to you for my time limit -- we have invested quite a large amount of resources in what we're calling Health and Human Service Academies, and we've partnered with the Center for Health Care Strategies, in each member state. We've put together a curriculum that is Medicaid focused, but we have about 35 to 40 individuals in each state come
together for six to eight sessions around using Medicaid as a financing tool and as a policy lever. So, training child welfare mid-level managers, usually, is a group that we want to attract, training them on what is a state plan and then what is an 1115 waiver, what are the basics of Medicaid and how can that help you. One of the aspects of those HHS Academies that's very important to us is that people within the state get to know each other and develop relationships across the agencies.

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

Lastly, in that area of strengthening state administrative capacity, we have a very close relationship
with the CMS regional office. So, for example, next month we will be partnering with them to host a training on how to do state plan amendments. And what we bring to the table is we will provide travel reimbursement for the state employees to attend that training, and we'll provide lunch, which is something the federal government can't do, so it's very important.

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

I'll talk about multistate purchasing, because I think that that's where your interest is. We have had several efforts in the area of multistate purchasing. The one that we are currently heavily involved in is around
electronic asset verification services. This was a requirement that CMS placed on states. It was a law that each state, as part of a Medicaid eligibility process for certain populations, each state needs to verify the assets of applicants at banks.

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

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

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

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

* MS. ANDERSON: Good morning. Thank you so much for the invite. Thanks, Elena, for your background. I'm Rhonda Anderson and I have been with the Center for Evidence-Based Policy about two and a half years. Prior to that I was the Deputy Director for Missouri Medicaid, so I'm fresh out of the hot seat and enjoying my tenure thus far, being able to extend the bench for states through collaboration and evidence.
So the Center for Evidence-Based Policy was established in 2003. We have about 35 employees, right, and I'm the only pharmacist. We have masters- and PhD-level researchers and physicians that comprise the institution called the Center for Evidence-Based Policy. We're based at Oregon Health & Science University, but we're not your traditional funding model or your traditional research model for a university-based organization.

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

We work with about half the country in some capacity, about 25 states that are either a part of the bucketed work, that I'll talk about here in a couple of minutes, or members in our collaborations, of which we run three collaboratives. We're not funded by industry, we do not lobby, we are nonpartisan, and we are completely
conflict-free. So again, our financial model is built around our collaboration with states.

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

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

The Center's mission is addressing policy challenges with evidence and collaboration, which is a pretty simple mission, and we strive every day to help our
states address these difficult policy questions by using evidence and extending their bench to do so. I talked about our work of the Center, and we can kind of bucket it in four different categories, if you will -- the multistate collaboratives that we run; single-state evidence assistance and data, so think of that more like offering direct evidence for single states that run generally health care commissions or have some sort of state requirement for evidence in their pooled purchasing.

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

We also have helped states with health processing engineering, so think “DSRIP-y”, right. Some states that
we worked helping them re-engineer some larger health systems would be New Hampshire, Texas, and, again, most recently the Washington State Accountable Communities of Health, the ACHs that were just rolled out over the last 12 months. We were the contracted evidence vendor for those ACH programs.

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

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

MS. FORBES: All right. Thank you. I think
those are very helpful introductions and set-up for the
questions we have.

The first I'll ask is, you each talked about sort
of some of the specific assistance the states get from
participation. They get evidence reports from you, or they
get procurement support on the electronic verification.

What are some of the maybe sort of intangible benefits that
states get from participation in a collaboration like this?

They pay dues to get sort of direct support, but what other
benefits do they get?

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

So, again, I'm coming from the perspective of
having been a participant in two of these collaboratives.

While I was in Missouri, I was the point of contact for
DERP and MED. So, as a participant, I can tell you that
one of the things that we got out of -- and what we receive
today out of these collaborations is a safe space and the
ability to interact with their colleagues, again,
completely conflict-free. So there are meetings all over
the country for Medicaid directors and pharmacy directors
and clinicians for Medicaid, but very few of those meetings
are without conflict or without industry being present.
And we offer two conferences a year for our members and monthly meetings that allow these states to get together and learn from each other and share experiences in a completely safe space.

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

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

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

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

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

So the governance process is as diplomatic as it sounds. Usually, once or twice a year, states get the ability to nominate topics for research. Those topics are then brought to the entire group and ranked in a ranking exercise, and we match the available funds for the budget projection with the number of topics and the potential size of these reports after a pretty robust scoping exercise, which involves kind of shaping the topics of interest. Figuring out you can't ever know everything about
everything, so you kind of do a hierarchy of scoping to
figure out what are the key questions that are most of
interest to the participating states.

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

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

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

It comes into play when I talk about the
organization as a whole and how the board members
themselves decide how to use the resources of NESCSo, and
one of the things that we find is because it's New England
and we have a lot of commonalities across the states, but we still have some states who have many more resources than others. And so we find that the services that NESCSO provides will usually go to the states that don't have as many resources. So even though everybody is a member, some of the larger states just don't take advantage of what we're offering because they can either access them through internal resources or other arrangements.

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

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

MS. ANDERSON: So not really, right? It's a consensus model to move forward, but I'm going to answer that in the reverse. So states actually in both of those collaboratives have the ability to commission
individualized work for questions or topics that are not chosen to move forward by the entire governance group. So there's a silo of funds or points that are commissionable by the state. It's like individualized research requests. So it's less the third rail of "Oh my god, don't touch this." So your vote of no would be the way that you attempt to kill a topic, question mark? I think that's what you're asking for.

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

COMMISSIONER GORTON: Thank you.

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

So it feels to me like both of these organizations, you're basically membership models. People join. They participate in leading the organization in
terms of deciding where its focus is, they call on you. There is some process for resolving questions about what are we going to spend time on, et cetera.

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

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

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

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

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

MS. ANDERSON: I'm going to answer your question in that our model has been about the same for the last 15 years. What has evolved is I think that we've gotten better as an organization at helping states tease out the research questions and the methods that we use to collect
data and evidence, and we've gotten much better at that. We used to have this standard set of research questions that would apply. Especially in the drug world, you can think back to the early 2000s when the blockbuster drugs were on the market. So we were having questions about purple pills and which one is better than the other. That's not really as appropriate in today's new drug landscape.

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

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

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

CHAIR THOMPSON: Right. Yes, thank you.

MS. NICOLLELA: But the services we provide, for example, this asset verification project --
CHAIR THOMPSON: It could be more available.

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

CHAIR THOMPSON: Broadly.

MS. NICOLLELA: Yes.

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

MS. ANDERSON: About 25.

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

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

MS. ANDERSON: So we are in a constant recruitment process. I'll put it that way. States are forever asking questions about how to, A, be a part of the group or, B, get access to the research that we produce.
DERP was nonproprietary for the first 10 years. So from 2003 to 2012, the DERP reports were accessible on an online website, and once we went proprietary in 2012 -- and I'll explain why and how that happened. We've spent the last five years or so fielding requests for these reports from everyone, from commercial insurers to the military. So the evidence was being used by a large variety of public and nonpublic pharmacy programs to help establish coverage criteria.

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

So in MED, they produce roughly 75 to 85 reports a year. They tend to be all about -- so DERP is drugs and pharmaceutical-focused, and MED is kind of everything else. So it can be anything from non-emergency transportation to managed care to some sort of home and community-based services model in MED.
DERP tends to focus on drugs. They are much more densely written reports that follow kind of the AHRQ EPC, Evidence-based Practice Center methodology for generations. So DERP does an average of 15 to 20 reports a year, but they are a lot more dense and meaty and check all the boxes of the AHRQ EPC kind of processes. So there are two different kinds of methods that follow behind these programs, but the states are able to get a vast amount of research. I haven't seen a state Medicaid program that has that internal horsepower.

CHAIR THOMPSON: Darin, you want to jump in?

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

But I will say, after using it for some time, then we got called in front of our legislature at times, it was like, "Why can't you use" -- these a misunderstanding of really what the service was and "Why can't you use an internal state resource for this? Why can't you leverage some of the university capacity that we have here?" We tried to explain the bulk benefit and the focus, and
eventually, we were able to get it to continue. So that's just a little --

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

COMMISSIONER GORDON: Yeah.

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

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

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

Now, on a different situation, because it's really around standing up solutions in which you start
getting into some of the dynamics of states' capabilities, states' preferences, prioritization, and I know New England has had a good history of that level of collaboration.

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

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

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

So one of the things that we've started to do in the last two years is to think about our primary audience as the person that we think of as a career civil servant, the person who is going to be there throughout the changes in administration, which is often the person that doesn't
get to go to the conferences and maybe is not aware of who
the person is in the neighboring state who's doing exactly
the same job as they are, so that's been our strategy with
those Health and Human Service academies, is to try to
address that, that challenge.

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

Darin, you had a really great point about not
being informed. It's hard. We try to help our state
partners extend their bench, not only from evidence, but
also for the process of having to reeducate constant
leadership changes not only from the executive branch, but
also the legislative branch. So we've gotten better in the
last 10 years of bringing the tools necessary to assist our
Medicaid agency partners in, again, spreading the word
about what truly this little budget item is that says
Portland, Oregon. It's pennies on the dollar for real if
you look at it compared to the Medicaid budget, but it's a
random Oregon contract that nobody really understands.

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

CHAIR THOMPSON: We have Chuck and then Melanie.

COMMISSIONER MILLIGAN: Good morning, and

welcome. It's good to see you again, Elena.

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

What I wanted to get at -- I have two questions,
ultimately. One is, from your perspectives, what are the
essential dependencies for your models to work? And one of
the things I'm hearing, I think, is that there's a public
university underneath that can both provide a kind of a forum, kind of a sense of independence from any particular administration of any particular state, but it's also a way of drawing federal funds and maybe simplifying some procurement stuff because public universities can sometimes be contracted with by other states without having to go through a procurement in the home state, so to speak. So one seems to be a public university as a key dependency. One seems to be a kind of, as you said, conflict-free or more of a consensus-based or collaborative approach from a governance perspective.

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

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

MS. NICOLLELA: Okay. So I think those are all true, and I would agree with those. I would add that explicit federal support is very helpful. So from the organization's perspective, we have
had, as you might imagine -- some of you had experience here -- this concept of the ability -- It's not NESCSO drawing down the federal match. It's the University of Massachusetts Medical School who draws down the federal match, but that arrangement has been audited several times at the state and federal level. So I feel very comfortable talking about it.

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

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

The other item that I would say has been really helpful and beneficial is that it needs to be easy for the states to participate and relatively cheap. I had a conversation with one of our state members the other day,
and he represents a pretty resource-rich state. And I said, "I struggle with how NESCSO can help you."

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

CHAIR THOMPSON: Melanie, did you want to --

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

MS. ANDERSON: I was going to comment that you pretty much nailed all of our essential dependencies, but I will add -- so you called out the university situation. You called out the ability to contract quickly and fairly easily with all of the states as important, and I'm going to say the only thing I'm going to add to this is the economies of scale for evidence, for both of these
collaboratives, it's just priceless to the states. And you can think about that really simply in the drug world as these new drugs are launched.

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

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

I have one other question, which is, Elena, it sounded like you were 1999-formed; and, Rhonda, 2003. Have you seen other models come back since 2003, and if not, other forms of collaboration, not your organizations? And if not, why do you suppose there hasn't been more take-up in general of this kind of model?
MS. NICOLLELA: We do see collaborations come about sometimes that are specific to an issue. I think one of the challenges is you need that administrative support to keep it going. So, say, the champion of X collaboration leaves for another job, then that partnership kind of goes away. So I think that's one of the things we've seen with other collaborations.

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

The Pacific Northwest of Oregon, Washington, and Idaho, under the then Governor Kitzhaber's administration, had this brainchild of trying to, again, answer the high-cost drug phenomenon back in the day with evidence. And those three states pulled together in the late '90s, early 2000s. And then, in 2003, when the Center was formed, the
invite went out for states across the union, and there were
12 original states that were onboarded as part of this
collaboration model, and it's just kind of grown from
there. But it takes inertia, it takes administrative
capacity, and the conflict-free thing is a major barrier
for many, I believe.

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

So, one, with all the Medicaid reform debate,
does NESCO play a role in that with the states, so like
those types of discussions? And then the second is, your
states are -- thinking about complex populations, whether
it's complex duals or behavioral health or any other social
factors, your states have very different delivery systems.
As they are challenged to figure out how to have capacity
within their state to do delivery system reform around
those things, how are you able to help them do that and how
do you bridge or overcome the variation in the delivery
systems, as they're all trying to come up with solutions to
these challenging populations?

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

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

So in regards to, say, long-term services and
supports where there are very, very different approaches to
delivery of those services, just last month we hosted, we
called it an LTSS Academy, and there was representation
from all six New England states. And what we did was we
really tried to focus on issues that were -- that all the
states were experiencing, and then to talk about the
different ways that they've addressed them.

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

And just really quickly, we're doing something
similar around market consolidation. We're partnering with
Milbank and the National Association of State Health
Policy. The concept is if the market, the commercial
market -- providers, hospitals -- are not viewing -- don't
define markets as states, but are really looking across the
country or across the region, how can we, as a region,
start to work together so that we change our responses? So
we have -- and again, every state is different, but we've
got a group around certificate of need coming together, and
how can certificate of need rules be changed? Is there something that we can do as a region to address certificate of need? So it is work to find those areas of common -- where there's benefit in having the discussion.

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

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

MS. ANDERSON: It really is, and this is an area that we are striving to improve on, right? As we moved out of the first decade of the 2000s and into the second, and
budgets really tightened, we had to figure out an ROI
model, and we're still kind of working on that because it's
different in every state.

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

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

So it's easy for us. We can only do that because
we've been around since 1999 and we've been able to build
up some reserves that we can spend. So if there were to be
a similar model set up, say, in the Pacific Northwest or in
the Southeast, they probably would not be able to, in the
first few years, provide as much benefit to their member
states.

CHAIR THOMPSON: Darin, are you trying --

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

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

COMMISSIONER DOUGLAS: Thank you both for
presenting. Good to see you, Elena. A question for you,
Elena, on managed care procurements, and if there's been
discussions on that front around, given the complexity of both developing the design, the criteria, as well as just the evaluation, if any of the states have thought about working together around that.

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

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

So you take what on paper seems like a pretty no-brainer for multistate partnership, but not just in the way
that it's being envisioned in each state but also the
timing is on very different schedules, and that's driven by
sometimes the legislative calendar and other priorities.

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

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

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

COMMISSIONER DOUGLAS: Okay.

CHAIR THOMPSON: Can I just clarify size? So,
Elena, how many people are working at NESCSO, and the total
budget, and same for you, Rhonda?
MS. NICOLLELA: We have two full-time equivalents. One of them is me. And then we do hire consultants on a project basis. They are usually paid by the hour. But it's a pretty lean organization. We have an operating budget of $2 million.

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

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

MS. ANDERSON: And so for the Center there are about 35 employees, total. The lion's share of that staff are researchers. Like we are an in-house research shop. We have six of us that are more leadership team-ish, right, the executive branch, if you will, and I kind of straddle the fence, being the only pharmacist, and pharmacy, of course, is all over everywhere, in the medical benefits and
in the pharmacy benefits. So I kind of have my fingers in
a bunch of pies, and I do some research as the DERP
director, as well.

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

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

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

MS. NICOLLELA: They are. So they provide us
with payroll services and HR services. And also, because
of our relationship to UMass Medical School, that does help
with that continuity. So it's not just, say, the executive
director of NESCSO, if that person leaves, NESCSO falls
apart. It's that there is this other entity ensuring that
it continues.

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

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

MS. ANDERSON: I'll go first. It's a little bit
easier, I think, in my world, because we are so heavy
clinical and clinician focused. So we port into the
states, generally speaking, in the pharmacy programs for DERP, and on the medical side with the medical directors as the point of contact in MED. And that's a broad generalization because there are some states that don't have a pharmacy program or don't have -- you know, they contract out with whomever, for certain services within their state. But, in general, we are so heavy clinically focused that in order for a state to maximize that opportunity, which includes -- because our collaboratives are run and totally focused on the states -- to get your money's worth, if you will, you need to send people to be really active in not only the creation of a question, like a topic, but also in how that topic is framed, so that you can get the answers to the questions you need to help for the development of policy as the end game.

So I say that to say, sending your financial person to a DERP conference doesn't make a lot of sense, because they are going to come from a different place. And we don't run these topics. We, the administrative team that supports the collaboratives. We are there to facilitate and to really administer, make sure that the
architecture is built to sustain the programs, and do the
mundane things like listserv generations, so states can
interact with each other seamlessly or help with the
contracting and make sure that the clearing house where the
reports are housed is working.

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

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

MS. NICOLLELA: I would add that what has been
necessary for us has been this explicit sense of ownership,
to having the state secretaries and commissioners, or the
Medicaid directors be on the board has been challenging,
because these folks have pretty challenging jobs. But to
ask them to be on a call once a quarter and to be engaged
and involved in decisions around the resources that we're
offering to their states and states across the country is very important. We have to show our value to those board members all the time.

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

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

MS. FORBES: I think everything has been covered. I think the only sort of final question is, given that this Commission's primary job is to recommend potential changes to the Congress, are there areas where you think that there are things that -- where there are changes in federal policy, or things that CMS can do? I know Elena mentioned one, submitting a letter. Are there any federal roadblocks or are there incentives or things like that that you think could make it easier for states to partner, or make it
easier -- is there something that you wanted to do and couldn't because of a federal issue, that you can think of, that is something that this Commission could take back?

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

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

And then also I think this model that NESCSO pursues, I have heard often from states across the country
that they would like a forum to be able to come together, and they'd like an agency. Again, it's pretty straightforward stuff. It's sending out the agendas, making sure the conference line is available. It's not all that exciting but if there isn't someone at the state agency who is going to take that on, then these discussions don't happen. So I think it's a pretty low-cost model that if there were federal government support for that, that would be very helpful.

MS. ANDERSON: And from the Center's perspective, we -- I can't even imagine what recommendation we would need. We've gotten a lot of support from not only the states that we are in partnership with but also from the federal government. Like the areas where we've been tapped -- SMART-D is a great example. We did a lot of research work. Those papers are available on the SMART-D website, and we kind of -- it was important to call out in SMART-D that we were interested in piloting alternative reimbursement in today's regulatory architecture. We were not trying to go lobby Congress to change pharmacy laws for Medicaid. That's not what the objective of SMART-D was. It was really to look at today's
regulatory framework and see if there were opportunities to potentially, either within the confines of the Medicaid drug rebate program or outside of the MDRP, is there the ability to think about purchasing drugs different? And we've found eight or nine pathways, legally solid pathways, where we think that that work could happen, and we've spent the last two years kind of pilot-testing some of that. And you guys are probably familiar with Oklahoma, which is one of our SMART-D states we assisted in the development of that health outcomes-based supplemental rebate contract that was ultimately approved by CMS in June. So we've gotten a lot of support across the country, not only at the state level but also at the federal government level, for the work that we do. And not to beat a dead horse, but I believe us being conflict-free helps to perpetuate this work, and also allows the states to lean on us to extend their bench from a clinical perspective.

CHAIR THOMPSON: Thank you. This has been extremely helpful. Elena and Rhonda, before we let you go I just want to open up for any public comments on this part of our conversation, so that we can take those into account
as we enter into our Commissioner-led conversation after
the break.

Are there any public comments on this topic?

### PUBLIC COMMENT

* [No response.]

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

[Applause.]

* [Recess.]

### FURTHER DISCUSSION ON MULTISTATE COLLABORATION

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

So I'll start off and then ask other Commissioners to jump into this. I just want to step back for a second and remind us that because of this longstanding concern that we've had about administrative capacity, we really wanted to explore this topic and think about different kinds of models or authorities or financing that could really be successful in promoting multistate
action as a way to address some of these concerns that we have about state administrative capacity.

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

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

There is a lot of activity. There is a lot of technical assistance. There are a lot of -- I mean, we need to recognize that there's a lot of forums and a lot of platforms that states use to gather together and learn from each other, and that's always been a point of emphasis for a number of states. And so I think we should be cognizant of that.
At the same time, I think that we recognize that some of the things that, Moira, you played out in your paper around where are the financing incentives and how difficult it is to initiate something if it's not already existing to join, if you have an idea for working with other states, what some of the downsides are for states in joining something not only in terms of expends some resources on their part to make use of it -- and I think we should be conscious of that and think about that aspect of this too if we want to be successful -- but also that they may -- especially if we're talking about purchasing or if we're talking about contracting or operation, have to give up some amount of flexibility.

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

So I still feel like we need to continue to play out what we would consider to be success because I think some of these different models, whether we're talking about developing reusable practices or tools and then disseminating them to the states versus trying to bring
states together to do something collectively as a piece of
collective action and whether or not we're talking about
what level of operational risk, what level of operational
demand exists for what we're suggesting happen.

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

So let me ask other Commissioners to jump in.

Kit and then Alan and then Chuck and then Brian.

COMMISSIONER GORTON: So I would add another
question to that, which is -- so I was a Medicaid chief
medical officer back in the '90s, and I participated in the
first-ever convening of Medicaid medical directors, which
happened in 1996. I think it was a NASHP grant-funded
opportunity, and there were 13 full-time medical directors
serving the Medicaid programs across the country, and 11 of
them were able to come because of the NASHP grant.
And it was the Wild West. We had zero of this, and everybody was making it up as they went along. One of the challenges many of us were confronting was in the commercial world and certainly very highly developed Medicare world, there are technology assessment processes for evaluating emerging technology and when it should be added to coverage and under what circumstances it should be paid for, for beneficiaries.

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

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

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

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

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

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

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

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

Alan.

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

Just a couple of observations and maybe something that is helpful for us in thinking about where to go. I don't think the timing of the creation is a mystery. The U.S. Office of Technology Assessment closed in 1995. That
used to be a federal function. I'm not saying it's identical to this, but the whole concept of having a federal infrastructure, doing assessment, was something we did for 20 years, and then we stopped. And people said there were a lot of people thinking what falls in its wake. DERP is only one of the examples.

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

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

Even when there's policy alignment, the other thing we heard is that there are two sides of the puzzle. So when you think about like electronic verification, you
may have a single federal policy, but you have very
different state operational interfaces required. So you
can say, well, it's all the same, but it's not because it's
a two-piece puzzle. And the second piece of the puzzle is
different in every state.

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

So with those thoughts in mind, I think if we're
serious about the efficiency opportunities here, I think we
have to be serious about one of two things, and I'll just
put them on the table. One is if we're serious about
administrative savings, we are going to have to recommend
places of policy alignment, or else there aren't going to
be administrative savings. And that's not something we
would take on lightly, but there are places where we might
say it shouldn't be up to the states. And it's got to be a single national policy, and once there's a national policy, we can get some uniformity. And then we can get some administrative savings. If we're not willing to say the policies need to be the same, I think we're kidding ourselves if we think we're going to generate administrative savings.

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

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

CHAIR THOMPSON: So let me ask you, Alan, in thinking about that. So that suggests that in order for something to be multistate, it has to be national, and that's a question that I have, which is -- so let's suppose there are five different ways of doing something. There's not one single policy alignment, but there may be types and taxonomies and models and lanes that most states are in,
and maybe there's some states that aren't in any lane. They've created their own little pathway. 

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

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

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

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

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

CHAIR THOMPSON: Thank you.

Chuck and then  Brian.

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

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

There are I think -- and I kind of alluded to it 
earlier. I think there's an informal or non-structured 
multi-state collaboration. When states hire national
vendors -- and United Healthcare, where I work, is one such place. We're in 28 states, more than Oregon. Mercer is another example, where there's scale. They're for-profit, publicly traded, that kind of thing, which I'll come back to.

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

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

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

And that the for-profit, the United for-profit is
an inefficient use that having multistate collaboration and
scale can help every state and the federal government avoid
waste.

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

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

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

CHAIR THOMPSON: Yeah. And I think that's a little bit of what I'm getting at when I say what does success look like because I think that that allows us. We've talked about a lot of things. We certainly tethered a lot of this conversation to the concerns that this Commission has expressed previously about state administrative capacity, and the idea that perhaps multi-state action provides a way to address some of those concerns, and I think we have to fill in the dots to that issue as well as some of the other things that you've
raised here in terms of saying how far do we want to go because I think some of those things that you've mentioned are easier lifts than other things.

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

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

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

CHAIR THOMPSON: Sure, okay. Yeah.

COMMISSIONER MILLIGAN: Because one of the things that I thought was interesting in the way Elena commented is that there's almost like a re-distributional element underneath NESCO where the smaller states maybe get more
value than some of the more wealthier, bigger states that can kind of go without needing NESCSO.

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

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

CHAIR THOMPSON: Right, right. Absolutely.

Brian.

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

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

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

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

CHAIR THOMPSON: One thing I'll say about that is
states have those authorities within statewide procurement authorities to establish the equivalent of IDIQs, the equivalent of short lists of preferred vendors for one activity or another

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

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

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

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

COMMISSIONER MILLIGAN: Yes.

CHAIR THOMPSON: Okay. Toby.

COMMISSIONER DOUGLAS: So I'm going to push back
on Chuck a little on this point. I definitely agree -- and
Alan's point -- on the policy and anything around program
design flexibility, I just don't think there is going to be
a national approach or a way to consolidate.

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

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

So I do think there can be solutions on the
administrative capacity and especially as the evolution.

When you think back on managed care, there are some
problems around the complexities of these procurements. I
think you know firsthand as well as the different
approaches to evaluation, to coming up with designs, if
there was ways to incent some more standardization to deal
with it, and then there's the capacity to be monitoring and
oversight, and are there ways around that to incentivize
better as we're going to go later through all the
requirements, since states and capacity, are there ways to
incent, encourage that.

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

CHAIR THOMPSON: Yeah, and I think just building
on this theme, I mean, I think there's a -- to me, part of
the conversation is by looking at what I would call a use
case or the business proposition, we can kind of back into
a question of what kind of model supports that end result that we're aiming for. And I don't know that it's the same, based on different use cases, or it's the same for every state. So small states versus large states, or states that have certain kinds of histories or experiences versus others.

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

So we have Darin and then Kit and then Sheldon and then Stacey, and then we'll have to bring it to a close.
COMMISSIONER GORDON: So I don't disagree with Toby's articulation or your articulation about the administrative capacity issue. I think we've beaten that to death. I do agree with Chuck, though. As I think about these things, and every time I'd be getting in conversations about these types of things, you can't really force that collaboration. It has to be a state-led interest in collaborating with others for some perceived benefit.

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

But I will, you know, make just the observation. As Chuck identified some places that are doing this, but then you have these organizations here today, that proves that, in some cases, it can be done and is being done. So
do we want to just see more of that? You know, I don't
know. I like the idea, if you want to add some incentives
in certain discrete areas, to help promote, get past some
of the challenges, that would make sense to me. But beyond
that, I think there are organizations that are finding ways
where there's a need, where's an interest, where a state
has expressed the need for help and that collaboration,
where it's working. I would like to see it more, but until
you get past those other hurdles, I don't see how you get
there.

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

COMMISSIONER GORDON: Yeah, that's where I say, I
think, to Toby's comment, the only thing that I can think
what that might look like would be if there are sufficient
incentives that are made available. So you're not forcing
them to collaborate. You're encouraging it to the extent
that you're willing to participate and devote the time. So
I like the choice aspect of it, because again, I don't
think you can force that collaboration. And that would
potentially help balance out some of the disincentives for
doing a collaboration approach.

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

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

COMMISSIONER GORDON: If you asked me, as a
director, if the lack of multistate collaboration was a big
priority for me, something that needed to be addressed, I
would have said no. I would have said the lack of the
exchange of best practices, yes, that is a serious issue
that needed to be addressed. And again, I mean, we're not
a huge state but we're the 16th largest state. We did have
a lot of the capabilities to do things we needed to do.

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

COMMISSIONER DOUGLAS: Yeah, and maybe it is back
to the problem, our definition of collaboration, because I
would say the same from a collaboration of policy and
defining direction and strategy. But from administrative
collaboration or understanding, you know, technical
assistance of how to do it. Like, for example, we went out
to Tennessee and learned on managed care, and how to do
administrative capacity. Or if you asked state Medicaid
directors about their ability to actually execute on a lot
of very complex administrative functions that are
duplicative across states, then I think you've got a
problem of, okay, that is a problem. How do we really
share best practices but leverage the resources to get to
the same end goal, that doesn't impact my specific autonomy
and policy and strategic direction?

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

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

[Laughter.]

COMMISSIONER RETCHIN: I just wanted to -- maybe,
when you talked about this a year ago, about multistate
collaborations, and at the time I thought we had really
picked off the high-cost specialty drugs. We got back to
the hep C. And I must admit, I don't have a good sense of
how much multistate collaboration is on there. But I remember asking Chris, like how much money is left on the table, particular for these high-cost drugs? And just sitting here reflecting on it, you know, it is interesting that on the provider side, providers form these massive GPOs to leverage maximum size in purchasing drugs. And I would think size matters but I don't know.

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

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

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

COMMISSIONER RETCHIN: So --

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

COMMISSIONER RETCHIN: Oh, I asked that before?

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

COMMISSIONER RETCHIN: That was brilliant.
CHAIR THOMPSON: -- felt like that they were big enough to get everything that they needed to get.

COMMISSIONER RETCHIN: Is that true?

MR. PARK: That's what they said.

CHAIR THOMPSON: Okay. Stacey and then Kit.

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

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

CHAIR THOMPSON: Where it's economy of scale.

VICE CHAIR LAMPKIN: Where it's economy of scale issue. And then there's the much more challenging area of where there's indirect savings for the program associated with program improvement, improving program value, that goes to technical assistance, staff extenders,
understanding best practices, being more sophisticated in your management of a program that's increasingly more complex, and how do you get there. And that's the area where there are these other options, but are states taking advantage of them? Do they cover all the territory that they need to cover if states are not taking advantage of them, or they don't cover all the area that they need to cover, what are those barriers, and are those barriers amenable to some recommendation or solution that we would propose?

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

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: Okay. Quickly, so I agree with Chuck that as we talk about this realm of multistate collaboration we shouldn't just limit it to the very
formal, you know, learning communities and all of those other things. I think there's important collaboration that happens amongst the national vendors. I think there is important collaboration that happens on regional levels, and I agree with Stacey that it might be useful to get some sense of how much reach each of those models has, and for me, one of the question is, is there room for those models to do more? Would it be useful to have 40 states in DERP as opposed to 25? Those kind of questions, because I do think there's money to be saved.

Somebody earlier said that Massachusetts doesn't have any problem running its program. I think the people in Massachusetts would disagree. Massachusetts has one contract manager, one single FTE supervising three managed care plan. So that is not a robustly resourced oversight capability. Now they use other things, and, you know, we haven't talked about EQRO, but I think it's actually a useful case in point. Because we have seen, over the last 20 years, consolidation of EQRO into some big vendors, but then there's still a lot of onesy-twosies out there. I mean, I love Ron Hanley, but what the heck is Arkansas Foundation doing, trying to compete with the likes of
So it strikes me that we have a role to -- so I don't think it's a matter of question that all states could use more administrative capacity, whether it's in people with the technical skills to be able to address the problems that they confront in an ever-fluid environment, or whether it's just processes and operational things. So if we need to do more work to do that, then, you know, let's send out a Doodle survey and ask the state Medicaid directors whether they have enough administrative capacity. So for me, that's not a question. The question for me, then, is -- and this is the point that you were making before -- are we getting the most efficient use of the public dollars that we have available? We're spending a lot on administering the Medicaid program. Are we getting as much bang for our buck as we could get? And my personal view is every time you have these onesy-twosy one-offs scattered around then there's money being wasted, and I do think that if we can get to some level of scale -- and we did hear from the drug collaboratives that as long as you've got 10 or 13 of them you've got enough scale to make it work. The managed care plans are all using PBMs of one
size or another, but even there, there are economies of scale.

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

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

And so I think that, you know, it is worth looking at, you know, where there are opportunities for
regionalization and where that would make sense, where there are opportunities for, you know, people to say, you know, "I want to do it the blue way," and other people saying, "I want to do it the red way," and other people saying, "I want to do it purple," and somebody else saying, "I want polka dots." But there probably doesn't need to be the infinite variability that we see, those of us who used to sell MMIS for a living. You know, you just don't need all this complexity and variation. That creates cost, it limits transparency, and it makes the program harder to oversee.

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

CHAIR THOMPSON: That's helpful. Thank you.

Okay. So Moira, this has been a great conversation, and I think there is a variety of different
perspectives here that we're going to have to sort through. And I think we should try to come back on this topic, with taking some of this feedback into consideration, maybe with some more peeling away the onion on the taxonomy and where the activity is going on now, where it could produce some additional benefit and action to sort of answer the question as to whether or not we really have a problem that can be solved through some of these additional mechanisms.

I think it would also be very useful to think about getting back to some states on this and validating some of our assumptions about where are the obstacles, where are the barriers, where's the value for you in some of these activities. And I would like to see us explore not just what has been done but really try to promote some different ideas of different models that have not existed before, in the program, and try to get some reaction to that, whether those kinds of models would have any traction here. Because I believe that we are probably in a place where we would want to create structures and processes and funding that states could take advantage of but that don't necessarily require states to gather together to do something. And so what would it take to entice states, or
to interest states in those kinds of models, and where would they want to prioritize their resources and interests? So I think that could be maybe helpful.

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

CHAIR THOMPSON: Yeah.

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

Because I'm not -- I just want to get some clarification before we would go down that road, because I don't know right now what we would build and how we would go about describing that without having -- I mean, I haven't heard somebody say a model that hasn't been discussed here is something that would look like X. And, you know, I need to know, and Moira will need to know, like what is it we're supposed to do if we don't have that?
I mean, maybe, Penny, you have an idea of something that we haven't had time to explore here, that we can do, and that would be great. But I'm trying to get some more clarity on how we could test those ideas when we don't have like a thing.

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

So I think there are ways to just play out, understanding some of the barriers and issues that we've been discussing, in terms of, well, a potential answer to that would be this. Would that work or does that not answer that question? And that's the way that we have to think about creating some kind of possible models that get
us out of just using the models that have existed, of which, you know, I think there are lessons to draw from that in today's conversation, are useful in that regard. Okay. Let's go ahead and move on to the next topic of the agenda, which is, we are going to have a short discussion about changes to the MACPAC conflict of interest policy, and Anne, you're on point for that.

### CHANGES TO MACPAC CONFLICT OF INTEREST POLICY

* EXECUTIVE DIRECTOR SCHWARTZ: Okay. By way of background, MACPAC does have a conflict of interest policy that we adopted in May of 2016, after several months of discussion. The policy defines the conflict of interest principles to which Commissioners are subject and establishes procedures by which a conflict of interest can be identified and addressed in advance of a vote on a recommendation to which that conflict relates. So the policy establishes definitions of reportable interests, it sets standards for when interests may pose a conflict, it creates a committee to review reportable interests, and the policy also outlines certain prohibited activities, activities that are inconsistent with service on the Commission.
The policy is published on our website.

Reportable interests are also published on the website for all Commissioners, and you can find these by clicking on the bio of each Commissioner.

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

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

So I'll open it up.

CHAIR THOMPSON: Does anyone have any questions,
comments, or interest in discussion on any of the changes that Anne has mentioned? I think it is clear that these are pretty technical and narrow changes to this policy.

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

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

[No response.]

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

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

And so, in alphabetical order, Melanie Bella.

COMMISSIONER BELLA: Yes.

CHAIR THOMPSON: Brian Burwell.

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter.

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise.

COMMISSIONER CERISE: Yes.

CHAIR THOMPSON: Kisha Davis.

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas.
EXECUTIVE DIRECTOR SCHWARTZ:  Yes.

COMMISSIONER DOUGLAS:  Leanna George.

EXECUTIVE DIRECTOR SCHWARTZ:  Yes.

COMMISSIONER GEORGE:  Darin Gordon.

EXECUTIVE DIRECTOR SCHWARTZ:  Yes.

COMMISSIONER GORDON:  Kit Gorton.

EXECUTIVE DIRECTOR SCHWARTZ:  Yes.

COMMISSIONER GORTON:  Stacey Lampkin.

VICE CHAIR LAMPKIN:  Yes.

EXECUTIVE DIRECTOR SCHWARTZ:  Chuck Milligan.

COMMISSIONER MILLIGAN:  Yes.

EXECUTIVE DIRECTOR SCHWARTZ:  Sheldon Retchin.

COMMISSIONER RETCHIN:  Yes.

EXECUTIVE DIRECTOR SCHWARTZ:  I'm going to note that Bill Scanlon is not present.

Peter Szilagyi.

COMMISSIONER SZILAGYI:  Yes.

EXECUTIVE DIRECTOR SCHWARTZ:  Alan Weil.

COMMISSIONER WEIL:  Yes.

EXECUTIVE DIRECTOR SCHWARTZ:  Kathy Weno.

COMMISSIONER WENO:  Yes.

EXECUTIVE DIRECTOR SCHWARTZ:  And Penny Thompson.
CHAIR THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay.

CHAIR THOMPSON: Thank you, all.

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

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

PUBLIC COMMENT

[No response.]

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

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

[1:30 p.m.]

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

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

### THEMES FROM INTERVIEWS ON THE DEVELOPMENT OF HOSPITAL PAYMENT POLICIES

* MR. NELB: Great. Thanks so much, Penny. So, yes, as you mentioned, there are a number of hospital payment policy items on our agenda for this meeting. I will have a closer look at DSH and UPL later today and
tomorrow. But before we begin that, I wanted to give the
sort of broader perspective about how states develop their
hospital payment policies by sharing some themes from
interview that we conducted with states and stakeholders
this summer.

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

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

So as you will recall, back in January of this
year, the Commission outlined a long-term work plan to
broadly consider all types of Medicaid payments to
hospitals. The Commission has been doing a lot of work on
specific types of payments, such as DSH and UPL, but
Commissioners expressed an interest in understanding how
all these different pieces fit together, kind of
understanding that theory of everything.
As a result, we developed this work plan based on MACPAC's provider payment framework, that really aims to collect a broad set of information about hospital payments, including information on payment methods, payment amounts, and outcomes related to payments. Ultimately, the goal of this work is to help inform the Commission as it evaluates whether payment policies are consistent with the statutory goals of efficiency, economy, quality, and access.

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

At the meeting, we talked about the fact that about half of fee-for-service payments in Medicaid are made through supplemental payments nationally. However, there is wide variation among states and their use of supplemental payments and in the type of supplemental payments that they make. In addition, we talked about the
fact that a large share of Medicaid payments to hospitals are now made through managed care, but that these payments are largely a black box. We don't really know much about how much they are and who receives them within each state. So even though we know a lot about what types of payments states make, Commissioners really wanted to know more about why states make the payments that they do. And so based on the feedback from the March meeting, we outlined a series of policy questions about why states use certain payment methods, and we thought it would be good to just ask states directly, to better understand some of these key questions.

I won't read through each of them, but just want to highlight a few. First, again, recognizing this large role of supplemental payments, we wanted to know more about what are the factors that affect the structure and mix of base and supplemental payments in different states. Second, since we don't have much data on managed care, we wanted to know how fee-for-service payment policies affect managed care payments to hospitals. And third, since we're always looking ahead, we wanted to know how states are planning to change their hospital payment policies in the
To conduct these interviews we contracted with Health Management Associates. I want to thank Tom Marks and Tim Beger from HMA, who are with us here today, as well as other members of the HMA team, for helping to make this research possible in such a short time frame.

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

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

This figure shows the distribution of hospital payments in our study states in 2016. These data come from some of the CMS-64 expenditure data that I presented.
earlier, as well as some additional information provided by
states, particularly around managed care payments.

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

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

As you can see, in some states the use of these
directed payments is quite large, so 31 percent of hospital
payments in Mississippi. But there's also quite a large
variation among states. In 2016, Virginia was not making
any directed payments to providers. However, they are
actual in the process of adding some new directed
payments now, as they expand Medicaid.

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

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

So let's dive into each of these findings in a
little more detail. First, again, as we're trying to
explain this increase in the use of supplemental payments,
the non-federal share is sort of the key theme that kept
coming up. And in pretty much all of the states that we talked to there was pretty much a common narrative around the growth of supplemental payments. First, there was a perception that base payment rates were low. However, states lacked the state general funds necessary to increase base payment rates, particularly during the latest recession.

In the absence of state general funds, states then looked to providers to help finance the non-federal share of these payments, using provider taxes or intergovernmental transfers from public hospitals. When they did so, both the states and the providers preferred to receive those increased payments in the form of supplemental payments rather than base payment increase, because it provided more certainty that the amount of payments that they were receiving were more than the amount that they were contributing in the taxes or IGTs. We found some variation among states in their willingness to use provider taxes, but once they decided to use those financing mechanisms they pretty much all chose to use them to finance supplemental payments rather than base rate increases.
One exception to this narrative I want to point out is Louisiana, which is actually currently planning to decrease its use of supplement patients and increase base rates in response to pending DSH allotment reductions. As you will recall, DSH payments pay for both Medicaid shortfall as well as cost of care for the uninsured, and so as a way of sort of mitigating the effects of pending DSH cuts, Louisiana has identified the portion of the DSH payments that are paying for shortfall and it is converting those DSH payments to rate increases instead. They are rolling this out as part of a new DRG payment system as well.

Our next theme was around managed care, and we found that in our study states managed care organizations tended to use fee-for-service methods and rates for most base payments to hospitals, even though managed care plans do have the flexibility often to pay rates that are different from fee-for-service. When we asked plans why this was the case, they noted several reasons. For one, capitation rates are often initially developed based on fee-for-service rates, so the plans felt that they needed to pay the fee-for-service rates to stay competitive.
Second, in some states, they required plans to use fee-for-service rates as a rate floor for non-contracted providers, so there was little incentive for hospitals to accept less than the fee-for-service rate. And finally, MCO representatives noted just the complexity of developing alternative payment models that differed from the fee-for-service rates, so they kind of went with the state model for simplicity.

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

The 2016 Managed Care Rule issued specific guidelines for directed payments, so many of our states were in the process of coming into compliance with the new rules. The regulations required states to phase out
payments that don't comply with the new criteria, which are referred to as pass-through payments. In all of our study states they were able to sort of make this conversion. There were some changes to having to use more current data and some slight distributional changes as a result of the new rules, but at the end of the day the states were still able to make the same amount of payments that they were making before.

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

Lastly, we talked to states about some of their base payment methods. Three of our study states recently converted from their inpatient hospital payment methods, from a per diem method, to diagnostic related groups, which is a policy that's been long used by Medicare and other commercial payers. We asked the states why it took so long to adopt these new methods, and they cited some common reasons, including resistance from the hospitals who are
concerned about the redistribution effects of new policies, and also they cited some of the operational and administrative costs involved in making any change to their payment methods. These often take several years and require outside contractors to help support states when making these transitions, and so it is resource intensive.

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

Some of the states in our study were planning to increase the use of value-based payment through managed care, so by requiring their managed care plan to direct a certain portion of the payment through a value-based
payment model. However, when we talked to plans about how they were planning to meet these goals, they noted that they were prioritizing investments in physician-based value-based payment models rather than hospital-based ones. So there still doesn't seem to be much progress on the hospital side.

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

CHAIR THOMPSON: Sheldon.

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

The statement by hospitals that they prefer supplemental payments -- let me get this straight -- they prefer supplemental payments because they are better able to see the net gain after the provider tax. But there is no provider tax on base payment, is there? Isn't that,
we'd rather see supplemental than a base payment increase, but there's no provider tax on base payment increase, is there?

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

COMMISSIONER RETCHIN: Okay.

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

COMMISSIONER RETCHIN: So and then I'll just make one comment before I, I guess, get to the value-based purchasing idea, the fact that hospitals -- I actually didn't know this; I should -- are still doing, or have been doing per diems, or that they have been paid on a per diem basis. And, of course, the transition to DRGs, it's a
novel approach. It's only been around 35 years. But saying it's hard to convert, when, you know, it's sort of like there is another payment that has a DRG administrative system already loaded, right? It's not like you have to invent a new -- but there will be some, because it's Medicaid and be different, but that seemed astonishing.

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

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

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

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

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

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

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

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

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

CHAIR THOMPSON: But the base rates would go to -
- so this goes back to the -- from a hospital standpoint, in terms of how they see these dollars flowing. If they're financing, you know, some portion of the directed payments, when you're dealing with directed payments as opposed to a pass-through, as opposed to a supplemental and a fee-for-service, you're going to have more of that risk to the hospital that their contribution is not necessarily coming back to them. It's being disbursed to whomever is delivering the services. Is that right?

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

CHAIR THOMPSON: And when we say it's an add-on to the base rate in a directed payment, can the base rate
have an add-on that qualifies who is billing and for what kind of beneficiary and for what kind of service in order to get the base rate add-on?

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

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

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

CHAIR THOMPSON: So some of those options still exist.

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

CHAIR THOMPSON: That's always been true.

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

CHAIR THOMPSON: Because you can reverse engineer --

MR. NELB: Yeah.

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

MR. NELB: And that's, yeah, basically these
states had to a lot of calculations with the hospital associations and others, but at the end of the day they were able to figure out --

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

MR. NELB: Yeah.

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

COMMISSIONER DOUGLAS: Yeah, I mean, I would say the fundamental difference, which makes it harder, is exactly what Stacey is saying, is before it was a retrospective, in essence, approach of states would figure out what was actually the utilization was and then added on, and then the plans would divvy it out to the hospitals. How it's got to be a perspective of looking at what utilization, based on actuarial principles, and it could turn out that utilization is way different from that, and
then they don't get all the money.

CHAIR THOMPSON: Okay. All right. Thank you.

Kit and then Chuck.

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

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

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

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

So it's sometimes easier to get the value-based payments done in the physician groups, because within an integrated delivery system the physician groups are generally less powerful than the hospitals. So the hospital that's negotiating for everybody says, okay, we'll
do that over here, but over here we want to do this.

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

CHAIR THOMPSON: Chuck.

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

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

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

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

So I guess my question is, in the work that HMA did or in the work that you've done generally, I had been kind of a skeptic about supplemental payments, because I had thought it was like a way of kind of burying a lot of the revenue in a bunch of kind of potentially questionable financing arrangements, but I'm coming around to the point of view where a lot of the supplemental payments are the path to value-based contracting for hospitals to get a line because revenue is protected in certain ways. And if you
step down that supplemental payment or if you cap the
trend, if you will, on the global budgeting, you can get
the benefit of utilization reductions without leaving the
hospitals at the side of the road.

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

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

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

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

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

COMMISSIONER MILLIGAN: Just a quick follow-up.

So one of the things going on in New Mexico, and it
happened the last 1115 waiver. And as part of a pending 1115 waiver is really moving a lot of that supplemental payment into a very overt 1115 waiver guarantee kind of structure so that it's completely transparent and aligned to more of the delivery system reform about that revenue guarantee.

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

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

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

One piece on the directed payments, it's technically a part of the regulation where you're supposed
to tie it to the state quality strategy. So, in talking to CMS and others, there is a view that maybe in the future, more of these directed payments will be tied to quality, but for now, a lot of these states in making the conversion are just still keeping pretty much the same amount of payments that they were making before.

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

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

I was also trying to distinguish between the supplementals that are there to promote a financing stream
and the supplementals that are there to acknowledge certain kinds of situations inside of hospitals that need to be acknowledged. Maybe there's something for us to think about there.

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

COMMISSIONER WEIL: I'm trying to restrain myself.

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

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

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

CHAIR THOMPSON: Yeah. And I do think that that comes through in these interviews.
Go ahead, Fred.

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

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

CHAIR THOMPSON: Chuck.

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

[Laughter.]

CHAIR THOMPSON: That you're under no illusions?

COMMISSIONER MILLIGAN: Yeah.
I always enjoy Alan's comments. They always get the blood flowing.

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

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

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

So it was a view that the counties want to see
their money coming back, but it wasn't quite as cynical as you might think, Alan.

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

[No response.]

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

#### DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS:

**POLICY CHANGES AND POLICY OPTIONS**

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

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

These changes create an opportunity for the Commission to potentially make recommendations about ways to better distribute DSH reductions among states, and so I'll be discussing a variety of policy options for the Commission to consider.
In addition, I'll be presenting other policy options to address other goals that the Commission has articulated, such as better targeting DSH payments to providers within states.

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

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

State DSH payments are limited by annual federal allotments. These allotments vary widely by state based on state DSH spending in 1992, and the ACA included reductions to DSH allotments under the assumption that increased coverage would reduce hospital uncompensated care and thus reduce the hospital's need for DSH payments.
The ACA reductions were initially scheduled to take effect in 2014, but they've been delayed several times. Most recently, the Bipartisan Budget Act of 2018 delayed DSH reductions until FY 2020. Under current law, reductions will now be applied at $4 billion in 2020, which is about a 31 percent reduction, and the amount of reductions will increase to $8 billion a year in 2021 through 2025, which is a reduction of more than half of state's unreduced allotment amounts.

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

In addition to the delay in DSH reductions, another important change to be aware of is the recent change to the DSH definition of Medicaid shortfall. So in March of 2018, the U.S. District Court of D.C. ruled that CMS could no longer consider payments from third-party payers when calculating Medicaid shortfall. However, the full cost of care for these patients is still included.
So a good example is a patient who is dually eligible for Medicare and Medicaid, the cost of care for those patients in the hospital is counted as Medicaid shortfall, but the payments that the hospital receives from Medicare for those patients is no longer included, even though Medicare is the primary payer of hospital services for duals.

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

MR. NELB: Yes.

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

So, in this case, we are talking about a situation in which -- because Medicaid is a payer of last resort, it may not be law make a payment that actually should be made by another payer. Once having complied with that rule and indeed having a hospital receive appropriate and proper payment from another provider, potentially to cover the full cost of care for that individual, the amount
that third party properly paid to cover the cost of
care is counted as a Medicaid shortfall. Do I have that
right?

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

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

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

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

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

[Laughter.]

MR. NELB: Okay. So, as a result of this change,
future DSH audits is expected to more than double in the aggregate.

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

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

While doing so, the Commission could also develop a package of recommendations to address other policy goals, such as better targeting DSH payments to providers or dealing with this recent change in the Medicaid shortfall.
Because allotment reductions are currently scheduled to go in effect in FY 2020, which begins in October of 2019, it would be useful for the Commission to make recommendations in the spring.

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

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

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

And, finally, Commissioners have also expressed
interest in using DSH payments to advance quality and access to care in the most appropriate settings.

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

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

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

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

To address some of that differential effect,
allotments could be based on the number of Medicaid and uninsured individuals in the state. This could be justified by the fact that DSH also pays for Medicaid shortfall, which is somewhat related to Medicaid enrollment.

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

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

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

Another option is that we could use DSH audits, which do align with the DSH definition of uncompensated
care. However, we only have them for a subset of DSH hospitals, and there's a something data lag of about four years. We currently just got the 2014 DSH audits, but it's 2018 right now.

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

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

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

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

So, for example, if future DSH funding were tied to the number of uninsured nationally, it would automatically increase or decrease if there are future
unexpected changes in the number of uninsured. To help illustrate these options, this graph shows DSH funding during the 10-year budget window considered by the Congressional Budget Office. So remember that without reductions, DSH allotments increase each year with inflation, and that under current law, there's a big reduction between 2020 and 2025, but after that, the reductions return to their higher unreduced amount. Overall, there's $44 billion in cumulative reductions over this period.

So that same amount of reductions could be applied across the full 10-year budget window to minimize some of the effects on providers. In this example, we illustrate a five-year phase-in that evens out to a 31 percent reduction in DSH allotments, which is proportionate to the decline of the number of uninsured since 2013, but there are a variety of other options we could model for you, if you'd like. So once the total amount of DSH reductions is set, then there's the question about how to best distribute the reductions among states first. So we illustrate several policy options here.
First, we've talked about before the option of applying reductions to unspent DSH funding first. As you'll recall in 2014, about $1.6 billion in federal DSH funding was unspent, and so if you reduce the unspent funding first, that means fewer reductions for states that are currently spending their full allotment.

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

MR. NELB: Yes.

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

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

So remember that the DSH allotment reduction formula is -- there are two parts. About half of reductions is based on some factors of how well states
target their DSH funding to hospitals, and about half of reductions is based on this uninsured percentage factor, the amount of uninsured in the state.

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

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

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

In your materials, you have some information about how current allotments compare to some of those
factors, and I just want to point out that rebasing could be accomplished in two different ways. First, you could lower allotments for states that are currently above some sort of threshold amount, and second, you could also use the rebasing process as an opportunity to increase allotments for states with historically low DSH allotments that are below some target amount.

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

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

MR. NELB: Yeah. Under interactions here.

So, finally, sort of once the total amount of funding and the funding by states, there are also options you could consider about how to better distribute the funding to hospitals within each state. So, as you'll
recall, MACPAC previously examined the number of different policy approaches to improve targeting of hospitals within states by raising the minimum eligibility criteria for DSH payments, and we published some of the effects of those different options in our March 2017 report.

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

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

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

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

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

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

In California, DSH payments are now distributed as a global payment to incentivize reduced hospital use, and hospitals can use the global payment funds to pay for nonhospital services that DSH doesn't normally pay for. The program has been in place for about two and a half years, and the early interim evaluation results were just published this summer.

They show that the health systems are making some positive changes to expand primary care, and they also find
that the hospitals report that they're in a better financial position as a result of the Global Payment Program.

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

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

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

Thanks.

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

VICE CHAIR LAMPKIN: Yeah. Thank you, Rob, very much. This was a really good package, really helpful, and I think the reward for your good work is going to be lots
more good work over the next couple of months, to hit this timeline.

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

So with that, my own opinion about the different options that you've shared here, and kind of where I'd like to see some additional exploration and work is really around -- I'm most interested in opportunities to change allocation across states and rationalize that a little bit, and take out some of the historical strangeness that underlies that, and really get in line with our goals of transparency and understanding what you're paying for where, is recognize the uncompensated care element of DSH and really think about Medicaid shortfall differently, and
pulling the Medicaid shortfall out, since we know that states have other opportunities to retain those dollars and deploy them as Medicaid payments.

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

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

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

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

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

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

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

COMMISSIONER WEIL: A question and then I'll try
to follow on to Stacy's. Just a technical issue. It's
alluded to in the materials. I know, like in tax policy,
sometimes they have them phase out the year before the end
of the window so that they can have a different baseline.
So I'm just trying to think about the unintended
consequences of spreading the cut over an extra few years.
That leads to a lower final-year level. Like is Congress
going to say we can't do that because we need to have a
higher baseline for the future?
MR. NELB: I mean, so in order to do these DSH delays in the past, the way Congress has done it is to apply larger reductions in the future, to pay for it. So if you do extend the DSH cuts that limits the ability of Congress to use those savings for something else. But this is a different issue.

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

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

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

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

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

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

So from a substantive perspective, just two really minor thoughts of guidance. I hate the term
"Medicaid shortfall." I much prefer "private sector overpayment," which I think is a far more accurate description. But I think the guiding principles really do need to be around objective need, setting aside state policy decisions that might play with what that is, particularly around shortfalls and numbers of uninsured.

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

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

Just the last spot. I think it's great, the DSRIPs. I think it's great, the California model that you've described. Again, I think at this stage the notion of having sort of a national push for states to figure out how to reallocate towards performance-based, I just wouldn't take it on.
CHAIR THOMPSON: And there could be an argument that when you're looking at these kinds of reductions you ought to actually let the states have more maneuvering room, to deal with that and to respond to that, in light of their specific circumstances.

Fred.

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

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

Also, things like the unspent -- how the DSH cuts are distributed, unspent DSH dollars, that seems to make a
lot of sense, you know, starting there, and I don't disagree with the idea that, you know, looking at statewide distribution, using objective measures for that. But that, in and of itself, is going to cause, you know, winners and losers, and it's hard to imagine how we get away from that if we move to some objective needs-based formula there.

CHAIR THOMPSON: Even status quo has winners and losers.

COMMISSIONER CERISE: Well --

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

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

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

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

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

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

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

CHAIR THOMPSON: I have Chuck, Toby, Sheldon.

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

I do think that it's sensible to pursue something that has cross-state winners and losers. That's more
objective. And partly for me it's not simply kind of the
fact that DSH is locked in, in some ways based on a lot of
state behavior in the early '90s, primarily.

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

So that's just my own personal view, that there
is embedded in the ACA and the Sebelius decision a view
that states should not be punished by their Medicaid
expansion decision or not. So that's just my own view
about kind of the redistributional aspects of our DSH
conversation to come.  

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

And the one last thing I just want to say about, there's been a lot of comment -- and I don't mean to carry on the kind of Alan-and-Chuck throwdown, which I'm enjoying, by the way. But I think if it's a $1.2 trillion or whatever the figure is, when states go through economic challenges or recessions, hospital rate cuts is the absolute first play in the playbook for a state Medicaid director, because brick-and-mortar providers can't go anywhere and they are dependent on Medicaid. And so brick-and-mortar providers like hospitals tend to be the ones that get the first-rate cuts and the deepest rate cuts because they're not going to move to another state, or they're not going to stop serving Medicaid patients, by and
And I do think, therefore, that how we deal with hospital financing matters, in terms of just recognizing that there are different provider type altogether, in terms of those other elements of the lifecycle of a Medicaid budget and economy.

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

But I want to be explicit that hospitals can kind of seek subsidies from public financing in different ways, that might have double-counting elements about the Medicaid
shortfall, if part of it is to defend avoidance of taxes
for nonprofit taxes in hospitals, if part of it is Medicare
cost reports, if part of it is Medicaid DSH. So I just
want to flag that, and then I'll top there.

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

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

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

And that gets to my final point, and this kind of
aligns with both what Alan was saying and then Fred. You
know, I'm still struggling on viewing DSH just in isolation when it's connected to so many of the other different funding sources, and the policies that we've set on this of how do we use the decision on this to get back to the question of how supplementals are flowing through, and are there opportunities here to be policies that are tied to DSH that are related to whether it's movements to DRGs or to how, you know, states and hospitals are not just using the other funds to fill in gaps but are more tied to quality and outcomes.

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

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

COMMISSIONER RETCHIN: So we've been talking about this since I've been on the Commission, and I'm sure it antedated me anyway. But I'm probably going to differ a little bit. I do think that we ought to be looking at some
equilibration formula amongst the states over a period of
time, but I'm not willing to give up on going into the
states, as well.

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

I think we ought to weigh in on the whole
provider tax and allocation business -- it's just me -- and
I will get back to what Fred said in terms of setting
expectations. We have hospitals that have double-digit
margins that are still recipients of supplemental payments.
There are no expectations in terms of comprehensive
management or ambulatory sensitive conditions, and this is
the opportunity to do it. Maybe it's just the
recommendation would have to be soft, but I think after
being and seeing this discussion for three years, this
isn't new, and I think we ought to be making some pretty
hard recommendations. That's me.

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

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

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

CHAIR THOMPSON: I agree, and I think there's
this balancing where we can directionally make things
better, from the standpoint of how to accommodate this
budget exercise in a way that's consistent with where we
want to see the larger view of hospital payments go, which
isn't to say that what we would suggest now is something
that solves all of those larger problems. But it's better
than what we might have in front of us otherwise. And so I
think this might be one of those circumstances where we're
saying, okay, how can we make this better without making it
necessarily all that we want it to be, while we're also
thinking more broadly about a whole set of interconnected
issues.

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

PUBLIC COMMENT

* [No response.]

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

I will say I do think that we still have a little
bit of sorting to do about -- on something like Medicaid
shortfall, are we inclined to say let's not include
Medicaid shortfall, or are we inclined to say let's make
some changes as to how you calculate Medicaid shortfall, which could include, you know, what's included or not included, as well, third-party payments among others, right?

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

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

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

MR. NELB: No. So we still don't know the full effect of that court change, but we're finally starting to get some information about the effect of Medicaid expansion, which, you know, due to that DSH data lag is
quite a while ago, but we're finally getting the data now so it's new to us and so we'll add that to the conversation.

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

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

[Recess.]

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

[Pause.]

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

#### OPERATIONAL CONSIDERATIONS FOR WORK AND COMMUNITY ENGAGEMENT REQUIREMENTS

MS. BUDERI: Great.

So today, we're going to continue our discussion of Medicaid work and community engagement requirements, and
previous MACPAC work on this issue has focused on policy design and the effects of similar requirements in other programs. This presentation will build on that work by discussing the operational details states are considering or will need to consider as they implement these policies and what we know so far about the approaches they're taking.

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

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

Additional states have formally applied for
similar waivers. It just became nine this week. Michigan became the ninth to apply, and other states have also expressed interest in doing so.

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

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

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

New Hampshire and Indiana are both on track to
implement January 1, 2019, though Indiana is planning to
gradually phase in the number of hours required to meet the
requirements.

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

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

So in the first three months, June through
August, most enrollees subject to the requirement were
deemed exempt by the state, and so they weren't required to
report their work or community engagement activities. And
these include people with income consistent with working
over 40 hours a week, who are exempt from SNAP work
requirements, and who have other exemptions the state can
identify through administrative data, and you can see here
that that number is represented by the green bar. And it's about 15,000 in June, 30,000 in July, and 40,000 in August.

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

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

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

MS. BUDERI: Yeah.

CHAIR THOMPSON: -- and ask a few questions?

MS. BUDERI: Sure.

CHAIR THOMPSON: So this is rolling?

MS. BUDERI: Yeah. So for June, it's the initial
group. So I believe that's people who were in that age group, but whose renewal date is between January and March, and then July would include those same people plus the next group.

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

MS. BUDERI: Yes.

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

MS. BUDERI: Right.

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

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

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

MS. BUDERI: Let me just take a look.

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

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


CHAIR THOMPSON: Melanie, you want to jump in?

COMMISSIONER BELLA: Yeah, just to clarify that.

I found myself asking how many people just didn't sign up for the two systems and then get a piece of paper at a post office address that they may or may not have anymore. So I'd be really curious understanding that.

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

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

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

MS. BUDERI: Sure. So --

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

MS. BUDERI: No, that's okay. I found the
numbers, so I can give you the number if you want it.
CHAIR THOMPSON: Oh, yes. Okay.

MS. BUDERI: Okay.

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

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

CHAIR THOMPSON: Yeah.

Go ahead.

MS. BUDERI: Yes. So for August -- and I can get you the June and July numbers later, but for August, out of those 16,357 people who failed to meet the requirement, 225 reported something, and the remainder, which is about 16,100, didn't report anything, so the vast majority not reporting anything through the portal.
CHAIR THOMPSON: And what is the process by which they're terminated from the program as a result of that?

MS. BUDERI: For Arkansas?

CHAIR THOMPSON: Yeah.

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

CHAIR THOMPSON: Okay.

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

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

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

CHAIR THOMPSON: Immediately before you get anything.

Okay. I think it's just important to recognize that that is a harbinger of something that should be of great concern to people, and we should be looking closely at what's happening with those individuals. Are they not reporting because they know they don't meet the
requirements and they -- "There's no point in me, you know, I'm not going to meet the requirements. I don't need to jump through some hoops to tell people I don't meet the requirements"? Do they not understand that they need to provide this reporting?

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

Okay. Keep going, Kacey.

MS. BUDERI: Okay, great.

Okay. So going to the next slide, after August, the state reported that 4,353 people were out of compliance for all three months, and they were disenrolled. So this represents about 17 percent of all people who are subject to the requirements for all three months, so people who
became subject in June the first month or a little bit over 40 percent of people who weren't identified as initially exempt by the state.

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

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

And then in all four states, beneficiaries who are not initially identified as exempt can submit information to the state if they believe they qualify for an exemption that's new or that the state wouldn't be able
And so for beneficiaries who aren't identified as exempt, states have set up different processes for them to report their work and community engagement activities. In New Hampshire, beneficiaries will be required to report monthly, and they have options for how they can do this. They can do it by phone, by fax, in person, through an online portal.

Beneficiaries in Arkansas and Kentucky are required to report monthly through the online portal, and these portals allow beneficiaries to self-attest to their participation in qualifying activities or any new exemptions they have. But there have been concerns about the challenges the portals are posing for beneficiaries. They don't require much manual staff intervention, but they require enhancements to the eligibility system.

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

So in order to enforce the requirements, states
need the capability to process what beneficiaries report and what that means for eligibility, and this includes having the capacity to suspend or terminate enrollment, or if a beneficiary comes back into compliance, resume eligibility in a timely manner.

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

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

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

So in terms of the outreach that states are doing -- and we know from our past work on implementation of similar waiver features, like premiums and healthy behavior incentives, outreach is one of the biggest challenges to
successfully engaging with beneficiaries and an ongoing challenge.

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

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

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

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

So the last major operational piece I'll talk about has to do with work supports, and I'll note that CMS
has specified that no federal funds can be used for this purpose. So this involves coordination with other programs and organizations.

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

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

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

The reports also need to include information on key metrics, and all the states will need to propose a list. However, CMS did specify some metrics to be included for Arkansas and New Hampshire, which include the number
and percentage of individuals who are exempt from the requirements, who were required to report, who were disenrolled or suspended, and who requested and received good-cause exemptions.

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

So I'll turn it back over.

CHAIR THOMPSON: Martha and Toby and Alan.

COMMISSIONER CARTER: Thank you, Kacey.

Of course, I'm concerned about access to care for Medicaid beneficiaries. I'm also concerned about other parts of the safety net system in terms of what happens when there's an abrupt change. We've talked about states electing not to expand Medicaid, but we're also then looking at states electing to allow, I guess, abrupt disenrollment of large parts of their Medicaid population.

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

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

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

We were just talking about DSH, and I actually
thought about bringing this up when we were talking about
DSH because if you've got an abrupt increase in
uncompensated care, then how does a state manage that, and
how do the other safety net providers?

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

COMMISSIONER CARTER: No.

CHAIR THOMPSON: Okay. The microphone spoke.

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

[Laughter.]

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

COMMISSIONER DOUGLAS: Great. Thanks for the presentation.

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

MS. BUDERI: I believe the number in June is 72 percent and then about a little over 80 in July and August, and those are the people who were not backed out by the
state. So those were the people who received notices that
told them they would need to report their work activity.

COMMISSIONER DOUGLAS: So of the 16,000 plus the

1,218, right, that's really the -- so 1,218 out of 17,500
or something?

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

COMMISSIONER DOUGLAS: Okay. Yeah.

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

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

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

COMMISSIONER DOUGLAS: Second question on that,
if we looked -- you mentioned about incentive -- other
types of healthy incentives or other ones that have tied to
participation. If we could look at kind of what the
disenrollment rates were for those compared to this, I
think it would be good.

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

COMMISSIONER DOUGLAS: Yeah.

CHAIR THOMPSON: Like how many people reported or

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

CHAIR THOMPSON: Yeah.

COMMISSIONER DOUGLAS: So maybe seeing, just
understanding this.

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

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

MS. BUDERI: Yes.

COMMISSIONER DOUGLAS: Then on outreach, a couple
questions on the outreach, again, maybe if you could -- one is how this information is being shared back with the managed care plans, using them to engage, again, before disenrollment. Are they part of the process?

MS. BUDERI: Yes. So I believe in each state -- so in Arkansas, I'll just say that they have this premium assistance system. So it's actually the exchange plans in Arkansas' case. I think in Kentucky as well as Arkansas and New Hampshire -- Indiana, I'm not sure about because I wasn't able to get in touch with them --

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

COMMISSIONER DOUGLAS: Okay. Then the final
question on outreach, again, this is kind of this connection back to supporter services and requirements to link them to job training. Is there anything that's -- looking again at -- was there any of this 80 -- 80, 90 percent that aren't responding, are they getting linked? Just a way, again, to be able to understand different ways from outreach and noncompliance.

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

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

MS. BUDERI: Well --

COMMISSIONER DOUGLAS: They're just getting a referral?

CHAIR THOMPSON: What does it mean to be referred?

COMMISSIONER DOUGLAS: So that there's no -- I thought the workforce agency would be reaching out.
MS. BUDERI: They have that contact information, so they might be reaching out, but they can't force the beneficiary to participate in their training programs.

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

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

Alan.

COMMISSIONER WEIL: This is very important information.

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

But I'm not really comfortable with us just offering some sort of a retrospective reporting on how many
people lose coverage. It does seem to me, even on the
basis of this pretty preliminary information, that as of
now, we don't have any evidence of increased engagement in
work-related activities, much less work, and we have
significant evidence of a large number of people losing
coverage. And it feels to me, as MACPAC, we have an
obligation to state that rapid implementation of large-
scale change of this nature across multiple states is a
really risky proposition.

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

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

CHAIR THOMPSON: Melanie, Chuck, Peter.
COMMISSIONER BELLA: Yeah. I just have a
question. It's sort of along where Alan was going. What are the kind of data collection mechanisms, and is there something or someone other than the state who wants this policy doing anything collection-wise or evaluation-wise? And how can we make that more real-time? Because it's not going to do us any -- even if we had a really nice academically rigorous evaluation, it's not going to do us any good three or five years from now.

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

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

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

In terms of an outside -- you know, they also
have to have independent evaluations, but like you said, those wouldn't be until three or five -- a few years down the line.

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

COMMISSIONER MILLIGAN: Thanks for the presentation, Kacey.

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

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

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

MS. BUDERI: The Arkansas waiver?

COMMISSIONER MILLIGAN: Yes.

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

COMMISSIONER MILLIGAN: Okay. I just wasn't sure if there was litigation in the other states as well.
MS. BUDERI: I don't believe so.

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

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

COMMISSIONER MILLIGAN: And I guess the last comment I'll make is I'm sensitive to -- I don't mean to
keep playing this game, Alan -- the comment about the rapid kind of implications of this. But I am aware that a lot of the states maybe would not have done the Medicaid expansion but for having this kind of program around it.

And, Martha, to your comment earlier, I want to articulate that I think the context of a state choosing not to expand versus a state choosing to expand, but doing it in this manner, creates some interesting implications for our role as a commission about how to weigh in because there are a lot of people in states that aren't doing this kind of model and chose not to do the Medicaid expansion that have higher rates of uninsured, higher burden on safety net providers.

And I just think that we need to be sensitive that in a lot of these states, the alternative might have been no expansion at all.

I do think one of the important takeaways from what you've learned and what Arkansas has published, though, is in some ways this puts to bed the implication that the majority of these people aren't working, aren't engaged in workforce, aren't engaged in activities, because we're seeing a lot of folks getting exemptions for doing
that very thing.  

Thank you.

CHAIR THOMPSON: Peter and then Kit and then Toby.

COMMISSIONER SZILAGYI: Yeah. I could almost pass because I had about six points, but everybody made them. And it was mostly about trying to find the truth about how many people are actually working or how many people got notifications, or what exactly was the job training.

The past experience with work requirements in other programs, there was a big variability in job training, and the programs -- or job referrals, and here, it sounds like it's some kind of an automatic referral.

My understanding of the evidence is that the programs that had intensive and somewhat expensive job training did achieve increased work, which was one of the goals, and it's certainly one of the goals of these programs. But I'm unclear about exactly what Arkansas is doing.

So maybe my only new question in addition to maybe a little bit of a comment, if I needed to report
every month about my work, I'm positive I would be uninsured because I would just forget, but that's a comment.

The question is, if we modeled ahead to September, October, and November, do we know how much the - - what's the denominator? How much is this going to go up? Do we know?

MS. BUDERI: I think the total number of beneficiaries who are going to be subject to the requirement is about 170,000, and that's in the first group. So that's the people who are age 19 to 49. I think it would be most of them would be backed out ahead of time.

I mean, I can't model ahead to see how many people would continue to be disenrolled, but I think the number is about 70,000 over the whole year who would be having to report something.

I know that wasn't very clear, so sorry about that.

CHAIR THOMPSON: I'm going to go to Kit, and then I'm going to try a little bit of a wrap-up and then get some reaction to that.

COMMISSIONER GORTON: I want to align myself with
Chuck in terms of this was the price of the ticket to the dance in these states, and I think we need to be very careful about criticizing their decisions that were made, clearly by people who were informed by their contexts. And, in general, I think that we should be open. If the states are going to be laboratories, then the states need to get to try stuff that maybe some of us are not comfortable with.

But, with that said, I want to align myself with Alan and say I hope these data scare the pants off the people in Arkansas because, if you're running as program, this is not very good. Any of us who have ever tried massive outreach to a Medicaid population -- in this case, this may be people -- since they're using a premium support model and what we're focusing on is adults, these are people who may have two and three part-time jobs who are all over the place, who may not know where the nearest public library is that they can use a computer on, let alone may not be able to get to the nearest public library during the hours that the library is open because they're working two and three jobs, and they didn't get the mail anyway because that address was bad.
I think the plans will be madly trying to find these people because they will want to keep them in. They don't need to be required to do it; they will want to do it.

My experience certainly in Massachusetts and in Virginia is that the state will be unable to provide them with the information they need to actually do that outreach, and so what happens then is people get disenrolled. And then, retroactively, they get reenrolled, but in the meantime, they miss necessary care or we generate uncompensated care. And you create an access and retrospective payment nightmare.

So I'm inclined to -- and maybe this meeting is sufficient. I'm inclined to just simply align myself with Alan and say the Commission has raised its eyebrows at these -- they are very preliminary, but they're scary preliminary. And we should pay attention to that. People should be looking closely. Maybe they don't want to report on all of these things on a monthly basis in Arkansas, because if I was the operational manager responsible for that in Arkansas, I would hate to have to report on all of these things, and you wouldn't have data streams. And the
plans would hate it too.

But somebody should be paying attention to this, and there ought to be a war room in place just looking at whether or not people are being negatively impacted by this policy who shouldn't be negatively impacted by the policy.

CHAIR THOMPSON: Yeah, go ahead, Toby.

COMMISSIONER DOUGLAS: I actually -- and the more I think about this and from experience on the other side, when we did enrollments, when things were going wrong, there were times where CMS came in and put the pause button on. Our role at MACPAC is not just to advise Congress, but the Secretary and the states. Looking at these numbers and without -- unless Kacey can go back and figure out all these questions and answer it, I think the recommendations right now should be putting the pause button on Arkansas until -- not stopping the work requirements, not taking judgments on whether it's good or bad, but understanding what's going on in the state and why people are not responding before they continue to disenroll people.

CHAIR THOMPSON: I'm trying to wrap up, so let me try to wrap up and see if I can get this. And we really need to get the public in, right, So we can get some
commentary from them as well?

So here's my concern about coming up now on the basis of this information, which I find very concerning. I find the numbers to be very worrisome, and I think we've identified a number of different questions that we have about what these numbers represent. One is that I am concerned about whether or not we simply don't have -- that there is an explanation, there is information about additional follow-up from the plans, there is information about what people have gotten or not gotten, there is some kind of monitoring effort that gives us some better sense about what's happening with these individuals, or there isn't. So that makes a difference, right, as to whether or not we have all the information or we don't have the information?

We're not the regulatory agency, as CMS would be. Presumably, CMS should be taking a look at this and perhaps considering whether it needs to take additional action or not.

I don't know to what extent this is about the fact that if people are not in circumstances where they can meet the requirements, that they haven't been given
adequate time to engage in job training or the other
connections that are necessary in order for them to meet
the requirement, whether this is about the fact that there
is only an online portal available for people during
certain limited hours, and therefore, that's the problem
because they can't get there.

So I think we have a number of questions about
what's happening, and I would feel better if we could get
some additional answers to those questions before deciding
whether we're in a position to say we believe we have
enough insight based on what we know about what's happening
to suggest that there needs to be some additional follow-up
with beneficiaries, there needs to be some additional time
given to beneficiaries to comply, there needs to be some
other steps taken with respect to the waiver as a whole.

So my suggestion is that we give Kacey the
opportunity to go back and collect some of the information
in response to the questions that we've raised, so that we
can have a better understanding about whether we have
sufficient concerns, to be wanting to write letters or
suggest a different course of action with respect to the
waiver.

So, Martha, do you want to tell me if --

COMMISSIONER CARTER: I did, and I think those

are good questions.

I'd like to add one, and that was I would assume

that Arkansas did make an estimate about how many people

would not meet the requirements and fail to report. So is

this a surprise? Are the numbers that they have out of

their first quarter -- I think the requirement was that

people had to report for -- they couldn't miss three

quarters, and I don't think that they were consecutive

quarters, but I could -- I mean months. I'm sorry. They

had to report three months, and since there have only been

three months, we don't know.

But was this a surprise? What was their

projection about the number of people who would lose

coverage, and how did that compare?

MS. BUDERI: I think the projections that

Arkansas made in its waiver application, when Arkansas

initially applied for this waiver, it was also talking

about rolling back eligibility to 100 percent of the

federal poverty level, so most of the coverage loss
estimates include that proposal as well. And it's hard to separate out the coverage losses estimated for people because of the work requirement itself.

CHAIR THOMPSON: And then, Kacey, the only other thing that I would want to add to this mix is these requirements under the waivers are conditions of eligibility, and there are rules about how eligibility processes work and how you audit eligibility processes and how you test eligibility processes; for example, that there are multiple channels for beneficiaries to come in and submit information related to eligibility. So I don't know if some of those were waived as part of the waiver to allow only an online process or not.

MS. BUDERI: The multiple means of submission requirement was waived for Arkansas only.

CHAIR THOMPSON: So I'd like to think about whether or not there's some lessons learned there or some activities there that we should be thinking about where -- a lot of the standards have been developed over time as people understand how to retain people in coverage and avoid some of the losses that are associated with confusion or process, and so if some of those particular requirements
are not being maintained under this waiver, how are they being monitored? Are there opportunities to change some of those STCs in light of some of these early findings and with respect to ongoing monitoring?

Alan, did you want to say something?

COMMISSIONER WEIL: I know you want to get the public comment in.

I will just say I appreciate that there are questions we can't answer, and I very much appreciate the notion that we are certainly on a position to say the work requirement concept is fatally flawed, no suggestion anywhere like that.

I am concerned about people's real lives and the meeting cycle of a group like us, which is periodic. Thankfully, we're in fall, so it's not as long a gap as it would be.

I think my only feedback would be to you as Chair. I would hope that we could come in next month with some willingness to not just ask questions, but to say something, because I think waiting longer than that -- I'm uncomfortable waiting that long. I understand the reason to, and I understand this is all fresh, but I would not
want us to just keep saying, "Oh. Well, now we have the answers to these three questions, but we have six more."

CHAIR THOMPSON: I completely agree, and it's my sense from the Commissioners that as a group, we have a serious level of concerns with the information that we're seeing. I think we just need to make sure that we're following up on some of the lines of inquiry that we've identified here, and I agree completely that in addition to having those responses that we should be prepared at the next meeting, should those responses indicate that our concerns continue rather than are ameliorated or mitigated by the answers, that we have an opportunity then to consider some communication to the agency around these issues in terms of what our suggestions are for next steps.

Okay. So let's open it up to public comment.

I just can't generate any kind of public comment.

Andy. Andy, will you mosey over to the microphone?

We will ask you to use the microphone for recording purposes.

MS. COWEY: I'm just curious if MACPAC has a role
in commenting on these waivers beyond just their
operationalization and more in terms of whether they align
with underlying statutory purpose of Medicaid.

CHAIR THOMPSON: And just again for purposes of
recording, can you just identify yourself and your
organization? Sorry.

MS. COWEY: Apologies. My name is Taylor Cowey.
I'm with Wynne Health Group.

CHAIR THOMPSON: Thank you.

I think that the Commission feels that it could, if it wanted to, comment on whether it thinks a particular kind of an approach to the program is a good or a bad idea. I think as we've talked about some of these questions, it gets caught up into a question of Secretarial discretion as well as what deserves evaluation as well as how solid is a hypothesis and does it deserve to be tested. So I think it was the sense of the Commission that we would be watchful on these waivers and continue to monitor events and I think particularly focus on some of these issues around operation and organization.

MS. PIFER: Hi. I am Rebecca Pifer, Healthcare Dive.
I was just wondering if the Commission has taken the results of the JAMA studies that were published just a couple days ago around work requirements and their scalability to a national model. I was just wondering if you all had seen those and if you're going to take those results into account when you're deliberating around the program.

CHAIR THOMPSON: Kacey, do you want to respond to that?

MS. BUDERI: Yeah. So two things came out in JAMA this week. One of them was looking at the number of beneficiaries who would meet the requirements -- excuse me -- who are subject to the requirements -- in other words, don't have an exemption -- and then of those, who would be failing to meet the requirements, so people who weren't exempt but wouldn't be working for the required number of hours.

And then the other one, I believe, was looking at nationally the portion of beneficiaries who would be subject to and not meeting the requirements and then the portion of Medicaid spending.

And I can send you more details on those, if
you'd like, but --

CHAIR THOMPSON: So I think --

MS. BUDERI: -- I can send you the articles too.

CHAIR THOMPSON: I think the commenter is suggesting that we ought to take a look at that in the context of what does that mean for the program, for the objectives of these waivers, how does that relate to potentially giving us some insight into some of the dynamics that we're seeing here and the operational contract that we're talking about. So perhaps that's just something, Kacey, you can take a look at and decide how to -- I think circulating the information is very helpful to the Commissioners, but I think maybe looking at that and seeing if that provides any additional thought or for additional conversation among the Commission.

Chuck.

COMMISSIONER MILLIGAN: I'd love to see the articles.

And going back to the first commenter about the statutory purpose of Medicaid too, if there was a way to do a synopsis of the Kentucky decision -- because I think a lot of what the Kentucky decision in the litigation is
raising is whether the Secretary in fact has the discretion
to approve a waiver that would condition Medicaid
eligibility on work requirements and whether that's within
the Secretary's discretion statutorily.

So I think, Kacey, if you're going to be sending
more stuff our way ahead of the next meeting, if there was
a good synopsis of the Kentucky decision, I think that
would be helpful context for this.

CHAIR THOMPSON: Yep. I agree.

MS. COWEY: Taylor Cowey with the Wynne Health
Group again.

Just on sort of a related point, I think earlier
you were talking about this being implemented in expansion
states. Are you planning at all to look at the states who
are considering this where they have not expanded? I
believe Missouri may be considering. It's nothing that I
believe has been submitted to CMS yet, but --

MS. BUDERI: I can bring you summaries of the
states that have requested these work requirements that
aren't expansion states. I can bring you summaries of
those waivers. I don't know what would be the most helpful
for you in terms of the non-expansion waivers.
EXECUTIVE DIRECTOR SCHWARTZ: But I think the point is that Kacey knows as much about this as almost anybody who is not actually working in one of the states or doing the approvals at CMS.

Yes. Presumably, if one of those got approved, that would be information we would share with you.

I may get myself in trouble, not being a lawyer on the Kentucky case, but it's my understanding that the decision in the Kentucky case was not based on whether the Secretary had discretion to do the waiver, which would have, I think, probably been the plaintiff's preferred result, but that it didn't further the objectives of providing medical assistance.

So we'll have to wait and see what happens with CMS, and then also now that a case is going to proceed in Arkansas, we'll see in that as well.

I also just want to make sure we underline one more thing before we leave. That both Arkansas -- well, actually, all four of these states are states that had previously expanded. So their decision to expand initially was not predicated on having a work requirement. We now have another group of states that face a very different
scenario: Virginia, North Carolina, maybe some of the others.

COMMISSIONER BELLA: As one of two new people, just as a point of process, I mean, there's a difference in getting information with like a letter from MACPAC that says we want to know these 10 things versus saying, "Kacey, go make calls, and go sort of dig around." Which one are we going?

CHAIR THOMPSON: The second.

COMMISSIONER BELLA: Oh.

CHAIR THOMPSON: So Kacey is going to go, taking in all of the questions that the Commissioners have had in response to the data that we're seeing here, digging into that, is going to come back at the next meeting, "Here's what we now know. Here's what we now understand," we've checked with, we've looked at, we've examined, we've conversed with, and give us some additional insight.

At that point, the question will be for the Commission whether those answers allay our concerns, don't allay our concerns, raise new concerns, and at that point, we're back to -- which we've done before -- then a question of do we write a letter to the agency, to the Secretary
expressing the concerns about the state of the waiver, how it's being operated, and the potential impact on beneficiaries' access to care. And if that's the case, then Kacey will have that piece available for us to consider based on those answers.

So we'll sort of be -- and we'll probably do it over two days. We'll probably have a Thursday conversation about here is what we found that will elicit some Commissioner conversation and response, "Yes, that then we're not ready to send a letter," or "That's a different situation than we thought," or "No, we're ready to send a letter and express concern," in which case we'll probably come back the following Friday, that next Friday, to look at a letter and vote on it in terms of sending it over to the agency.

COMMISSIONER BELLA: Just a question. Why would we not just send a note saying we want answers to these things, we're going to be exploring these things? Do we not do that?

CHAIR THOMPSON: We may send a formal request for information, or we may just reach out to the people that we work with on a regular basis to get the answer.
For the most part, the staff work with CMS and the states in a very collegial fashion, and generally, that additional process is not necessary in order for us to collect the information that we need.

EXECUTIVE DIRECTOR SCHWARTZ: I can't think of one instance in which we have actually sent that formal kind of letter seeking information.

Kacey has reached out to all four of these states in advance, had conversations with a number of them, and that is always the better path.

CHAIR THOMPSON: Okay.

MS. MCDONALD: Ruth McDonald with Avalere Health.

There are a couple of things. Arkansas actually did open up a phone reporting line at some point, but it was, I think, sometime in August. And then, of course, getting the information out that the phone line had opened is another challenge of how are you communicating that with folks.

I think the other piece is I'm not sure why CMS decided to waive the multiple reporting requirement for Arkansas in particular. I don't know how it measures against some of the other states, but I think the internet
connectivity in Arkansas, compared to some of those other states in particular, but looking at it alone and then especially with this population, did the state actually do any work to try to measure how many folks in Medicaid had internet connectivity in Arkansas? And regardless of the Medicaid population, how many people in Arkansas have internet connectivity? And a lot of folks also have temporary phones, that kind of thing.

The other comment I just want to have is -- I don't know. Has Arkansas put out explicit data about -- the number of folks meeting the work requirements, I think are below a thousand. So if you have -- I don't know how that aggregates up for each month, but if you have those number -- you know, if you're dropping more people than you are helping with the -- a thousand, you know, who -- or less than that who have gained employment, I don't know if anyone has any comment on that or if there's sort of any precedent in sort of a new policy that may help a quarter of Medicaid beneficiaries, but may actually hurt coverage for another three-quarters.

CHAIR THOMPSON: Well, and that's the -- I mean, states have always had the opportunity to refer people for
supportive services in order to do job search and other kinds of activities that can help achieve employment, and so the theory of this, right, is that the additional incentive on the part of the Medicaid program to make a requirement that this is condition of coverage solicits more traffic, right, over -- and I think that's the proposition that the evaluation is intended to measure.

I think part of the process here is can we get people into a process where that's what they're doing, is seeking those new kinds of opportunities and engagement. So, here, I think your point about internet connectivity -- Kacey, you've made this in your background material about what we might be looking at there, and that is also part off, again, the eligibility processes and systems using user-centered design to understand the profile of the users that will have to come into contact with the system and how much of that was done here in order to understand people's circumstances and what would make it easier for them to submit reports and comply and how that fits within things that they might otherwise be doing. I'd be curious to know how much of that was taken into consideration.
Then, again, there's the issue of timing where people may not meet requirements today, but may need help to get into education, get into an employment arrangement, and are we giving them adequate time to engage the state resources that are being identified for them to do that? That may be another issue here, which I think we had Commissioners asking that question about how many people are over there on the other agency side now linked up looking for employment, and has there been an increase in volume over on that side of the question?

MR. WEINSTEIN: Dan Weinstein from NHeLP.

I'd just like to ask you all if you have the spare time to read the court decision. It's a good read. And I have a question regarding tracking of the cost of care for the population that is disenrolled. Is there anything being done regarding monitoring of that population, seeing how that impacts the larger state Medicaid expenditures?

CHAIR THOMPSON: And that goes back to, Martha, your question: Are those people ending up in the DSH formula?

COMMISSIONER CARTER: Where are they ending up,
and who is paying for them?

MS. BUDERI: I think that's something we can look at as we see the monitoring reports, when they come out, and then when we see the evaluation design plans, we can look for things like that.

CHAIR THOMPSON: Do you have a sense about whether the monitoring plans -- have we looked at the monitoring plans?

MS. BUDERI: So only one state's monitoring plan is available right now, and that's Arkansas. And I don't believe it's tracking the cost of care for people who are disenrolled for noncompliance.

CHAIR THOMPSON: So I think that's something, again, that -- I guess the question would be, Does Arkansas not have that in its monitoring plan because it considers that to be part of what could be a formal evaluation down the line, a distinction that they're making between kind of monitoring for the objectives of the waiver specifically as opposed to the longer term or other impacts of the waiver?

But it would be helpful to understand what people think they're looking at now versus looking at later and making sure that we have an opportunity to weight into
Okay. Let's wrap up this part of our conversation.

Kacey, thank you very much. We appreciate the work that you're doing and continuing to do on this subject.

We're going to turn our attention now to high-cost drugs.

[Pause.]

CHAIR THOMPSON: So Chris, Rick, we're going to be sure to give this the proper amount of attention. We're running a little bit behind time so our plan will be to power through, in a saying, and give you your full 45 minutes for this session, so that we're giving it adequate attention.

MEDICAID COVERAGE OF NEW AND HIGH-COST DRUGS

MR. VAN BUREN: Thank you, and I will try to speak quickly.

So good afternoon. This is the -- this session is going to focus on prescription drugs. It continues the Commission's work in this area. Last cycle, as you will recall, the Commission made technical -- recommended
technical changes to the rebate program. This cycle we will be looking more broadly at issues related to the coverage of complex, high-cost drugs. Specifically, today we'll be looking at challenges states face in covering new drugs, accelerated approval drugs, high-cost drugs. We'll talk about some issues surrounding the rebate cap, and then discuss some of our upcoming work in this issue.

First up, we are going to talk about covering new drugs, and just to level-set, recall at the grand bargain of the Medicaid Drug Rebate Program is that states get rebates from drug manufacturers for the drugs they pay for. In exchange, states have to cover essentially all of participating manufacturers' covered outpatient drugs as soon as they approved by the FDA.

The state Pharmacy and Therapeutics committees, or the P&T committees are responsible, generally, for putting drugs on the formulary, which under Medicaid is called the preferred drug list or PDL. State P&T committees will review evidence to determine coverage criteria. They will look at the label, they will look at the studies that were used to approve the drug, and then they'll compare the drug's relative safety, relative
effectiveness, and finally cost to other therapies in the class.

This is relatively easy for some drugs, for new statins or drugs that states are used to seeing, if it's not particularly complicated. For other drugs, particularly first-in-class or complex therapies, this can be a pretty time- and labor-intensive process.

You will recall that at the December meeting you heard from Renee Williams from the Tennessee Medicaid Program, who talked about some of the challenges that the state faces in establishing coverage criteria, figuring out prior authorization, and utilization management for these drugs. I also note that CMS does not actively monitor states to ensure they are complying with the coverage requirement, and there have been some instances of states taking substantial time to develop this coverage criteria.

Medicaid is unique among federal payers in the requirement that it cover new drugs as soon as they are approved by the FDA. For Medicare Part D, plans have to make a reasonable effort to review new drugs within 90 days and make a coverage -- a formulary determination within 180 days. If a drug is one of the six protected classes, where
Part D plans are required to include substantially all of the drugs on the formulary, plans have 90 days to make a decision. After that, the drug is added to the formulary. Qualified health plans offered on the exchanges follow the Part D rules for non-protected class drugs, so they have 90 days to review and 180 days to put on the formulary.

One of the options in this space that could ease the strain on state Medicaid programs would be to allow for a formal grace period before coverage is required. This could align with the Part D QHP model of 90 days and 180 days, or with the accelerated Part D protected class standard. One benefit of the grace period would be it would give states time to review the drug and the FDA approval documents to make clinically informed coverage decisions. Note that this policy could be combined with a policy comparable to the Part D protected class standard that could require, after the grace period, the drug is mandated to be placed on the PDL, and that might ensure that states use the grace period to develop clinical coverage criteria.

A few things to keep in mind about this policy. Access would likely be limited during the grace period. We
expect manufacturers would be opposed to this, given kind
of the overall structure of the drug rebate grand bargain.
And it is worth noting that drugs on the preferred drug
list can still be subject to relatively restrictive
coverage criteria.

So moving right along to accelerated approval
drugs, just a very quick, very high-level overview of the
FDA approval process. FDA approval generally has three
rounds of clinical trials to show that a drug is safe and
effective. Effective, in this instance, means that it
achieves a clinical outcome. The beneficiary, or the
patient -- sorry -- feels better, functions better, or has
improved survival rates.

The accelerated approval pathway allows FDA to
approve drugs that have not yet shown a clinical benefit
but have shown an effect on what's called a surrogate
depoint, which is essentially a proxy that's supposed to
predict a clinical benefit. So blood pressure is an
example, HIV viral load, those are examples of surrogate
depoints.

For accelerated approval drugs, manufacturers are
required to perform post-approval studies once the drug is
on the market, to confirm a clinical benefit. If a drug fails to show a clinical benefit in these post-approval studies, it can be withdrawn from the market.

There are a few characteristics of accelerated approval drugs that are concerning to state Medicaid programs. The first is cost. As you can see from the chart, in fiscal year 2017, the average cost per claim on an accelerated approval drug under Medicaid was $6,600, and 27 accelerated approval drugs approved since 2014 cost Medicaid programs $686 million.

The second issue that's concerning to states is there are some questions about the effectiveness of these drugs. There have been drugs approved through accelerated approval even though it's unclear if they work. Some drugs have had small study sizes. For some it's not clear if the surrogate endpoint is predictive of a clinical benefit, and the post-approval studies that are supposed to confirm a clinical benefit for these drugs can take years to complete and, in some instances, some of them have never been completed.

There are also concerns about safety around these drugs. A study in the Journal of the American Medical
Association found post-market safety events were more common among accelerated approval drugs. These are all taking place against a policy backdrop right now that seems to be favoring getting drugs to market faster. 21st Century Cures made some headway in this, and the FDA has been really prioritizing getting drugs out faster, even under the accelerated approval pathway.

So what are some policy options that this Commission could consider? The first would be value-based purchasing. This could be optional or mandatory, possibly linking payment through outcomes for these drugs. Another policy option would be to require a higher statutory rebate on drugs approved through the accelerated pathway. That could be required until the manufacturer completes the post-approval study confirming a clinical benefit. A benefit of this approach would be to ensure beneficiary access while mitigating costs to state Medicaid program and providing an incentive to manufacturers to complete those post-approval studies.

Finally, the Commission could consider coverage flexibility around these drugs. That's similar to what Massachusetts requested in its waiver that was, of course,
not approved by CMS.

A few things to keep in mind in this space.
Value-based purchasing may not be an option for all of these drugs. Value-based contracts can be difficult to set up, it can be hard to agree on outcomes, hard to validate outcomes, and there are data limitations for some of these drugs. Additionally, coverage flexibility obviously could affect access, and there would probably be concerns about what it means for the bargain that's at the core of the rebate program.

I am now going to turn it over to Chris.

MR. PARK: Thanks, Rick. The next section here is focusing on high-cost drugs, and to kind of set the stage, overall, in Medicaid spending, a lot of the spending trends have been driven by spending on brand drugs. As you can see on the slide, the brand drug share of total claims went down a couple of percentage points, from 2014 to 2017. However, kind of the inverse happened, that their share of total spending, even though the proportion of claims went down, actually went up about 4 percentage points. And this inverse relationship reflects an increase in the average price for a brand drug, which increased...
about 40 percent since 2014, from about $294 per claim to $411 per claim. And that should actually say FY17 on the slide and not '18.

This increase in the average cost of a brand drug is due, in part, to an increase in use and price of high-cost drugs, which we'll see on the next slide here.

This table focuses on the number of claims and gross spending, which is the spending before rebates, on drugs that are over $1,000 per claim. We just kind of chose this threshold. It's not like a formal definition of a high-cost drug, but it was kind of representative of what a lot of people kind of think would be high cost.

As you can see on this table, in 2017, these drugs are only about 1.2 percent of total claims but they made up about 44 percent of total gross spending. And, you know, this shows, in the trend, that the proportion of total claims increased slightly, from 0.9 percent in 2014 to the 1.2 in 2017, but the proportion of total spending increased substantially, from 31 percent in 2014. And also you can see on this table that the average spending per claim went up from about $2,600 to over $3,000 per claim.

And so this price increase reflects not only just
general price inflation for the existing drugs but the
introduction of new high-cost drugs over these last few
years.

High-cost drugs span a wide variety of cases. You know, some are widely used medications such as
antipsychotics, while others are used by a small number of
individuals, such as treatments for muscular dystrophy or
other orphan drug designations. These recent trends in
spending for high-cost drugs are expected to continue in
the future. While there is no official definition of
specialty drugs, a lot of the industry reports have
indicated and project that specialty drug spending for all
payers will continue to grow at rates that exceed the
spending growth for traditional drugs, and most of these
specialty drugs would be considered to have a high cost.
As well, a large proportion of the upcoming drug pipeline
will be for specialty drugs and orphan drugs, which, again,
are expected to be high-cost and really create additional
spending pressure for all payers.

So as far as policy options, these essentially
mirror the policy options we just talked about for
accelerated drugs, but we could expand those concepts to
drugs that exceed a certain cost threshold. You know, value-based payment arrangements could be used. Some of these could be outcomes-based, or another model that has recently been proposed by Louisiana for hepatitis C drugs is a subscription model where they would agree to pay a certain amount of dollars over several years but would have immediate access to an unlimited supply of the drugs up front. So essentially, that would just be kind of stretching the cost over several years, while they would get the drug immediately.

Additionally, high-cost drugs would be subject to a higher statutory rebate. One way you could do this could potentially be to tie it to some independent assessment of economic value, such as the work, you know, like we heard this morning from the DERP group, or ICER, which is another group that does that type of research. And additionally, you could create additional flexibility to either exclude coverage or further restrict use of some of these drugs.

Again, these considerations are all pretty much the same that you heard for accelerated approval, but they would apply to a larger scale. Particularly, you know, we expect manufacturers would be opposed to any higher rebates
since these high-cost drugs are making up the greater percentage of their revenues. And additionally, you know, that could lead to some actions by them to try to increase launch prices or try to cost-shift to other payers. And also any type of coverage flexibility could affect access.

This next part is on the cap on the Medicaid rebate. So it's not quite in the same areas as the other pieces of our presentation but it does come into play a little bit later. And so under the statute, Medicaid rebates are capped at 100 percent of a drug's average manufacturer price. So generally speaking, this cap will come into play for drugs that have a significant inflationary rebate due to large price increases over time. Some policymakers believe that the cap reduces a manufacturer's incentive to limit price increases. Once a drug hits the cap the manufacturer can continuously raise prices without being subject to a corresponding increase in Medicaid rebates.

And so a manufacturer may be willing to basically give Medicaid the drug for free because they're getting about a 100 percent rebate, but could raise prices on other payers substantially without any additional losses on the
A possible policy option would be to remove this cap on the rebates. We have previously mentioned this as an option in prior Commission meetings, among a package of other options. Additionally, this option has gained recent attention as it was included in the administration's blueprint to lower drug prices. Removing the cap on rebate will result in savings to Medicaid through increased rebates. We don't have an official CBO score but we were able to get some summary data from CMS for a quarter, and based on that information, removing the rebate cap would have increased rebates by about $690 million for that quarter.

Also, this policy could create downward pressure on price increases and cause manufacturers to kind of moderate price increases over time, and this would potentially be very helpful to other payers as well. And also this policy may be needed to amplify the effect of other policy options that we may choose to propose, that increase rebates. Increasing the rebates would mean drugs would hit the cap sooner. So removing the cap would allow these other policies to achieve their full effect.
Considerations for this policy, you know, we would expect manufacturers would oppose this policy because it would essentially require them to pay Medicaid for using some of their drugs once they exceed the cap. In response to the administration's blueprint, they mentioned that such a policy would lead to further market distortions. Presumably, you know, they're talking about cost shifting and higher launch prices. Also, this policy doesn't necessarily address all high-cost drugs, just those with large price increases over time. If a drug launched at a high price but only raised prices at or below the rate of inflation, then the cap would likely never be hit and this policy wouldn't have any effect on those drugs.

And so with that we'll turn it back over to the Commissioners. We are particularly interested in any feedback you have on the information we've provided today and any of the options that we've presented that you may want to move forward with, need further research and analysis on. As well, you know, if there are specific data or analysis that would be helpful in making a decision on these options, that would be nice to know.
As an additional point, we just want to bring up the fact that we do have work ongoing to compare Medicaid preferred drug lists, you know, their formulary coverage decisions, as well as utilization management restrictions and see how they compare to other payers, such as Medicare Part D and commercial payers, and we hope to bring that information to you in a future meeting.

CHAIR THOMPSON: Okay. I'll jump off and then, Alan, you join in.

You know, of the different options that you've presented, I'm pretty comfortable with some version of the grace period, just as a practical matter, to allow states to figure out what their coverage rules are going to be and how that's going to operate. And I'm inclined towards lifting the cap, but I'd also like to understand if it's a matter of lifting it entirely or if there's another point at which raising it to 125 percent, you know, or something like that, gives us most of the benefit of that.

So I'm a little uncomfortable with the couple of options that have to do with attacking high-cost or accelerated approval drugs in the ways that we're talking about, because I'm not sure that that's the right
categorization of concern.

The FDA is doing accelerated approval because there is a desire to get drugs onto market faster, to make them more available to people. No doubt, inside of the drugs that are being subject to accelerated approval, just like drugs that are subject to regular approval, there are people who would say that drug isn't very useful or isn't really working as it's expected to work, et cetera, et cetera.

So I'm not sure that the fact that it's going through that process, given the fact that it's identified an acceptable FDA process for determining whether a drug is ready for market, ought to be the distinguishing characteristic that determines what the rebate is, or whether states have to cover it or not, under different circumstances.

And the same with high-cost drugs. You know, as you point out, in that category are a lot of life-changing, life-saving drugs, orphan drugs, and drugs of widespread applications. So I'm just worried that by looking at that category as an entire category that we're mixing a lot of apples and oranges, and that the way that we're thinking
about attacking some of the pricing issues will have negative impacts on access to important drugs that are critical for our population.

So I'd just like to understand a little bit better, maybe at a subcategory level, are there other ways to slice and dice some of those kinds of drugs, in terms of understanding and being a little bit more precise about which drugs we're targeting and for what reason.

I don't have great suggestions for, even if we found the right things that we wanted to target, is it about the rebate amount, is it about VBP, is it about something else? So I'd be interested in hearing about whether there are any other different options that we can think of there. Both of those approaches seem like they could work, but as you point out, VBP will only take us so far on certain drugs, and, you know, increasing rebates, you know, maybe that would be something that we could look at. But I would like to understand some of the impacts and effects of that in terms of what gets returned back to the states, and whether or not that simply just substitutes federal rebates for what states could get on supplemental rebates, in any event.
COMMISSIONER WEIL: Well, you read my notes so I will just very quickly say I think a delay, given that it exists in other programs, is understandable. I think changing payment policy on the basis of approval process is not defensible. Value payment is a lovely idea but it's not ready, and it's certainly not ready for new drugs, because that's part of the problem is you don't have the value proposition. I'm all in favor but I don't think that gets us anywhere. So, I mean, Penny, my notes are exactly the same as yours.

The only thing I'll add is that you quickly noted the denial of the Massachusetts waiver. I think, as a Commission, if we're going to move into this area and we're trying to find more than little things, this is the big question. And I'll put it in the same context as our past discussion about the work requirements, which is this is -- it's complex, it's unclear what the implications of these approaches are, it's got to be done carefully and monitored as it goes. But I think, you know, the excessive caution - - and I don't know the statutory basis for the denial of the waiver for Massachusetts -- but the cautious approach
to something designed to, you know, in an evidence-based way, try to save some dollars in Massachusetts, you know, I think the question of what we can learn from that kind of approach, whether states should be permitted to try that, under what circumstances, I think that's worth exploration, more so than some of -- that's where I would put our energy, as a Commission.

CHAIR THOMPSON: You know, that's very interesting, Alan. I mean, I think it was the President's budget that had a proposal for up to five states to do some rebate alternative program. Was that it?

MR. PARK: That's correct. It had a proposal for five states to do a demonstration, where they would waive out of the rebate program but would have the option to exclude coverage of certain drugs.

CHAIR THOMPSON: You know, I think something along those lines may be something worth thinking about, whether, again, in the sense of recognizing the complexity of the problem and the risks associated with impeding access to prescription drugs for the beneficiary population, to ensure that we have a contained opportunity for innovation and experimentation.
But it also, as I was reading your paper and thinking about some of the areas where we're like, well, maybe this class of drugs we handle differently, and this class of drugs, is there a way to provide a little relief to states where they have some way to create a little bit of maneuvering room for themselves, based on a proposition about specific drugs, specific drug costs, that would, you know, allow them to have a way to vent some steam from the program in a way that allowed to say, well, you know, we want to have an exemption or an exception to the rebate program, or to the coverage requirement for these particular prescription drugs, for these particular reasons. Would that be a more targeted, focused way to address some of the issues that we have concerns about?

In any event, I'm agreeing with Alan that maybe there's some way that some kind of experiment or some kind of ability to give states a little bit of wiggle room is some of what we need to consider her.

EXECUTIVE DIRECTOR SCHWARTZ: That couple well, though, when we have the results of this project, that we could --

CHAIR THOMPSON: I think that's absolutely true.
We need to take that into view, yeah.

Okay. Chuck, Fred, Kit.

COMMISSIONER MILLIGAN: Thanks, guys, for your good presentation, as always. The one that I feel the most aligned to is the grace period issue. I think the panel that spoke in the spring did a very good job of articulating the rationale for that.

My question is, is that a statutory change, regulatory change, and, in general, as we come back to this topic over the next few meetings, the more you could articulate statutory, regulatory, sub-regulatory, you know, is it agency discretion, is it congressional action, that would be helpful, just framing, I think. But with respect to the grace period, does that require statutory change?

MR. VAN BUREN: That's a good question. I believe it would. Yeah, I can't think, off the top of my head, why it wouldn't. So yeah, I believe it will be a statutory change.

COMMISSIONER MILLIGAN: Okay. Thank you.

CHAIR THOMPSON: Fred and then Kit and then Toby.

COMMISSIONER CERISE: Yeah. It's a great summary, guys. Thank you for this. I would agree with
much of what's been said, that a grace period, I think, makes sense. I would tie that to some independent analysis, just because I don't think the state Medicaid programs have the fire power to do these drug evaluations. And, you know, we heard from the Oregon group earlier today, and I think it makes a lot of sense to tie that, because you use the example of the drug that was approved in a trial with 12 or 13 people in a trial. That may have significant cost implications and you would like to hear the experts weigh in on whether you make a drug like that available for wide-open use or what sort of use restrictions that you would put around that.

CHAIR THOMPSON: So you would like to see us say something about what are you doing inside of that grace period, to come up to that conclusion about who gets covered and under what conditions?

COMMISSIONER CERISE: Yeah. And I worry about value-based purchasing arrangements, just because, as others have said, I mean, it can get real gimmicky, I'm sure.

And then the other thing you mentioned, and I actually talked to Rebekah recently about the subscription
program. That's intriguing. And it goes beyond just sort
of smoothing out your expected costs over some period of
time. But the way she described it to me, if I've got my
numbers right, she said they had like 90,000 people with
hep C in the state and they treated 235 in their program.
I mean, it's some dramatic delta like that.

And so the idea would be those people aren't
getting treated anyway, and so if you gave the manufacturer
some expectation that they're going to get some amount --
because they're worried about that going down. As people
get treated, pressure on prices comes down. If you give
them some assurance that they're going to get those dollars
then they would open it up to treat a lot of people who
would not otherwise be treated.

It's an intriguing idea. It seems like you have
to move to exclusivity with, you know, with a particular
manufacturer to do something like that, and it doesn't work
for a lot of conditions. But things that are time limited,
curable, like hep C or vaccines or an outbreak, some things
like that, I think it's an intriguing idea. But I would
also tie that to some independent analysis, somebody
outside of, you know, just state-by-state Medicaid agencies
looking at that.

CHAIR THOMPSON: And is Louisiana seeking -- do they need a waiver to do that?

COMMISSIONER CERISE: She said they're writing a waiver and, you know, writing an RFP. They would need a waiver to do it.

MR. PARK: Yeah, I think if it was solely for the Medicaid population and done under a supplemental rebate agreement, I don't think they need a waiver, but they might need to get the contract approved by CMS, because it might be different than a normal supplemental rebate agreement.

I think where they may need a waiver is they are considering trying to expand that to like the corrections population as well as maybe uninsured individuals. And so if they try to bring some of those individuals in, there may be some need for a waiver to get them under kind of like a Medicaid rebate agreement, that wouldn't affect best price.

CHAIR THOMPSON: Well, I was going to ask about best price implications for an arrangement like that.

MR. PARK: Yeah, if it was just done under like a state supplemental rebate agreement it would not affect
best price. But depending on how many populations are
covered it may have some implications.

CHAIR THOMPSON: Okay. Kit, Toby.

COMMISSIONER GORTON: So I'll agree with
everybody else. I think the grace period idea makes sense,
from a purely operational point of view, either in the
state agency or in the plans. Ninety days is really
pushing it. You know, you've got to hold your breath and
turn blue, stand on one foot and spin around and try to get
it done. And this stuff comes up too often.

So I would argue, from an operational point of
view, if you want to have the kind of evaluation that Fred
is talking about then you need the 180 days. That's the
usual formulary amendment timeline. You have to go in
front of multiple committees on multiple occasion, and the
committees generally meet quarterly. So just 180 days
gives you the time to get all of that done in an organized,
thoughtful, evidence-based way. And so I would suggest
that if we're going to opine on a length of time that it
would be the longer one rather than the shorter.

CHAIR THOMPSON: So for both QHPs and Medicaid,
they review within 90 but make a coverage decision within
180. Is that right?

MR. VAN BUREN: Yeah, that's right. That's for

the --

CHAIR THOMPSON: Presumably we would follow some

existing standard --

COMMISSIONER GORTON: Yes.

CHAIR THOMPSON: -- rather than to put a --

COMMISSIONER GORTON: Well, there's an expedited

standard, right?

CHAIR THOMPSON: And then for Medicare, if you're

in a protected class --

MR. VAN BUREN: Right. Yeah.

COMMISSIONER GORTON: Yes. So I think, as a

general rule, we might want to say, okay, for a protected

class. But as a general rule we should go for the longer

period of time.

Value-based purchasing, interesting idea.

Unproven, right? So let's do some work and figure out

whether it works or not. Nobody's ever shown actual value

over a period of time from a value-based purchasing

pharmaceutical program, and so it might be interesting to

see. But certainly I don't think we're in a position, as
an evidence-based organization, to recommend that we move forward with that.

And then -- what was the last thing I wanted to say? I'm getting too old for this. Oh, with respect to -- I agree with you with respect to the approval processes. FDA's got to do its job. You know, if they're not doing their job, well, then that's FDA's problem. It's not our purview to say yes or no.

I do think that removing the rebate cap is an interesting piece. I personally would be interested, both in the grace period and in removing the rebate cap, in understanding whether it's from a staff estimate or whether it's from actually going to CBO and getting a number, what the saving associated with that would be. I think, actually, a six-month grace period for the Medicaid plans, for these new drugs, my suspicion is that it will result in substantial savings. And that's worth tagging a number to so people understand the cost of the decision that they're making.

I would be interested in seeing the numbers on the rebate cap.

And so those were the things I wanted to say.
CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: So a couple of quick points or questions. Grace period, I'm definitely supportive of that as well. I was wondering, on the analysis on the brand, is there a way to add in the net of expenditures net of rebates for state and federal and then compare that, in part to get to this issue about changing the cap on rebates. It would be interesting to look at, for all brand, and then looking at for the high-costs, net of, and then for the accelerated.

And one concern is when you get into the high-cost and accelerated, the leverage and the ability to get some of these supplemental, state supplementals decreases, and understanding what's going on just with the net of, and how that changes for these different subsets of brand drugs would be interesting to see, to get at, to Kit's point.

MR. PARK: Yeah. So currently we do not have access to specific rebate data for individual drugs. So we might be able to get some kind of high-level summary on certain groupings of drugs from CMS, to try to get a net estimate of like what the rebates are for, like, accelerated approval drugs or drugs that have a certain
cost threshold. But that would require working with CMS to try to get kind of this high-level data. We wouldn't necessarily be able to cut the data in multiple different ways once we got it. We would have to kind of come up with specific groupings so that they could provide that data to us.

COMMISSIONER DOUGLAS: Part of the legislative -- okay. Well, I think this is important, I mean, to really answer this question, or, you know, know what, because, I mean, just again --

CHAIR THOMPSON: If we're making the right slices and dices.

COMMISSIONER DOUGLAS: Yeah, and just qualitative back to what we hear from, you know, medical directors, the leverage. There's just no leverage on a lot of these issues.

CHAIR THOMPSON: And so say more about that. Why --

COMMISSIONER DOUGLAS: Well, I'm thinking back to hep C --

CHAIR THOMPSON: -- certain of these classes, there would be less leverage than in others?
COMMISSIONER DOUGLAS: Well, let's go back to hep C and Sovaldi. So there was no --

CHAIR THOMPSON: Alternatives.

COMMISSIONER DOUGLAS: -- yeah, and it has to be provided. So there's no ability, whether you're a California or you're a consortium, what can you do? They just look at you and say, "Well, we're paying the federal rebate." It's not like saying, "Well, I'm going to go with an alternative class," which happens with a lot of the other brands. So I think being able to illustrate those differences would help on determining the right policy.

CHAIR THOMPSON: Yeah. I mean, I think that that is part of why I think the categorization is not quite precise enough when we talk about some of these categories, because some of these places are, you know, a drug comes on the market and it's coming on through the accelerated approval process because it is an important therapy that isn't otherwise available. Same with a particular specialty or orphan drug, or not. And so distinguishing between those cases seems very important, because it not only goes to the question of delivering good care to beneficiaries, but also the extent to which a state would
have some kind of market leverage to exercise over pricing otherwise.

And so I think those are the hardest cases that we're talking about here.

Okay. I'm very interested in seeing the formulary information, because I think if we can bring that into view as well, maybe that will give us some ideas, as well, as to how to think about some of these cases and where to draw some exceptions or different policies or focus innovations. So that will be very useful.

When, Chris, did you say that you were going to have that for us?

MR. PARK: This project is going in two phases. The first is just looking at the criteria, and that should be done shortly, and we may be able to bring that to you in October, or December by the latest, probably. The second phase would actually be trying to tie that kind of formulary and qualitative information to actual drug utilization. And so like if you have a certain policy in place, does it actually lead to shifting in that particular therapeutic class? And that would probably be done in the spring.
CHAIR THOMPSON: Can we ask, though, because I think I feel like we have an agreement among the Commission about the grace period, and some potential interest in maybe raising the cap, at least. At least on those two issues, can we come back in the next meeting, potentially with the idea of trying to promote some potential recommendations along those lines so that we can dispense with those matters as we grapple with some of these other difficult questions?

Okay. Any final comments from the Commissioners?

[No response.]

CHAIR THOMPSON: Any final comments from the public?

### PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: We are adjourned, and we'll see you tomorrow.

* [Whereupon, at 4:39 p.m. the meeting was recessed, to reconvene at 9:30 a.m. on Friday, September 14, 2018.]
PUBLIC MEETING

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

Friday, September 14, 2018
9:40 a.m.

COMMISSIONERS PRESENT:

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

ANNE L. SCHWARTZ, PhD, Executive Director
Session 8: Managed Care Oversight

Moira Forbes, Policy Director

Session 9: Oversight of Upper Payment Level (UPL)
Payments: Additional Analysis and Policy Options

Robert Nelb, Principal Analyst

Session 10: Mandated Report: Therapeutic Foster Care

Martha Heberlein, Principal Analyst

Public Comment

Adjourn Day 2
CHAIR THOMPSON: Okay. We're going to kick off today's meeting with a conversation about managed care oversight, and Moira Forbes is going to lead us through this conversation.

#### MANAGED CARE OVERSIGHT

* MS. FORBES: Thank you.

So it's been a while since we've talked about managed care generally, so here's what we'll cover this morning -- a little bit of background and context, just to remind you of what we've done and why we're talking about this today; the purpose and framework for managed care oversight specifically. We'll talk about the oversight approach in a few key areas, and then I'll remind you of some of the policy questions that the Commission has raised.

So a little context for why we're talking about this now: Commissioners have raised questions about the adequacy of managed care oversight as part of streamlining conversations that were held earlier this year, also just as the general importance of the issue, given the number of
enrollees receiving care under managed care arrangements. You may have also seen the state oversight processes and accountability mechanisms are receiving a lot of media scrutiny in a number of states. CMS is continuing to issue guidance to states on implementing the 2016 rule, although it has also indicated that it may propose changes. Our understanding is that a Notice of Proposed Rulemaking is under review at OMB right now.

So the Commission has previously raised, but not answered, several policy questions, such as how do we assess compliance versus performance and what data are needed for oversight. But rather than take on managed care oversight as a whole right now, we suggest examining four areas that correspond to issues the Commission has previously raised, which are appeals and grievances, network adequacy, readiness, and care for populations with complex health care needs.

To begin with, I'll just restate why managed care has its own oversight framework. Over the past 20 years, Congress has amended the Social Security Act to provide new flexibilities for states to use managed care and also to
spell out specific mechanisms for the federal government to hold states accountable and for states to hold MCOs accountable for the services they've agreed to provide under capitated contracts.

CMS then published rules to implement the statute and create a comprehensive regulatory structure that applies across the multiple authorities states can use to implement managed care.

The accountability tools provided for in statute and regulation include standards such as quality strategies and access standards; the various assurances that are documented in state plans, waivers, and contracts; prospective reviews such as readiness and rate-setting reviews, ongoing performance monitoring; and retrospective reviews including external audits and encounter data analysis.

So over the next few slides, I'll walk through how this plays out in the four areas I mentioned before and a little about what we know about how the current rules support effective oversight.

Managed care has its own procedures to authorize services. MCOs and primary care providers are responsible
for determining whether enrollees need specialty or ancillary services and managing the service authorization process. If the MCO denies a service or authorizes fewer services than were requested, there are procedures enrollees follow to appeal the coverage decision within the MCO, and if it is not resolved, the enrollee can then access the state process.

Federal rules require MCOs to establish specific processes. So there is a lot of consistency across states in the timelines and notices. The rules also require states to provide oversight of the process.

Grievances and appeals can suggest problems with access or quality care. Some of the specific metrics that can be used to monitor this include the type, numbers, and reasons for grievances and appeals, which you can look at by MCO, by population; whether grievances and appeals are resolved within required time frames; the number of grievances that are later reversed on appeal; the number of appeals that go on to state for hearings and so on.

However, there aren't any federal requirements that states collect or use any of these specific grievance and appeals metrics for oversight or for program monitoring.
activities. States have flexibility in what they require
MCOs to report, how often they need to report it, how the
data are analyzed, and what form the data are made public.

We see a lot of variation among states in how the
data are used for oversight. They conduct routine
monitoring. Some do focused quality studies using
grievance data to identify quality-of-care issues. They
use it for assessing compliance with federal and state laws
and regulations. Some use it for public reporting.

Just one example, Iowa publishes quarterly
performance reports that include summary data on grievances
and appeals, including the percentage of grievances and
appeals resolved within 30 days, the top reasons for
grievances and appeals, and the number and reasons for
state hearing requests. And they break all that out by
plan.

But little is known about how states use these
data to identify concerns or follow-up. Not one has looked
sort of across states for this. Many of the state reports
we see are mostly descriptive, and they don't indicate how
the states monitor trends, identify concerns, or follow up
with the plans.
It's possible that we may have better information in the future. The 2016 rule requires states to develop a comprehensive quality strategy. Those were due to CMS by July 1 of 2018, so they were just due this summer. The plans must include goals and objectives and a description of quality metrics and performance targets. I looked at a few of them, and they did discuss using grievance and appeal data. So they may be a useful source of information on how states will use these data to monitor and improve performance. They were just due this year. So the first information on how states are using the data and actually reporting on them won't be available for a few more years.

In terms of network adequacy, MCOs are required to provide access comparable to that in fee-for-service. To demonstrate that they meet this, states must have network standards, and MCOs must document that they have adequate networks.

Some of the metrics include showing that they have the capacity to serve the expected number of enrollees; that they provide an appropriate range of services; and that they have a sufficient number, mix, and geographic distribution of providers.
More detailed rules for Medicaid managed care networks went into effect on July 1st of this year. For example, states must now have time and distance standards for several specific provider types.

Each state is allowed to develop its own standards and approach. CMS declined to develop national standards. It allows each state to set its own time and distance standards and ratios. This approach allowed CMS to sort of standardize the processes while still promoting state flexibility by allowing each state to have its own standards.

A variety of data and reports, again, can be used to monitor compliance and access to care. These include geomapping, encounter data analysis, provider participation reports, enrollee surveys, enrollee and provider complaint data analysis, secret shopper studies, and a review of authorization and referral data.

A lot of these approaches are costly and time-intensive. They may require frequent data from the health plans.

Mathematica developed a tool kit to assist states in developing access plans, and they looked at what states
are doing now. They found that states use, of course,
different combinations of these tools at different
frequencies. They also found that there's really no
standards or best practices for how they should be used to
monitor network adequacy. The hope is that as these plans
go into effect, CMS may be able to learn which state
methods result in better access outcomes. Again, so it may
be a few years before we have better information on this.

We also note that states have conflicting goals
for network adequacy oversight. While they must ensure
that MCOs comply with their contractual obligations,
states' immediate object is really access for enrollees,
often in the immediate term.

So when network deficiencies are identified, many
states prefer to work with the MCO to resolve the access
problem first rather than address it as a contract
compliance issue.

Readiness is an important oversight issue when a
state implements a new managed care program or makes major
changes, such as when a new contractor enters an existing
program or when the state adds new benefits, populations,
or expands to a new geographic area.
CMS and states conduct pre-implementation MCO readiness reviews that assess the ability and the capacity of the MCO to perform in major operational areas, ensure that they are prepared to comply with program and contract requirements, and that they are ready to deliver services to enrollees.

Before 2016, readiness reviews were typically required as a waiver condition. Since 2017, they have been required by regulation.

There's a mistake on this slide. It's actually a significant mistake. The process must include both desk and on-site reviews.

Darin and I were talking yesterday. He couldn't be here today, so he shared his notes with me on this presentation. It says that the findings must be submitted to CMS at least three months before the effective date.

Actually, the requirement in the regulation right now is that the review must be started at least three months before the effective date and must be complete in time to ensure a smooth implementation.

And what Darin and I were talking about is that the timeliness of the readiness review is really actually
the key aspect of the readiness review. Readiness isn't really a check-the-box kind of activity. If it's not done well, then you don't really know if you're ready. So that's an important correction I should make because the timeliness of the review and sufficiency of the review is really important.

It is submitted to CMS as part of the contract review process, and CMS can delay the program implementation date based on the readiness findings.

While states, of course, can and do conduct readiness reviews for many aspects of their programs, the federal requirements do focus mainly on the MCO readiness. It is worth pointing out that some of the other aspects of program operations that have been problems in some of the states that we have recently been hearing about are some of those areas that aren't addressed in the regulations, such as enrollment broker readiness, state staff training, provider education, member education, and identifying enrollees with special health care needs who require care transition planning. There is nothing in the regulation about state readiness, for example.

The last area is oversight for MCOs to enroll
individuals with significant or complex health care needs. Managed care enrollment may be advantageous for people with disabilities when plans take responsibility for coordinating care and ensuring that enrollees can access a range of needed services.

However, certain aspects of managed care, including defined provider networks and incentives to contain costs, may counteract these objectives. For these reasons, there are significant federal rules in place to protect the best interests of persons with significant or complex health conditions. These include provisions relating to access to care, continuity of care, standards for timely referral, and expedited authorizations.

Federal rules specify a lot of these beneficiary protections; for example, the requirements for MCO networks specify that the network must be sufficient for all enrollees, specifically including those with physical and mental disabilities. Federal rules also detail care coordination and continuity of care responsibilities, including ensuring that enrollees have an ongoing source of care appropriate to their needs and access to full a range of community support services. However, again, the rules
say very little about how a state should monitor compliance and performance or how a state should respond to any problems.

A quick review of state data showed variation to which states collect data in a way that supports oversight of the care provided to individuals with significant or complex health care needs. We saw that some states show utilization or grievance data broken out by population, risk or acuity score, diagnosis. We found a state that specifically monitors and reports on utilization of care management, that reported on out-of-network referrals, things like that.

Again, this was a very quick review. It was not a comprehensive study, but some states are specifically looking at some of these things, and other states do not appear to.

Prior MACPAC research: we did a study a few years ago looking at contracts, contract provisions specifically around children with special health care needs, and found that while states are likely to include protections for individuals with significant or complex health care needs in their contracts, they are more likely to include the
specific provisions when there's a federal requirement to include specific language.

So the Commission has raised several policy questions in prior discussions about managed care oversight including, How do we balance between flexibility and control? Where are national standards appropriate, and where is state variation acceptable? How do we assess performance versus compliance? Where is process review sufficient? Where is outcomes monitoring valuable? What data are needed for oversight? What metrics should we use? When is self-attestation sufficient, and where are external audits needed?

It would be helpful for staff to hear from the Commission about the types of information that you would find useful in assessing the adequacy of oversight in these areas and then forming any action steps.

As I noted, as I've gone through the slides, we've done some quick reviews of online information. Some things we could do would be conduct interviews with a variety of states. We could do a roundtable. We could review contracts, other types of qualitative research that might shed some more light on the issues and concerns with
managed care oversight.

We do remember your caution about focusing on the practices of the high-performing states because of the unique focus in history on those states. Darin did remind me of that yesterday.

But if there are other research approaches you suggest, particularly that we could pursue in the short term, we certainly welcome your thoughts.

CHAIR THOMPSON: All right. Wonderful. I think this is such an important topic, and I think we spend a fair amount of time talking about payment issues. And I think this is central to our access agenda in thinking about how beneficiaries served in these particular settings and whether or not we have the right kind of confidence and the right kind of action to respond to information.

So I'm very happy that we're taking on this work, and I think largely, you've hit the mark in terms of both what we've talked about in the past and what I think is a way to shape the conversation and the research so that it's not boiling the ocean of everything that a managed care plan does or everything that a state does in contracting with and overseeing managed care.
I'll just make a couple of comments and then open it up for other Commissioners to weigh in.

I just want to be sure that as we do this work, we think about both contract language, service-level agreements, and enforcement. I mean, I think that in all of these areas, we should be looking at what does the contract require a plan to do, how does a state know whether the level of performance is meeting contract expectations, and if there isn't the result that's expected or the service level that's expected, what action is available for the state to take.

I also think that it's useful to -- one of the areas that I think we should pay some attention to is people can have a lot of data, but it doesn't necessarily trigger action. And I think that if we think about action, then it's easier to trace back to the pieces of data that you need in order to actually change something.

So instead of just saying, well, we need lots of reports and we need lots of data, it is what would tell me -- I think the key question for a state is what would tell me that something has gone awry inside of a plan and I need to intervene or I need to ask more questions or I need to
take some kind of action, and I need to have the tools available to do that. But I also first need to know that that's a level of concern that I need to be responding to. And so I think the early warning -- Stacey has talked about on the appeals and grievances, making sure that we think about complaints as well, but it's not just about looking at the results of that process, but also how that gets looked at in terms of what level of concern do I have with a certain kind of complaint or grievance or appeal by a certain kind of beneficiary relating to a certain kind of service, and when do I step in and start asking questions of a plan, when do I start wondering whether the plan is performing as required? I do think there has been increasingly better information accumulation by states, but I still think there's always this question of what am I doing with that information and do I have an idea in my head about why am I looking at a piece of information and how I should be interpreting it and responding to it.

All right. Let me open it up for other commentary or questions.

Bill.
COMMISSIONER SCANLON: Thanks very much. That was very helpful, and I agree that this is a very important topic.

Let me start with your last slide where you talked about the balance between flexibility and control, and I actually think there's a precursor, which is accountability. I'd be very happy to a grant flexibility as long as I knew there was accountability for delivering the services and the care that we are expecting, and I'm not sure that that expectation is a control as much as it's an expectation, "We're going to let you approach this the way you choose as long as you deliver what is required sort of for beneficiaries."

Part of that is -- a key part of that is reporting, and from some of the examples that were in the write-ups, we've got examples where the reporting has turned out to be false or flawed, and so there's a real important thing, I think, on the part of CMS to be looking behind the information that they're getting, to feel confident that this is reporting sort of what is actually sort of happening on the ground because that's key in terms of serving this population of people that in many cases are
sort of disadvantaged in terms of getting these services on
their own.

And that leads me to my second question, which is
maybe also could turn into another comment, and that goes
to the appeals and grievances and how good of a measure
that is in terms of performance.

What I am concerned about is the ability of
people and particularly people with disabilities to
actually take advantage of a grievance and appeals process,
to know what their rights are, and to be able to then
pursue them in a way that they're going to show up in these
statistics that we're going to use to monitor whether or
not there has been performance.

And this is a comment, and I'll put it in context
so that you don't think I'm criticizing managed care. This
is coming -- I've heard this many, many times from the fee-
for-service side. What beneficiaries will be told -- and
it's not just Medicaid, but it's also Medicare-only
beneficiaries. What they'll be told is "Medicare,
Medicaid, CMS won't let me do that. You cannot have that
service," and I can tell you that there are a number of --
many occasions when I know for a fact there is no
Medicare/Medicaid rule against that service being delivered. It was a provider choice to not do that. And so there's this issue that I think is important of beneficiaries being given the information that they know what they should be expecting, so that they can act, before we can really rely on their filing a grievance or a complaint even and use that as a sole measure. So I think that's an important part to look at that.

So I guess the question part there is how much has been done to look at sort of the education process for people as they're enrolling sort of in managed care, particularly people whose circumstances are exceptional? I mean, people with disabilities, where it's not just "These are your services. You're entitled to physician care. You're entitled to sort of inpatient care," et cetera. It's like we need to give them more information about the kinds of services that they are both entitled to and need.

Thanks.

CHAIR THOMPSON: That's a good point, Bill, and I think there are ombudsman requirements especially for long-term services and supports.

Is that right, Moira?
MS. FORBES: There's a -- I don't know if it's
ombudsman. I mean, there is a requirement that there be an
independent enrollment broker.

CHAIR THOMPSON: No, I'm thinking of something
different.

I do think that this is a little bit back to
Stacey's question about complaints too, so in addition to
making sure that we're not overly defining the process as
the exercise of rights, that we're looking for pockets of
information that may exist in a variety of different places
that may be indicative of problems associated with
accessing services.

COMMISSIONER SCANLON: I'm not sure how exactly
the ombudsman relate to managed care in Medicaid, but in
looking at an ombudsman with respect to sort of nursing
home care, there are ombudsman in every state that perform
a function to provide oversight.

The reality is, though, the resources are so
sparse relative to the potential in terms of how much
oversight should be done that it's very thin protection.

CHAIR THOMPSON: Kathy, you want to jump in on
this point?
COMMISSIONER WENO: Yeah. I was a Medicaid
ombudsman for a number of years, and I would actually
confirm a lot of what you're saying, where about 90 percent
of the MCO appeals and fair hearings that I was involved
with would settle, and so none of the data that you would
be looking at would be reflective of what the true problems
were with Medicaid. I would see the same things again and
again that would never go to hearing or you could resolve
within the MCO.

CHAIR THOMPSON: So say a little bit more about
that again. That just may be something that we can ask the
staff to be looking for. It's almost like before you get
to an appeal?

COMMISSIONER WENO: Absolutely. Well, it's just
like any type of legal proceeding where you are trying your
best to resolve the problem for the individual beneficiary.
So a lot of the trends and things wouldn't show up in the
data because you could point out to an MCO that their
contract was X, and they were not meeting that, and they
would agree with you, whereas they would not probably say
the same thing to the beneficiary.

CHAIR THOMPSON: Stacey.
VICE CHAIR LAMPKIN: Yeah. And that's exactly where I've raised the issue of complaints before. It's been exactly that point, and maybe the question is better more generalized: What are states doing to monitor at the front end? What are their early warning signs that there's an access problem? What are they doing for that? Maybe it's an integrated complaint system. Maybe it's an ombudsman process, but what are they doing, and is that effective?

CHAIR THOMPSON: And I think to also give credit to Bill's point, if we believe that one of the problems may be beneficiaries don't even know they can argue the point, then what are the other mechanisms to compensate for that potential problem, and what are the kinds of systems that you put in place, whether that is beneficiary, interviews, or secret shopper? What are the other ways that you can acknowledge the limits of that system to give you the information that you're looking for, and how do you adjust for that?

Okay. I think Martha was coming in. Then I've got Chuck. Then I've got Brian.

COMMISSIONER CARTER: I think I'm coming from the
transparency issue, again, from the bottom up. As an organization that contracts with managed care companies, I think the transparency is lacking, in terms of how they're taking care of our patients, you know. I can't really, at this point, as far as I know, find out what sorts of complaints our patients have had with MCOs. You know, we can't steer patients to any particular MCO. But, at the same time, in our contracting process we have some flexibility in terms of what we're looking for and whether we contract at all.

So I would like to hear more about what are the transparency requirements and what's accessible to health care providers and patients as far as those reports.

CHAIR THOMPSON: So Martha, you're suggesting that in addition to thinking about how does a state oversee a plan, how does the state make some of the information available to create the right kind of market forces, if you will, to reward the high-performing plans. Okay.

All right. We've got Chuck and Brian.

COMMISSIONER MILLIGAN: One of the other areas, to me, is the federal oversight of the state. I mean, I think we're focusing here on state oversight and state
readiness, and all of that, early warning signs. But as you sort of introduced this, Moira, you were sort of framing it as with waiver reform in our previous work. Do we have the right balance in terms of oversight of states? And I think that's part of this framework that we need to talk about.

A couple of things come to mind about that. One is, I think one of the major areas, and we've seen this disruption in Iowa, as an example, is plan withdrawal, big disruption to members, big risk to members. And I think underlying that -- and people can have kind of different opinions about it -- but kind of the adequacy of the way in which the rate setting is done. So on the one hand, do MCOs go in with their eyes open, that the rates are low, but on the other hand, what is the state obligation in terms of adequacy of the data book and rate bids and all of that stuff. So I think part of the member protection here is federal oversight of payment too.

And the second to me is whether or not it should be phased in, how it should be phased in, do you need to kind of walk your way in or can you go statewide with all populations, all of that quickly?
So I think -- and others might have other ideas about that, but I think, to me, part of the framing here is if it's going to be simpler for states to get approval to do managed care, what is the federal role in the oversight of it, even if it's a SPA, waiver, or whatever.

The second thing, and I want to kind of come back to the complaint comment. Let me give an example in my own organization. We've got a vendor that was delivering a service, and we were looking for complaint data related to that service from that vendor. And what they were sending us, we thought, was under-reported. And when we got underneath it, what they were sending us was what they perceived to be substantiated complaints, as opposed to all complaints.

And there's another example, in terms of provider network, which is providers sometimes don't realize they're contracted for Medicaid and they will say, "No, I'm not a provider of that service." Sometimes what that raises, then, is an intervention is required to do education.

And so whatever form the feedback is coming in, I would think the more raw the data is, in certain ways, I think all complaints matter, substantiated or not, as an
indicator of not just is there a problem, in terms of the underlying delivery of the service, but is there a problem in terms of education and outreach and information.

And so if we get into the complaint area, I just want to raise for you the nuance that folks might only report so-called substantiated complaints, and I think that that's insufficient to do oversight.

CHAIR THOMPSON: Brian and Sheldon.

COMMISSIONER BURWELL: I'm not sure where to go with this, but I would like for our work in this area to acknowledge the diversity of managed care types of programs, and how oversight requirements may vary according to managed care type. For example, behavioral health managed care. How should oversight requirements vary for managed care programs that just cover behavioral health services? And the area of that is just emerging. In most states, persons with intellectual disability have been carved out of managed care initiatives. But I know a number of states are considering having specialty plans for that population, which, obviously, has very different needs and very different oversight responsibilities.

I'm not sure how to bring this into our work, but
I think we just need to acknowledge that managed care is not just medical managed care. There's a real diversity of plan types that states need to oversee.

CHAIR THOMPSON: Sheldon, then Stacey.

COMMISSIONER RETCHIN: I think this is just a terrific area, Moira. I'm really pleased that the Commission is continuing to press on not just the MCO issue but also just access in general. I continue to remind all of us that that's in the name of the Commission.

So maybe you could help me out on this, and I don't think that -- I think the MCOs are really a bellwether. Like Bill, I don't know that there's that much difference between the MCOs and fee-for-service. There may be. But certainly in the area of transparency and being able to follow actual delivery of care, it's much more difficult to follow that within the MCOs.

So in the last, I guess, now, three years, the Medicaid program has seen a growth of about 20 percent in enrolled beneficiaries. I can't really figure out where they all went for providers. So let me ask you, in terms of the context of MCO oversight. Were there any changes in expansion states, in terms of their network adequacy
standards, as a result of expansion?

Let me bring it slightly --

MS. FORBES: I mean, I don't know. It's
certainly something we can look into. I don't remember any
states expanding particularly, like expanding the number of
MCOs particularly because of the Medicaid expansion. I
don't know why they would have changed their standards.

COMMISSIONER RETCHIN: So I shouldn't -- maybe
there's a metaphor here that a surge in grocery stores,
unfortunately, in front of a hurricane, but the shelves
will be depleted very rapidly. But with a 20 percent
growth they use the same network and just said, "We assume
you have capacity." How do you measure that? I just don't
know how you administer that.

MS. FORBES: No, it's certainly a question we
could -- I mean, that's a -- it's a question we could look
into.

CHAIR THOMPSON: Stacey.

VICE CHAIR LAMPKIN: Yeah, thanks. I'll be
brief. Thanks, Moira. This is really helpful, I think.
These do feel like four very good areas for us to explore,
and the policy questions are interesting. The early
warning thing was a point of feedback that I had, that we already talked about. And the other one, I think, is just to echo Penny's comment about enforcement, because that's part of the foundation that I think that we need to understand to address some of these policy questions, is just to understand to what extent states are enforcing contract requirements with their MCOs and what are the barriers to enforcement when they're not enforcing them, would, I think, also be a useful question. Thanks.

CHAIR THOMPSON: Okay. All right. Toby.

COMMISSIONER DOUGLAS: The only other policy question kind of relates back to our discussion yesterday, is around administrative capacity and just how are states -

CHAIR THOMPSON: Thank you, yes.

COMMISSIONER DOUGLAS: -- developing the right administrative capacity to react and appropriately enforce.

CHAIR THOMPSON: Yeah, Fred.

COMMISSIONER CERISE: Just one other quick one. We talked about early signals and I'm not sure -- the complaints is kind of late the game so just a plug for, you know, testing of the attestations and the network adequacy,
and are they delivering what we say we're going to deliver
before we get to the complaint stage.

CHAIR THOMPSON: Okay. Good. So, Moira, I know
that, you know, part of this is we're trying to focus, and
we keep broadening, right, but that's what the Commission
does.

I just wanted to pick up on a couple of points
that have been made in this conversation. So whether or
not we call it focusing on appeals and grievances, maybe we
should be thinking about the data that is the early warning
system, you know. And so where does that data reside? Who
has it? Is it sufficient? Does it tell us what we want to
know? Maybe that's a way to think about that part of the
question that you're posing.

I do think that, then, on top of this is this
state administrative capacity. How is the state organizing
itself? Does it have the right resources? Does it have
the right approach to thinking about this as a delivery
system, as a contract, et cetera. And then, you know,
underneath all of this, I think, is a desire to especially
focus on beneficiaries with complex health care needs or
substantial health care needs. And so maybe that's a
window of how we look at these issues, in general, in terms of oversight.

I want to also come back to Chuck's point. We have been talking about trying to focus this just because this is a big subject, but in terms of how are states overseeing plans. But I think it is worthwhile to remember that we do have a federal regulation that is under review, that we will want to be commenting on. I think we should keep our eye on that.

We should keep our eye on this question of whether or not some of the kinds of problems that have occurred in states with plan withdrawals or with particular concerns being expressed by some families and beneficiaries about the level of service that's been approved for them, whether that is rooted in fundamental issues of rate setting. And so I think we should be also conscious about making sure that we believe that there is a regulatory schema that helps ensure that underlying resources are available for plans to be successful within the states.

Any final commentary on any of that?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just wanted to comment for Commissioners. You have a lot of
ideas and thoughts about things that we want to know. So I think we are going to, at the staff level, have to go out and figure out how we're going to learn those things. So that will not be something we will come back to you with the answers to these in October, December. It's going to take us some time to go out and get this information.

So I would just say, I think we have enough now to go write a scope of work, but then we'll have to let a contract to do some of this. So just hang tight and, you know, we'll deal with the NPRM when it comes out. But on this I think it's going to take us a while to gather the information, to have a next productive conversation about it.

CHAIR THOMPSON: Yeah, and I just want to encourage you to think about whether it splits into parts, so that we're looking at different aspects of this in pieces over time. I think there are some opportunities for that here that I'm sure that you'll be able to take advantage of.

I think it's clear from the Commission's conversation that the idea that there needs to be a robust system of collecting and using data for action around
beneficiary access is really an important part of success for the program, and ensuring that there's an appropriate set of levels of review and oversight by the state and the federal government with respect to that, I think, is certainly the case. And we just want to be sure that as we're examining this, we're thinking always about what some of those most efficient and most rewarding places for investment are.

Okay. Thanks. Let's go ahead and move on.

CHAIR THOMPSON: And we have Rob back, because we cannot get enough Rob, to talk about upper payment levels.

### OVERSIGHT OF UPPER PAYMENT LEVEL (UPL) PAYMENTS:

ADDITIONAL ANALYSIS AND POLICY OPTIONS

* MR. NELB: Great, thanks. Yeah, just when you thought you were done with hospital payment I'm back for more.

Today I'll be focusing in on of oversight of UPL payments, the upper payment limit.

For today's presentation I'll begin with some background on UPL rules, and share some of our latest findings from our review of hospital-specific UPL data that CMS shared with us this summer. So this complements some
of the state-level data that I had presented in the spring and allowed us to get a closer look at how the UPL is being calculated in different states. And I'll focus on some of the concerns that you raised in the spring meeting around data completeness, UPL compliance, and the methods that states use to calculate their Medicare payment estimates.

In addition to reviewing this hospital-specific data, we spoke with CMS and state officials about barriers for improving UPL reporting and compliance, and so I'll share some of those findings, and finally conclude by discussing some potential policy options to improve UPL oversight.

So first some background. The UPL, as you will recall, is an upper limit on aggregate fee-for-service payments for a class of providers, and it's based on a reasonable estimate of what Medicare would have paid for the same service. If a state makes base fee-for-service payments that are below the UPL, then the state can make UPL supplemental payments to make up this difference.

States are allowed to make UPL payments for a variety of providers, including hospitals, nursing facilities, and physicians, but the vast majority of UPL
payments are for hospitals, so more than 75 percent. And so we're going to focus our analysis today on hospital UPL payments, which are also the only ones that we have facility-specific data for.

In order to demonstrate compliance with UPL requirements, states are required to submit UPL demonstrations annually to CMS. These demonstrations include hospital-specific data on base and supplemental payments that states make as well as estimates of what would have been paid according to Medicare payment principles.

As I mentioned, earlier this year we had some state-level data for '14, '15, and '16, and then in the summer we were able to obtain hospital-level data for state fiscal year '16 for 47 states and the District of Columbia. We had, of course, initially collected this information as part of our long-term hospital work plan, just trying to better understand these payments and how they were distributed, but as we were reviewing them we identified some more urgent concerns around UPL oversight, that I want to focus on today.

First, when we're doing the hospital-level data,
we identified several concerns with data completeness. In several states there were missing payments, particularly missing data on the UPL supplemental payments that states make. We're not exactly sure why the data is missing but one potential reason is that several states submit their UPL demonstrates prospectively, and that may be before they finalize their payments for the year under review. So a state may kind of do the UPL calculations to figure out what their UPL gap is and then later they use that to figure out the UPL payments they make, but in several of the states they never actually put the UPL payment data in their UPL demonstration.

In addition, we identified several missing hospitals in about half of states. Unfortunately, the hospital-level data that we got didn't have the right identifiers to sort of match it with other sources, so we can't really say too much about the specific hospitals that are missing. However, we do know that many of the missing hospitals are government-owned hospitals, and we know that CMS doesn't require states to submit UPL demonstrations for hospitals that are paid on a cost basis. So that might explain some of the discrepancy. However, when we matched
the data with our own compendium of sort of which states pay hospitals on a cost basis, we found that there were -- it didn't really explain all the discrepancy, that there were some states that didn't pay on a cost basis, that were still missing a lot of hospitals.

So to better understand some of this data that's missing and how the spending compared to actual spending, we looked at the data on the UPL demonstrations and how it compared with the CMS-64 expenditure reports, which were the data on the actual spending that was made. Based on your feedback at the April meeting, we made several adjustments to the 64 data to try to make it as comparable as possible. So looking at the same state fiscal year and also making adjustments for various prior period adjustments.

However, the data aren't perfectly comparable. One key difference is that UPL demonstration data is based on the date of service, while the expenditure reports are based on the date that the payment was made. And then there are some other technical issues. For example, UPL demonstrations exclude crossover claims for patients who are dually eligible for Medicare and
Medicaid. But on the 64 data, we can't exclude those payments.

Overall, when we did -- I made these adjustments and did the comparison, we found that actual spending on the 64 exceeded UPL demonstration projections in most states.

So this figure shows the spending reported on the UPL demonstrations compared to the 64 spending in state fiscal year 2016. You can see that there's quite a large difference. So overall the 64 spending was $10.8 billion higher than what was reported on the UPL demonstrations.

The biggest discrepancy was for supplemental payments. Part of this could be due to some of the missing supplemental payments, but we also found large discrepancies even in states that did report their supplemental payments, that there were still -- the actual spending was higher than what was reported.

In addition, we also observed large differences in base payments. Some of this may be due to some of the missing hospitals. But some of it could also be if actual utilization was perhaps higher than what states projected.

Overall, these findings raised several concerns
about UPL compliance in several states. So in some states, even though the actual spending was higher than what was projected, it was still below the states' UPL that they calculated. However, in 16 states that reported, UPL spending exceeded the UPL gap on their demonstrations. And, overall, the UPL spending in those states exceeded the UPL gap by about $1.5 billion in the aggregate.

When we then compared total base and supplemental payment spending to the UPL, we found that even more states exceeded the UPL, so 27 states in this case, when we did this method, they exceeded the UPL by about $4.7 billion in the aggregate.

As I mentioned, because the base payment spending we found was a bit higher than what states projected, that could be due to increased utilization, and so we also looked at this another way, kind of giving states the benefit of the doubt and assuming that with increased base payments that their UPL gap might increase as well. Doing that method, we found that 12 states had base and supplemental payments that exceeded the suggested UPL amount, and the amount was -- they exceeded the UPL by about $2.1 billion in the aggregate.
Lastly, we also used the hospital-specific UPL demonstration data to examine some of the methods that states used to calculate the UPL. Currently, CMS provide states with several methods that they can use, including cost-based methods, which are higher than what Medicare currently pays hospitals.

In 2016, about half of states used a cost-based method for inpatient hospital UPLs, and most states used a cost-based method for outpatient UPLs.

One other quirk of the cost-based method is that states can increase their UPL to account for the provider taxes that hospitals pay. Although most states do have provider taxes for hospitals in place, we found that only a few states actually reported these adjustments on their UPL demonstrations. And in the aggregate, the amount of these adjustments was less than 10 percent of the UPL amount.

So to better understand some of the barriers for improving UPL reporting and compliance, we spoke with CMS staff, and we also spoke with state officials in three different states that used a variety of different methods for calculating the UPL. From both state and CMS officials, we heard some common challenges.
First is the fact that there are different reporting processes used for the data that go into the UPL demonstrations versus the data that go into the CMS-64. So states get the UPL spending information from their Medicaid Management Information Systems, MMIS systems, which, as I mentioned, you know, record claims based on the date of service rather than the date that the payment was made. And there's little process to sort of reconcile the data between these two sources.

Second, some state officials noted that there was a bit of confusion about the UPL requirements, so this is a new process that CMS has put in place, and there's been sort of several revisions to the CMS guidance. And so that in the earlier years, there was some confusion about what to put on what line and different things.

There is a standardized template now in hopes that this will get better as states have more experience with it. But, you know, there's still more guidance that probably could be helpful.

And, finally, states noticed that -- mentioned that they really haven't received much feedback from CMS about their UPL calculations, and CMS noted it doesn't
really have a process in place to certify the data that states submit. So as a result, states, you know, they submit these calculations and then make payments based on them, sort of assuming that their calculations are correct. But there isn't a process to sort of check it in any way. CMS for its part noted that they don't feel they have the resources necessary to fully audit all the state data, and particularly don't have the information to verify whether the state data is correct. And for their part, they'd prefer if there was some sort of independent entity or some other way to help them in their review.

So I've highlighted a number of concerns here around oversight of UPL and wanted to outline a couple policy options just to jump-start your conversation today.

First, to address some of the concerns that UPL spending appears to exceed the state-calculated UPL gap, CMS could monitor actual UPL spending relative to the UPL gap calculated by states, and this could be done through a change to the CMS-64, so the same way that DSH payments, for example, are tracked in the 64 against state DSH allotments, you could track state UPL spending relative to their calculated UPL amount.
Second, to address some of the larger concerns that overall base and supplemental payment spending exceeds the UPL, CMS could review UPL compliance retrospectively using actual data for the year rather than state projections of what the utilization might be for the year.

And, finally, to address concerns about the cost-based methods that states use, CMS could require that states calculate the UPL based on actual Medicare payment methods. If the UPL were calculated based on actual Medicare payment rates, it could potentially be possible in the future for CMS to calculate the UPL for states using claims data from T-MSIS or others. But it's probably a bit challenging to do that right up front.

So that concludes my presentation for today. I look forward to your feedback on some of these options as well as ideas for any other policy options we should consider. If there is interest in Commission recommendations in these areas, we can further develop policies of interest and prepare specific recommendation language for you later this fall. Thanks.

CHAIR THOMPSON: Thank you, Rob.

I'll kick things off. I'd like to separate two
things, one thing which is, is the calculation of the UPL and the method for doing the UPL proper? Could it be improved? Could it be simplified? Versus there is a UPL but we don't use it, and it doesn't have any impact on expenditure reporting.

So in that latter category, there's a couple of things I want to ask about. One is states certify their expenditures. How do states know -- so a lot of our conversation is about the fact that CMS doesn't know whether the expenditures are consistent with the UPL. How does the state know whether the expenditures they're claiming are consistent with their UPL?

MR. NELB: For what it's worth, the states we have talked to had the perception that their payments were consistent with the UPL, but these sort of calculations sort of happen in a separate part from the people who actually sort of make the payments.

I do think they use these calculations that they submitted to CMS and then sort of base their payments on it. But there is -- so states are responsible still for compliance with UPL requirements, but, yeah, when we shared some of the data that we had with states, they were
surprised as well.

CHAIR THOMPSON: So, I mean, I say that in part to say this doesn't appear to be solely a federal issue. I think there are issues at the state level, too, in terms of people -- in both the state and the federal government, it sounds like people who do the UPL demonstrations are over here; people are claiming the expenditures are over there; and there aren't necessarily processes to validate that these are consistent with that, and I think we should keep that in view. So that's one point I want to make.

The second point I want to make is that there's a process by which CMS can ask a state questions. So even appreciating that there may not be a specific crosswalk between the UPL demonstrations and the CMS-64, and to do so may, you know, require systems changes and programming and, you know, et cetera, et cetera. But the people who are reviewing state-claimed expenditures and approving those should be making use of lots of different pieces of information in order to assure themselves that the claims for expenditures are proper. And there's a process by which the CMS staff can ask questions of a state and say, "I need more information or documentation to assure myself
that these claimed expenditures are proper." That's the deferral process.

So as those expenditures are being claimed on the 64 and are being reviewed, questions can be asked of states: Well, what does this mean? Why does this number look like this? If CMS isn't satisfied, it can issue a deferral. There's a process by which states submit additional documentation.

So even if there isn't this, you know, more elegant crosswalk that occurs on the 64 itself, there is still a process of federal financial management that allows people to ask questions and collect information. And so, you know, I think there's also an opportunity to use that process to say, you know, "As I'm reviewing your claimed expenditures, I'm looking at your UPL demonstration, and I'm missing some information." Or, "I'm not sure that this is correct. Can you show me your calculations to ensure that this is proper?"

So I just raise those points to say part of this is a dual responsibility on the part of both the federal and the state government to ensure that claimed expenditures are proper. And I think in terms of any
advice that we might want to give both the states and CMS,
both of whom are within our mandate to be able to advise,
that each should be looking at ensuring that the proper
process is being used to comply with the requirements of
the UPL.

I think there's a different subject about, you
know, how the UPL is calculation and, you know, are there
places where that doesn't provide the kind of fiscal
protection that people want it to provide for federal
match. And that to me is a more complicated matter, and
maybe that's something that we should be taking into view
as we have this larger conversation about hospital payments
and know kind of what the UPL does and doesn't do in the
current system. But I think on these other aspects of just
process and operations and confidence about the appropriate
claiming and match for expenditures, there are some -- a
variety of different steps that both the federal and state
government can do to correct the situation in the shorter
term.

Stacey, were you trying to jump in and say
something?

VICE CHAIR LAMPKIN: At any point.
CHAIR THOMPSON: Go.

VICE CHAIR LAMPKIN: So thanks, Rob. This is really helpful, kind of in line with our conversations about hospital payment and financing transparency. A state policymaker said something to me one time about this system being something of a Rube Goldberg contraption, and it certainly does look like that, of course. And situations like this just make it worse and harder to understand.

And so from my perspective, I agree with Penny about the bifurcation that she made on the first two policy options on your slide. I personally would like to see us develop those options a little bit and see some pros and cons with the potential recommendations to come in those areas. I think that does seem like an area we should look at.

On the third one, with respect to how the UPL is calculated, I'd like to understand a little bit more about why it is the way it is, why there are the options that there are, before we come to any conclusions there. I mean, there are some strange-looking things about it, but we also know that, at least historically, Medicare hasn't done a lot of maternity and newborn kinds of claims, and so
there may have been systems developed to work around inadequacies of Medicare pricing to be able to calculate a Medicaid UPL. So I think we could use some more information on that before knowing whether there's fertile ground there for a recommendation. But thank you for doing this. This was really helpful follow-up to the spring.

CHAIR THOMPSON: All right. We've got Toby, Brian, Bill.

COMMISSIONER DOUGLAS: So more of a question, just understanding the two different -- you know, from a state perspective. There's the UPL, achieving the compliance or getting approval for your UPL, and then the payments. And it is kind of like the left and the right hand are separate. And Penny's raising this idea of bringing them together, and I just want to understand on the current rules, is that really -- would that trigger a deferral when CMS had approved the UPL and yet it wasn't in line with the actual payment?

MR. NELB: Let's see. CMS, as part of the UPL demonstrations, has made maybe just a handful of deferrals for a couple states where they're -- on the calculations that they've submitted to CMS, they exceeded the UPL. But
the UPL demonstrations are submitted prospectively, and
they're never like officially approved by CMS, and so there
is no process after the fact, if actual payments are above
or below, there's no process to go back and sort of
recalculate it or do any adjustments.

Part of it, it's a reasonable estimate, so it's
not -- sort of as long as it was close enough, there's no --
it's never sort of a final number that's used to track,
unfortunately.

CHAIR THOMPSON: Well, let's talk about what the
deferral process -- what approval or deferral process or
disallowance process does, which is that if there is any
information indicative to CMS that the claims expenditures
are not proper, CMS has the opportunity to ask questions or
defer those expenditures and allow states to respond. So
any external information can be used -- a GAO report, an
OIG report, prior conversations or issues that occurred
between the federal and state governments -- to ask those
questions. That's the duty of the CMS officials who are
approving federal match for those expenditures.

And so the point is that say it's a state plan
amendment or a waiver, that state plan amendment may be
approved, that waiver may be approved, but you are unclear how the expenditures are lining up to those authorities. So this is the same kind of question in my mind. It doesn't mean that you have some kind of systems-based, code-based crosswalk that says, you know, oh, this is the level of expenditures approved under, say, the state plan amendment. But if you have a state plan amendment that says we're doing these kinds of services and this kind of geography, and the expenditures are far more than what would have been expected or projected under that, you have an opportunity to ask the question: Are these expenditures correct? These look a little different than I would have expected given the approvals that you're operating under.

So that's the process that I'm talking about, and to the extent that there is a question in the federal staff's mind about the appropriateness of those expenditures, there are established processes that ensure states have due process as those expenditures are being matched or deferred from match.

COMMISSIONER DOUGLAS: I understand. Part of this gets to the question of up front or retrospective, and from a state's perspective, it is viewed as kind of we got
approval, we're going forward, and yes, the UPL. Then it
gets into utilization and all the different things, the
factors that play out.

It would give me pause that this would turn into
a retrospective and then giving back funding and states not
being able to deal with the impacts and having to take that
back from hospitals as well as their budgets. But there
needs to be more work on the front end on really improving,
if this is an issue going on, then it gets to the questions
on the front end, what are we doing to set the right
policies so that there is better accuracy.

CHAIR THOMPSON: Well, right. I think that we
would all agree better to have clarity and confidence up
front and then to be in a mode where expenditures have been
made but now are not being acceptable for match. I mean,
that's a bad situation.

COMMISSIONER DOUGLAS: Yeah.

CHAIR THOMPSON: And that's, again, why I'm
asking what steps are the states taking to ensure that the
expenditures they are making and then claiming are in fact
in accordance with the UPL, as they understand it.

There can always be a dispute between the federal
and the state governments as to whether or not we're all interpreting the UPL in the same way, and the state can say, "Well, I think I'm operating in accord with my approved UPL," and the feds can say, "I don't think you are." Then they've got to sort that out.

But it sounds like what we have now is a lot of people -- here's a UPL, but then the expenditure claiming happens without a nexus to that, and the expenditure review and approval happens without a nexus to that. And that's what I think -- this is not the only situation in which there are necessary authorities in order to claim expenditures. That happens all the time. All expenditures operating under approved authorities.

So we should just not create a new -- I'm just suggesting we shouldn't create a new process for this, and it's not even a new question. It's the actual use and relevance of the UPL demonstration to the expenditures.

So we have Brian and then Bill.

COMMISSIONER BURWELL: So I have a question. Can you explain to me kind of conceptually the similarities or differences between the concept of the Medicaid shortfall and the UPL gap?
MR. NELB: So Medicaid shortfall that we talked about with DSH is the difference between a hospital's cost and the payment that is received for Medicaid services.

In a state that does a cost-based UPL demo, the upper payment limit is the hospital's cost. So it's sort of the same thing, the difference between the payments and the cost. The amount that they could make is a UPL payment.

Some states do use actual Medicare payment methods, which are below. Medicare doesn't fully pay hospital's costs, so that level is a bit lower than cost.

COMMISSIONER BURWELL: I guess the bottom line is they're double counting. Are they the same? Because they overlap in those two definitions.

MR. NELB: No. So for DSH, Medicaid shortfall is calculated after accounting for the base and supplemental payments. So if there's anything left over after that, then it counts as Medicaid shortfall for DSH.

For the UPL, we're just looking at the fee-for-service payments.

COMMISSIONER BURWELL: Okay.

CHAIR THOMPSON: Bill.
COMMISSIONER SCANLON: Okay. This relates to Brian's question as well as what Stacey was talking about in terms of how Medicare pays and sort of how you might sort of adjust, because when I was looking at the materials, I was thinking to myself why would you have cost be the basis when the principle is we're trying to have an upper payment limit, which is what Medicare would have paid, and there is the issue of case mix, which you have to make that adjustment.

And I can imagine there was a time maybe about 10 years ago, where it was relatively convenient to say, well, use cost because Medicare at that point was paying on average sort of the cost of care across the country, that Medicare margins were typically around zero. And that's changed, and it's changed, very deliberate policy change, but not in some respects what one might think of as a major sort of shift in payment methods.

We still are using the prospective payment system, DRGs. What we've done is we've changed the updates. We changed the updates from being sort of inflation to something less than inflation, to recognize -- and this has been a MedPAC position. MedPAC has been
reporting on this for a long time, continues to report on
it, that there's a difference between what are reported
costs, which are accounting costs, and what you might think
of as the necessary cost to deliver care. And they're
trying to encourage through policy that hospitals cost,
that the money they are actually spending comes closer to
those necessary costs.

And what MedPAC has demonstrated over and over
again is that hospitals -- and you shouldn't be surprised,
given they're nonprofits -- they spend the money they get.
You look at hospitals that have much stronger private
revenues, they spend more, and their spending grows faster
than hospitals that have more limited revenues.

And we don't detect big differences or any
differences, significant differences, in terms of quality
of care.

Admittedly, our measures of quality of care sort
of need to be improved, but the reality is we don't see
anything in terms of what we have sort of measured now.

This idea of using cost, over time it's going to
continue to increase what the upper payment limit cap is,
as opposed to if we were going to what Medicare's current
sort of payment methods are, which I would say is an effort
to try and make sort of our spending sort of on health care
more efficient, which would benefit Medicaid beneficiaries.

Part of the problem that Medicaid beneficiaries
have is care costs are growing too much, and states are not
ready or able to meet all those increases in cost, and this
ends up creating sort of access problems.

I'll go back to Brian's comment about the
Medicaid shortfall. I would like the word "necessary"
inserted in that sentence, which is "The Medicaid shortfall
is the difference between what Medicaid pays and the
necessary costs of delivering care." I understand that
there would be difficulties in terms of how to measure
that, but I think we need to have that focus if over time,
we're going to bring more rationality to the cost of care,
which is going to improve access and ultimately can also
probably improve quality if we can think about how do we
focus our attention on what good quality is and say we are
insisting on that as well as we're insisting on sort of
better access.

Thanks.

CHAIR THOMPSON: Fred, you wanted to jump in?
COMMISSIONER CERISE: Just a quick comment. First, Rob, great work again, and I do think it's important to put better structure and parameters around this, just because as we talk about the other supplemental payment methods you squeeze on one area, it's going to balloon out in the other area. And so having some parameters around this, more definition is going to be important.

I agree with Bill's comments around the cost issue. I think you're better of tagging to Medicare and in those situations where Stacey references you don't have good -- to figure out something that's not just strictly based on cost.

Then your comment about the provider taxes being included in there, if we're going to talk about the means of financing as a perverse incentive to do these things, it would not be unreasonable to not include those costs.

CHAIR THOMPSON: Okay. Any other commentary on this?

[No response.]

CHAIR THOMPSON: So, Rob, let's separate out these two questions. I think there's a lot of interest in
continuing to look at the underlying methodology, the choices that states have about how they're going to calculate the UPL, what's going to be included, et cetera. And I think that is something we'd like to put on your agenda to come back to us on.

The easier piece for me is this kind of just administrative hygiene piece, where I think that we can come up with some steps that we think both CMS and states ought to be taking to give greater confidence. That to the extent we're living under a UPL system today, with whatever flaws it has, that at least it's being applied equitably and correctly across states and across expenditures. So maybe that's something that you can come back with as early as next meeting, with some language and parameters around what we ought to be saying to CMS and states about that.

Let me just pause and see if there's any public comments on that subject or any others that we talked about this morning.

[Pause.]

CHAIR THOMPSON: All right. Let's move on to therapeutic foster care.

Thank you, Rob.
[Pause.]

CHAIR THOMPSON: All right. Martha. Thank you.

MANDATED REPORT: THERAPEUTIC FOSTER CARE

* MS. HEBERLEIN: Okay. So good morning.

As Penny said, we're going to conclude our meeting today talking about a mandated report on therapeutic foster care.

So I will begin by describing the congressional request that has led to this work before explaining Medicaid's role for children in child welfare. I will then provide an overview of therapeutic foster care and state practices before turning to some questions for your consideration.

So, to begin, in the report accompanying the fiscal year 2019, Labor, Health and Human Services, and Education Funding bill, the U.S. House of Representatives Committee on Appropriations requested that MACPAC examine therapeutic foster care.

Specifically, the committee expressed concern regarding the lack of a uniform definition of therapeutic foster care in Medicaid and has requested that within 12 months of enactment that MACPAC conduct a review for the
development of an operational definition of therapeutic foster care, examine the advantages of the universal definition, and include a list of potential services to treat mental illness and trauma that would be within the scope of such a definition. So we will begin to address this request today.

So, if you recall, we wrote a chapter on the intersection of Medicaid and child welfare back in 2015, so these findings sort of draw from that earlier work.

So the majority of child welfare-involved children and youth are eligible for Medicaid either because they receive child welfare assistance, because of their low family incomes, or because of their disability status.

Children involved in the child welfare system often have significant medical, behavioral, and other social needs for which a range of Medicaid-covered services may be necessary and appropriate.

For example, among children eligible for Medicaid based on foster care assistance, 49 percent had diagnoses of mental health disorders, and 3 percent had diagnoses of substance use disorders.

For other children in Medicaid, the figures were
11 percent and less than 1 percent respectively. Although it is not possible to identify the entirety of the child welfare population enrolled in Medicaid, about 1 million children were reported as ever enrolled based upon their receipt of child welfare assistance in fiscal year 2011. This accounted for about 3 percent of nondisabled child enrollees; however, due to their high health needs and service use, Medicaid benefit spending for these children totaled about 5.8 billion in fiscal year 2010 or about 9 percent of spending for nondisabled children.

So there is currently no uniform definition of therapeutic foster care in either federal statute or regulation; however, therapeutic foster care can be described generally as the practice of serving children and youth with serious conditions in a family-based setting. Children receiving therapeutic foster care most often have serious emotional or behavioral health needs, but may also have serious medical conditions. Given their high needs, these children and youth would typically be placed in a group or institutional setting, often referred to congregate care.
Therapeutic foster care provides a less-restrictive environment and allows the needs of these children to be met in the community.

All states provide some form of therapeutic foster care, although the programs vary widely in a number of dimensions, including which children they serve, what services are provided, and whether the services are paid for by Medicaid.

Even though the definition of therapeutic foster care is not uniform, there are certain common elements. For example, the services provided within therapeutic foster care typically include crisis support, behavior management, medication monitoring, counseling, and case management services.

Children in therapeutic foster care receive an individualized treatment plan, and their treatment team typically meets on a more frequent basis than children in more standard foster care arrangements.

Foster parents serving these children typically receive higher levels of training, payment, and case worker support, and are considered part of the treatment team.

Many states have multiple levels of therapeutic...
foster care with higher payment levels to families, depending on the child's needs, and states can also pay higher rates for more intensive Medicaid services. So similar to how states provide other health services to the child welfare population, they often use Medicaid funds to pay for the clinical aspects of therapeutic foster care, such as behavioral health treatment, and child welfare funds under Title IV-E to pay for living expenses, such as room and board, administrative costs, and recruitment and training of foster parents. Therapeutic foster care is not currently included in the list of optional or mandatory Medicaid benefits. As such, states have used a variety of approaches to finance the treatment component of therapeutic foster care using Medicaid funds. For example, many states define therapeutic foster care as a rehabilitative service, which includes a variety of services to treat mental and physical health conditions, designed to return children to function at age-appropriate levels. Of the 38 states that responded to questions regarding Medicaid billing for therapeutic foster care
services for children in foster care, 31 reported having specific billing codes for therapeutic foster care under rehabilitative services. Twenty-two reported specific billing codes under targeted case management options, including a large number that also reported using the rehabilitation option.

Other states consider therapeutic foster care a behavioral health service, and some states report that therapeutic foster care services are provided under waivers.

So as the Commission considers the merits of a universal definition of therapeutic foster care, some questions come to mind. For example, would a uniform definition result in consistency across states, and how would that change state flexibility?

As just discussed, all states provide some form of therapeutic foster care, but the specifics vary. As in the case of many other Medicaid policies, this variation likely reflects both the needs of the enrollees and state decisions regarding available resources. It is not clear how much this variation would change with the adoption of a universal definition, as states do not always adopt the
options provided to them and may view their current approach as the most appropriate for their circumstances. Furthermore, the effects would likely depend upon whether the definition is operationalized through guidance or added to the statute as a mandatory or optional benefit, as well as how prescriptive that definition is.

Operationalizing a universal definition of therapeutic foster care may be done through the issuance of sub-regulatory guidance. This guidance could describe how therapeutic foster care can be provided under existing law. Further direction from the Secretary could help clarify which benefits should be included in therapeutic foster care, appropriate billing practices for such services, steps to ensure participation from qualified providers, and ways to effectively coordinate with other agencies serving these same high-need children and youth, including child welfare, juvenile justice, and behavioral health agencies.

Such an approach would not add a new benefit to Medicaid but merely clarify how states can use the existing benefit design flexibility to provide therapeutic foster care services.
Alternatively, therapeutic foster care could be added as a statutory benefit. Designating therapeutic foster care as a mandatory benefit would require all states to cover the service, but would limit a state's ability to pick and choose which benefits to offer under a therapeutic foster care umbrella.

Adding therapeutic foster care as an optional benefit, would not require states to provide therapeutic foster care, but may allow them to more easily cover a consistent package of services as opposed to piecing therapeutic foster care together from available benefits, such as rehab and targeted case management.

In this case, states could choose to add therapeutic foster care to their state plan, choose not to offer the benefit, or continue their current state practice.

Unlike operationalizing a definition through guidance, adding therapeutic foster care as a statutory benefit could potentially limit state flexibility. On the one hand, states would continue to have the flexibility to define medical necessity and the amount, duration, and scope of the benefit; however, the Secretary could still
put parameters around this flexibility if he chose to
further define the benefit through regulation or guidance.

Furthermore, designating therapeutic foster care
as an optional benefit under Section 1905(a), has
implications for the early and periodic screening,
diagnostic, and treatment, also known as EPSDT, benefit,
which requires states to provide any medically necessary
service named in the Medicaid statute, including optional
services not otherwise covered by the state, without caps
or limits. This could potentially result in states
providing therapeutic foster care to a broader population
of children and youth.

States face a number of difficulties in providing
therapeutic foster care, including recruitment and training
of caregivers, ensuring delivery of quality, evidence-based
services, and securing adequate funding. A universal
definition of therapeutic foster care may assist in easing
some of these concerns, but may not eliminate them.

For example, therapeutic foster care requires
highly skilled and committed caregivers, and while these
programs provide additional training, support, and payment
to these families, recruitment is a challenge in most
Concerns have also been raised regarding the quality of TFC providers and agency screening of foster parents.

To address some of these concerns, advocates have promoted coupling a universal definition with requirements for specialized training and accreditation. Provider requirements are typically the purview of states, although federal standards have been established in some circumstances, such as for nursing facilities.

In addition, while a uniform definition may provide some consistency in the children served and services provided across states, it may not increase the adoption of evidence-based practices. There are two evidence-based therapeutic foster care approaches that are discussed in your materials, yet most states have not adopted these approaches, given the difficulty of implementation and caregiver capacity.

So, finally, therapeutic foster care is less costly than congregate care, it is more expensive than standard foster care. Many states are interested in shifting from congregate care settings and expanding their
use of therapeutic foster care, but child welfare funding limitations may impeded their ability to do so.

So, with that as background, I will turn it over to you for discussion. Our plan to fulfill this congressional request is to come back to you at a later date with a draft response for your comments and review that draws on your discussion today and any additional research you request from us.

CHAIR THOMPSON: Thank you, Martha.

I just want to clarify one point about -- as I read the request, talking about a universal definition does not necessarily mean that we get into a conversation about coverage or benefits as opposed to -- and this goes back to kind of, I think, your first point, which is there's an ability to kind of construct, this is like the preferred model for therapeutic foster care and here's how you put together IV-E and Medicaid in support of that model as something states take and use and say, okay, I will either do that because that gives me kind of a standard to reference, or I'll just keep doing something else that makes more sense in my state, versus, well, are we constructing a new benefit. Help me understand your
thinking about how a universal definition of what this is,
which has to do with delivery of care and thinking about
the professionalization and the standardization of these
services as against constructing a new benefit or a way of
producing federal match for something that we don't
currently match.

MS. HEBERLEIN: Oh, I think there are a number of
approaches you could take. I think you could say this is
sort of the state of practice and these are the things that
we think are good about that practice and that we should
encourage among states. And that could be, you know, how
you frame your response.

The Secretary could provide additional guidance
that sort of supports that, or it could go as far as a new
definition. I think from what I've read, all the states
are currently figuring out some way to do this and have
pieced together something from already available benefits.
And so then the question becomes, you know, if they're
already sort of doing this, what's sort of the best way to
encourage -- if you think there should be more uniformity,
what's the best way to encourage uniformity across the
states? And I think you have different options as to how
you would want to do that.

CHAIR THOMPSON: Thank you. Okay.

Kit?

COMMISSIONER GORTON: Okay. Well, nice to be asked to do work. So I want to disclose that my response to this is not from my typical perch but from a different perch, so I'm going to answer this -- I'm going to provide feedback as a pediatrician who worked in federally qualified health centers for 17 years and as a person who has done therapeutic foster care for two children, one of whom had profound physical disabilities and one of whom had behavioral health issues.

So it's an important service, and while I have been a frequent critic over the years of expanded EPSDT in OBRA '89. In my view, this is a service which clearly should fall into that rubric and clearly should be available. So while I think it's great that states have figured out a number of piecemeal and partial responses to delivering this service, my personal experience in a fairly well-put-together large state was that it was a struggle with both of our kids just because of the system lines and children, youth, and Medicaid and mental health and
substance use -- so it's a morass from a bureaucratic and administrative point of view trying to take care of these children, and it's certainly hard on parents, and hard on the kids. So I do think that there is value in regularizing this, and my personal view would be that it probably should be added -- I don't know that it needs to be added as a statutory definition. I mean, there's an awful lot covered under what is medically necessary care for children before their 21st birthday. But we ought to push it into that realm so that -- because I don't think -- you know, typically I stand here and I say states need flexibility and blah, blah, blah. This is a place where these are some of the most vulnerable children and some of the neediest children we have, and if we don't want them in congregate settings, which is not good for them, then we need some other option for it.

And so I would encourage us to end up being in a place where this is not seen as, no, we don't want to do that here. And if the only way to do that is to add it to the standard benefit, then that's fine. If there are other ways to do that, I don't know the benefit rules well enough to know, but I don't think this should be optional. That's
my personal opinion. This is as important to these
children as ambulances are to people having heart attacks
and as medicine is to people who need medicine. And it can
be life-altering if done properly. So that's one thing I
want to say.

The other thing I wanted to say is I was alarmed
in reading the materials to see some states saying, oh,
this is a behavioral health service, or this is a rehab
service, because in some ways it's a habilitative service,
not a rehab service. These are people gaining stuff that
they didn't have before. And, you know, my thought's
heavily covered by my son, who, you know, yeah, he had some
cognitive and intellectual stuff, but his overarching issue
was his spinal muscular atrophy, and so it was his physical
disability. And if we think about serving kids with those
kind of complex needs, it makes me anxious to be siloing
and bucketing because --

CHAIR THOMPSON: You're afraid it distorts the
service --

COMMISSIONER GORTON: It distorts, yes.

CHAIR THOMPSON: -- because of fitting it into
some category that really isn't -- doesn't have the right
parameters.

COMMISSIONER GORTON: Exactly. So, you know, expanded EPSDT gives us the opportunity to serve these kids, not in congregate settings, in ways which meet their needs and give support to families. And so I'm glad we got asked to do this, and that would be the direction that I would hope we would take moving forward.

CHAIR THOMPSON: Toby, Chuck.

COMMISSIONER DOUGLAS: Well, I have a follow-up on just this definition of EPSDT from -- so California, when I was there, we were litigated over -- a litigation called Katie A. And my understanding is that we covered -- and we worked a lot with CMS to try to fit -- there were multiple components to it, therapeutic foster care being one of the three major pieces. But I thought it was an EPSDT benefit, and that was through working with CMS. So I am a little confused on the definition.

MS. HEBERLEIN: So if you have adopted a service, or not, but a service that is listed in 1905(a) is covered under EPSDT, and so in California's case, you had provided some of these services. And so EPSDT applies to anything that's in 1905(a). And to Kit's point, the services that
many of these kids need may already be services listed in 1905(a). So the question then is: Is there enough there to sort of cover the services these children need? Or are we adding sort of a new 1905(a) service, which would then have its own EPSDT requirement with it.

COMMISSIONER DOUGLAS: Meaning the way California implemented it, it was by taking the services that were already in 1905(a) --

MS. HEBERLEIN: Yes.

COMMISSIONER DOUGLAS: -- and turning into the definition of therapeutic --

MS. HEBERLEIN: That's my understanding of Katie A., not reading the full --

COMMISSIONER DOUGLAS: Okay. Yeah, if you could talk with us offline about --

MS. HEBERLEIN: That would be great. Thank you.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: A question, and I want to make a comparison to opioid conversations we've had before where there's emerging through a lot of work a kind of -- a sort of standard of practice based on kind of characteristics of individuals who need the service kind of
working up a range all the way to kind of inpatient, but, you know, a variety of outpatient treatments and so on. And so using that as an analogy, with respect to therapeutic foster care, is there a body, a professional body that is developing clinical criteria, accreditation, licensure, that kind of rubric, or not in terms of kind of what work is out there that could be leveraged?

MS. HEBERLEIN: So there is an association of the providers, and it's FFTA -- and I'm not going to remember the acronym correctly, and I apologize for that -- and they have done a toolkit that sort of talks about what the practices should be. And I think, you know, sort of the idea is that these kids need a lot more services and can receive those services in family-based settings as opposed to congregate care. And I think to Kit's point that the services they need are very dependent upon the children, and in some cases they might need more medical services, and in other cases they might need more behavioral health services. They might need more social skills training. I think it depends upon the kids themselves. But there is a body that has focused on sort of what the providers should provide and the provider training and that sort of stuff.
CHAIR THOMPSON: I'm wondering, Leanna, is there anything that you want to add to this conversation?

COMMISSIONER GEORGE: I think my biggest question is: How is this different than alternate family living? That is one of the residential models that are out there, where an individual can go and live with another family. I'm just trying to figure out what is the difference between these two items.

MS. HEBERLEIN: Well, I'm not familiar with that model, so I will try to answer the question.

COMMISSIONER GEORGE: I stumped her [off microphone].

[Laughter.]

MS. HEBERLEIN: I know, stumped. I'm the first one. I will go down and say that with honor that I have been stumped by Leanna today.

So I think the -- so most of these kids are child welfare-involved, and so Title IV-E funds, if they are Title IV-E eligible, would pay for their room and board and those other services. And so that might be what is slightly different in this model, is that, you know, in some states they are not all child welfare-involved youth,
but for the most part they are child welfare-involved, and so you have a different agency that's sort of paying for part of their services and is responsible for, you know, their physical well-being and trying to establish permanency for them. And then you have Medicaid that sort of comes in and fills in the medical piece of it. So I think that's part of the issue here, is that there's also at least two agencies, if not more, sort of responsible for the child's well-being.

CHAIR THOMPSON: But it does raise the question of making sure that we take into view similarly situated children with similar needs and how they're being served and how that does or does not line up to something that people might be interested in for foster kids.

Chuck?

COMMISSIONER MILLIGAN: And I'm sorry. It took me a little while to kind of formulate a follow-up to my earlier questioning. Going back to Kit's example with his two kids, what I'm struggling with here, Martha, is: Is this a service or is it a constellation of services under the name therapeutic foster care? Because if it's really - - it's almost like saying HCBS is a service when it's a
modality of delivering an array of services. And so I think that's what I'm struggling with in terms of how we define whether this is a service or this is kind of an overarching umbrella name we give to an array of services underneath that are customized to kids.

MS. HEBERLEIN: My personal opinion -- and there may be others who disagree with me -- is I think it's the latter. I think there are -- it's whatever this child needs, they're sort of piecing together what they can for this child under the Medicaid covered services. And then where the services are not Medicaid covered, they may be paying for them with IV-E funds or something else.

I think there's also the idea that this takes place in a particular setting, similar to what you're saying about HCBS, is that these services are typically provided in a therapeutic foster home, and so this is the setting and you can sort of think of them as a constellation of services that are provided within this particular setting.

CHAIR THOMPSON: Any other comments or questions?

[No response.]

CHAIR THOMPSON: Martha, first of all, very
useful materials, very informative, good discussion. I think that you're on the right track. I think you're asking the right questions. We'll be very interested to see some of the different options that you're coming back with.

I think, you know, the question for us is: How far do we want to go in making particular recommendations or suggesting new benefits? I think at minimum, to the extent that we can record and reflect the state of practice and how to make this work, even under the current authorities, I think that'll be a big contribution and help. And then I think, you know, bringing some light to some of the issues that you've identified will be helpful to the Congress as they contemplate what additional steps they might want to take on this subject. So we'll look forward to that conversation.

Okay. Any final comments from the Commissioners on this topic or others?

[No response.]

CHAIR THOMPSON: Any final comments from the public?

PUBLIC COMMENT
* [No response.]

CHAIR THOMPSON: All right. We are adjourned.

[Whereupon, at 11:19 a.m., the Public Session was adjourned.]