PUBLIC MEETING

Reserve Officers Association
Top of the Hill Banquet and Conference Center
Minuteman Ballroom, 5th Floor
One Constitution Avenue NE
Washington, D.C. 20002

Thursday, March 2, 2017
10:45 a.m.

COMMISSIONERS PRESENT:

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ANDREA COHEN, JD
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ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

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1 P R O C E E D I N G S

2 [10:45 a.m.]

3 CHAIR ROSENBAUM: All right. We are ready to --
4 oh, my goodness. We are ready to start. It's like having
5 an extra placemat at your seat. Good morning, everybody,
6 and welcome to the March MACPAC meeting. We have a very
7 full agenda, so I am going to get us started right away
8 with the opening session, which is "Changing Medicaid
9 Approaches to Treating Opioid Used Disorders," and I am
10 going to turn matters over to Nevena Minor, who will
11 introduce the panel.

12 **### CHANGING MEDICAID APPROACHES TO TREATING OPIOID**
13 **USE DISORDERS**

14 * MS. MINOR: Hi. Good morning.
15 At the October 2016 Commission meeting, you heard
16 about Medicaid prescription opioid utilization and
17 expenditures, and available research, although limited to
18 certain states, suggests that Medicaid beneficiaries have
19 higher opioid prescription rates than individuals with
20 other coverage.
21 Medicaid enrollees are also at a higher risk for
22 overdoses, and nearly 12 percent have a substance use

1 disorder, which may include an addiction to opioids.

2 Staff in October presented the results of a
3 MACPAC analysis of MSIS data, which among its conclusions
4 found that in 2012, 15 percent of Medicaid enrollees had at
5 least one opioid prescription. Medicaid paid for over 34
6 million claims, and opioid prescription rates varied
7 considerably by state.

8 Across states, percentage of enrollees with at
9 least one prescription ranged from less than 10 percent to
10 almost a quarter of enrollees.

11 The presentation then outlined policies states
12 are using in response to regulate prescribing and identify
13 potential abuse. These include patient review and
14 restriction, preferred drug lists, prescription drug
15 monitoring programs, drug utilization reviews, step therapy
16 and prior authorization requirements, and quantity limits
17 on opioid dispensing.

18 Staff also provided an overview of the substance
19 use disorder benefits available across states and
20 authorities used to provide that coverage. States are
21 required to cover certain services, such as medically
22 necessary inpatient hospital, outpatient hospital, and

1 physician services, but many others are optional. These
2 include counseling, licensed clinical social work services,
3 targeted case management, medication management, clinic
4 services, and peer and recovery supports.
5 States are using mechanisms such as Section 1115
6 waivers and the health homes option to expand both coverage
7 of services and the number of individuals eligible for this
8 care.
9 Based on that presentation, your subsequent
10 interest and input in learning more about how state
11 Medicaid programs are fighting the epidemic, we've
12 organized an expert panel to provide a more in-depth look
13 at Medicaid programs' responses, with a focus on how they
14 are identifying and improving access to effective models of
15 treatment.
16 First, you will hear from Kelly Murphy, program
17 director at the Center for Best Practices in the National
18 Governors Association. Ms. Murphy is coauthor of "Finding
19 Solutions to the Prescription Opioid and Heroin Crisis: A
20 Road Map for States," and you have an outline of that road
21 map in front of you. This publication offers tools to help
22 states respond in a comprehensive manner utilizing public

1 health and public safety strategies across the continuum
2 from prevention and early identification to treatment and
3 recovery.
4 Next is Dr. Katherine Neuhausen, Chief Medical
5 Officer for the Virginia Department of Medical Assistance.
6 Dr. Neuhausen is leading implementation of changes to
7 substance use disorder treatment and coverage and delivery
8 under an 1115 waiver.
9 And finally is Beth Tanzman, interim executive
10 director of the Vermont Blueprint for Health. Ms. Tanzman
11 heads the Medicaid Hub and Spoke program, the health home
12 initiative, targeted to treat individuals with opioid use
13 disorders, and there is a two-pager that was in your
14 materials this morning as well, that outlines the program.
15 And I'll turn it over to Kelly now.
16 * MS. MURPHY: Thanks. Thank you so much for
17 introduction, Nevena, and thank you to the Commission for
18 having me here today to talk about this really important
19 issue that I spend a lot of my time on at the National
20 Governors Association. So happy to be here today.
21 As was mentioned, I'm a program director in the
22 Health Division at the National Governors Association. I

1 lead all of our public health work, which includes all of
2 the opioid work that we've done over the past five or six
3 years with states around the country.
4 I do have some slides for you today, but a lot of
5 them, I am just going to touch on. You guys do know some
6 of this information.
7 I am going to mention who we are at NGA. I am
8 going to talk very briefly about an overview of the opioid
9 crisis. I am going to talk about the publication that was
10 mentioned and the placemat that you have in front of you.
11 Feel free to take it home. Have an interesting dinner
12 conversation over it.
13 [Laughter.]
14 MS. MURPHY: And then talk a little bit about
15 some of the Medicaid strategies that align with the
16 discussions that are in our road map.
17 If you've never heard of the National Governors
18 Association before, we are the nation's oldest organization
19 serving governors and their staff. We really have two main
20 parts. We have the Office of Government Relations, which
21 represents the position of governors to Capitol Hill and
22 the administration.

1 That is not where I am. I am in the Center for
2 Best Practices. We are a think tank for governors'
3 offices. We see ourselves as a consultancy, and I am in
4 the Health Division there.
5 Before I turn to the next slide, I want to
6 mention that this crisis is bad, and the next slide shows
7 the impact from 1999 to 2014, where there was a 200 percent
8 increase in overdoses across the country, and it should go
9 through the years and just show you, going from neutral
10 blue to really red, more red, you can see some of the
11 pockets emerging across the country of the epidemic,
12 Appalachia in the West, and over the course of those years
13 some really startling, troubling statistics.
14 Today, we have 91 people dying every day from
15 opioid overdoses. I just had to revise that statistic
16 sadly. It was 78 last year.
17 The map that's in front of you shows fentanyl,
18 which you all have probably heard about, which really is
19 spiking overdose death rates across the country. In 2013,
20 we saw fentanyl, which is 50 times more powerful than
21 heroin, 100 times more powerful than morphine, spiking
22 overdose death rates; really starting on the East Coast of

1 the United States, and this is where you're seeing front-
2 page headlines that people are dying with needles still in
3 their arm because it's so powerful.
4 We have now over the course of the past couple of
5 years seen it move more into the West, so I do think that
6 states will continue to see not only prescription opioid
7 abuse and heroin abuse, but also things like fentanyl and
8 carfentanyl, which is even scarier, coming into their
9 cities and impacting their populations.
10 Something to be concerned about, something that I
11 think will continue to drive this conversation in states,
12 is as we see this on the front page of the news.
13 This just shows the spike in fentanyl from 2013
14 to 2015. The numbers are less important than the
15 trajectory of that curve, which really shows you the very
16 sharp increase from 2013 to 2015, the 72 percent increase
17 individual deaths related to fentanyl. And I should note
18 that it's illegally produced fentanyl, not diverted medical
19 fentanyl, that is causing most of these overdoses.
20 So in order to help states respond to this
21 epidemic and these very scary overdose death rates that
22 they are seeing, NGA released a road map, which was

1 mentioned, and the placemat that you have in front of you.
2 The goal of the road map was really to give states very
3 clear process in order to think about impacting this
4 problem and integrating strategies into their current work.
5 We have three steps, starting with states
6 assessing their situation. That definitely includes
7 looking at your data. Step two, selecting policies and
8 practices. We really try to narrow in on some evidence-
9 based policies and practices and tell states what's
10 working. And three, finalize, implement your policies, and
11 definitely evaluate. We tried to make sure that that was a
12 big focus of the work that we were helping states with.
13 As a part of the development of the road map, we
14 really took time to assess what the major factors were that
15 were driving this epidemic in order to target the
16 strategies appropriately. It really boiled down to three
17 things: the wider availability of prescription opioids,
18 the lack of access to treatment for opioid use disorder,
19 and the changing economics and supply of heroin. And it
20 also really wanted to acknowledge the underlying biological
21 and social risk factors for substance use disorders that
22 exist as well.

1 From that research, which really included
2 conversations with probably hundreds of people, including
3 state experts, national experts, thinking about this issue
4 on a daily basis, we developed a comprehensive policy
5 framework. We integrated health care and public safety.
6 We really felt like that was important, and NGA's
7 initiative has always been a partnership between the Health
8 Division and our Homeland Security and Public Safety
9 Division. We encourage that in states too, and many of the
10 state teams we have worked with have integrated those folks
11 on their state teams. And then across the continuum, from
12 prevention through treatment and recovery.
13 We sort of bucketed the strategies out into four
14 areas: the health care side, prevention; the public safety
15 side, prevention; the health care side of treatment; and
16 the safety side of response. I'm going to focus a lot on
17 the third bucket there because I know you guys did have a
18 presentation earlier on sort of more the prevention side of
19 things, but if there are questions on that, I can certainly
20 speak to those two.
21 Before getting into the specific strategies, I
22 wanted to mention probably what you all know much better

1 than I do, the Medicaid levers that exist, and then I also
2 wanted to highlight a couple of the barriers and
3 opportunities that we hear a lot about from states.
4 The levers, as you know, many of them are already
5 mentioned -- state plan amendments, waivers, contracts.
6 States are using all of these to impact the epidemic.
7 On the barriers and opportunities side, I wanted
8 to mention a few of them. The IMD exclusion is something
9 that we hear about a lot. I think states have told us that
10 it's difficult to treat someone based on their medical
11 necessity if they have a really hard limit of 15 days being
12 paid for, so I wanted to throw that out there.
13 42 CFR Part 2. I know this isn't a CMS strategy,
14 but I would be remiss not to mention it. It really is
15 prohibiting the flow of information between providers and
16 the ability to coordinate care for folks that are getting
17 addiction treatment and seeing other providers.
18 I wanted to mention the opportunity of
19 teleconsultation models. I'll talk in a second about some
20 Project ECHO work that we have happening in states. It's a
21 model coming out of New Mexico to train providers in rural
22 areas and underserved communities in order to increase

1 access to medication-assisted treatment.

2 And then, of course, housing. Housing is health.
3 I know that CMS issued a bulletin in 2015 about housing and
4 Medicaid reimbursement for housing services, and states are
5 working on integrating these into their Medicaid benefit
6 designs.

7 I also just wanted to note that under the ACA,
8 obviously we have Medicaid expansion, where 31 states and
9 D.C. have expanded Medicaid, increasing access to mental
10 health services for the expansion population. 1.2 million
11 individuals with SUD and mental health conditions have
12 gained access, and then, of course, health homes, another
13 mechanism that states are using. I'm sure Vermont will
14 talk about their fantastic health home that I talk about on
15 a regular basis.

16 So back to the strategies that are listed in the
17 road map, I was just going to go through a couple of them
18 and then highlight some of the Medicaid or if that's being
19 in states to reflect these.

20 So, first, changing policies to make sure you're
21 expanding access to evidence-based MAT and recovery
22 services, reviewing and removing barriers like fail first

1 and prior authorization. For example in 2016, New York
2 forbid their Medicaid managed care plans from acquiring
3 prior auth for buprenorphine and injectable naltrexone.
4 Using Medicaid payment strategies to increase
5 access, again, to evidence-based treatment. Maryland has a
6 really innovative re-bundling initiative where they created
7 a separate payment for SUD services, counseling services to
8 sort of incentivize the counseling component of that.
9 New Jersey also is using some of the money that
10 they're saving through the Medicaid expansion to increase
11 payment rates for SUD treatment providers.
12 And then expanding and strengthening the
13 workforce and infrastructure, definitely a hot topic in
14 states. Again, Vermont tends to come up with a health home
15 Hub and Spoke Model, which I'm not going to steal any
16 Beth's thunder by talking about that, but it's definitely a
17 model that we try to share with other states.
18 And, again, Maryland has a health home program
19 that was developed for individuals with behavioral health
20 needs who are at high risk for additional chronic
21 conditions.
22 Then finally, on this slide, talking about

1 Project ECHO, which I mentioned before, Project ECHO has an
2 integrated addictions and psychiatry clinic. We actually
3 have taken a group of states to New Mexico to learn about
4 this in order to build ECHOs in their own state, in order
5 to increase their treatment capacity by tele-consultation
6 training of providers that they can then provide the MAT in
7 rural and underserved areas. Also, Colorado is using
8 Project ECHO to train providers in their ACOs.
9 Creating linkages. So linking people with
10 addiction to MAT and to peer recovery services, which has
11 been a very hot topic at NGA, we have gotten a lot of
12 questions about this from states. In terms of the reach of
13 peer and family supports, the Virginia -- which I'm sure
14 Kate will talk about -- has an 1115 waiver for addiction
15 treatment services that we have found to be really
16 innovative, and also Rhode Island, maybe you have heard of
17 their AnchorED program, which is a peer recovery program.
18 They also have what's called Anchor MORE, I believe, to
19 community-based programs, so not even just in ED, but
20 trying to connect people who have overdosed with peers to
21 not just get them help but get them treatment, have a
22 friend, all of those really important things. I would

1 think that program is probably one of the things we've
2 gotten most questions about from other states and them
3 wanting to implement.
4 And then, of course, connecting individuals to
5 Medicaid post incarceration. We are about to do a project
6 with Massachusetts, where we highlight some of their work
7 in their drug courts and in their court system. They are
8 really good about making sure that folks get their Medicaid
9 set up before they are released from incarceration so that
10 they continue their MAT, which they were getting in prison,
11 outside as well.
12 And that's my quick highlight, and I think I am
13 turning it over to the states to talk about their projects,
14 which is always my favorite part of the panel too. So
15 thank you so much for letting me talk with you today.
16 * DR. NEUHAUSEN: Okay. Hi. Good morning. Thank
17 you so much for inviting me here. I've read MACPAC's
18 reports, and you all do extraordinary work. So it's an
19 honor to be here today.
20 My story in Virginia actually started as a family
21 physician. I had worked at VCU Health System, and even
22 before I started in my safety net clinic, I heard, "Don't

1 even bother to refer your patients, most of whom are
2 uninsured and Medicaid. Don't even bother to refer them
3 for substance abuse treatment. It's not available. Even
4 if they have Medicaid, it is going to be a 6- to 12-month
5 wait for any kind of addiction treatment, and I was told
6 that was the single greatest challenge and frustration of
7 working in the safety net in Virginia.
8 So I think Virginia has a unique story. We're a
9 purple state. We're a non-expansion state, and we're a
10 state that has historically, dramatically underinvested in
11 community-based mental health services, community-based
12 addiction treatment, and social services. And it was a bit
13 of a shock.
14 I came from California, where I had practiced the
15 safety net, was actually able to get treatment.
16 So, luckily, all that is going to change. It
17 really started with our governor. When Governor McAuliffe
18 took office, he received a letter from all of our
19 congressional delegation asking for a task force for the
20 heroin and opioid crisis, which was particularly bad in our
21 southwest, the Appalachia region in Virginia, with heroin
22 really entering into Northern Virginia and our major metro

1 areas.

2 So the governor formed the Governor's Task Force
3 for Prescription Drug and Heroin Abuse. One of their major
4 recommendations was how important it was for Medicaid to
5 increase rates, so we could attract providers and actually
6 be able to offer services. So these were the barriers that
7 came out of our task force, which I think are actually
8 probably pretty universal, particularly among non-expansion
9 states, states in the Southeast, red or purple states.

10 So, first, Virginia had limited coverage. So we
11 had a substance abuse treatment benefit in 2007, but it was
12 partial, and it only covered residential treatment for
13 pregnant women. So, as a result, people were getting
14 detoxed, but it was happening in emergency rooms, inpatient
15 hospital wards, intensive care units, and jails, so all the
16 most expensive settings.

17 And then we also had the issue of a non-expansion
18 state where our pregnant women would lose eligibility 60
19 days after delivery, so they would get their children -- if
20 a baby was born with be neonatal abstinence syndrome, the
21 child is referred to CPS. The mom is referred for
22 treatment. She's on a wait list for six months. By the

1 time she gets in, she's lost her coverage, and there was
2 really nothing for a childless adults because they were not
3 covered.
4 And then we had a fragmented system where our
5 community-based addiction and mental health services are
6 carved out in a behavior health administrator, and the
7 physical health is carved into managed care plans. And I
8 think that's pretty common, in managed care states.
9 Then we have the issue of the lack of providers
10 that I experienced firsthand when there was no one to refer
11 to. Because the rates hadn't been increased since 2007 and
12 were so low, providers were not reimbursed for the actual
13 cost of providing care. I used to tell people you could
14 earn more waiting tables than doing addiction treatment.
15 So we had very limited providers, and then providers, even
16 those who were treating Medicaid, didn't know who to bill
17 for services, and members didn't know where to seek
18 services.
19 So in response to the governor's task force, our
20 Medicaid agency worked with our Department of Behavioral
21 Health to design a benefit, and this was actually driven by
22 the 1115 waiver opportunities. CMS released the state

1 Medicaid director letter in June 2015, where they gave the
2 opportunity to get an 1115 waiver and waive the IMD
3 exemption, which I'll talk about in a minute, but to do
4 that, the state had to have a robust, comprehensive,
5 evidence-based substance use disorder benefit.
6 So our governor said to Medicaid, "Figure out how
7 to get new federal dollars under the waiver. Figure out
8 what we need to do to get our benefit aligned." So CMS
9 worked closely with us. This benefit did three things that
10 our Medicaid director said are pretty unprecedented in
11 Virginia. One expanded the coverage for addiction
12 treatment to our entire population, all 1.1 million members
13 across all eight categories. So we expanded short-term
14 inpatient detox to all of our members, expanded short-term
15 residential treatment to all of our members. Two,
16 increased rates, up to 400 percent, which was
17 unprecedented. We never increased rates to where all of
18 our rates for addiction treatment for the whole continuum
19 are now at average commercial rates. So that was
20 unprecedented for Virginia to attract providers and build a
21 network.
22 We added new services. We added peer support

1 services for both mental health and substance use disorder,
2 and I think it's pretty rare for a state to cover both.
3 We also carved these services into managed care,
4 and then I'll talk later. We have a lot of money for
5 training and workforce, which was unique.
6 So our General Assembly passed this, our
7 Republican General Assembly. This was a bipartisan effort,
8 and we go live April 1. This is what the transformation
9 looks like, so we are covering the full continuum and
10 evidence-based treatment, everything from inpatient detox,
11 residential treatment, partial hospitalization, intensive
12 outpatient, the medication-assisted treatment. We're also
13 covering screening under SBIRT, and then the new services -
14 - well, the case management and the new services for peer
15 recovery. These are all being carved into our managed care
16 plans effective April 1, with the goal that we'll have
17 fully integrated physical and behavioral health continuum
18 of care.
19 And then by the end of 2018, about 90 percent of
20 Virginia's Medicaid population will be in managed care.
21 We're craving in long-term services and support this
22 summer. For the 10 percent remaining members in fee-for-

1 service, these services will be covered by our behavioral
2 health services administrator, Magellan.
3 So, again, the advantage for this is you can
4 leverage the commercial networks. For example, we have
5 Anthem and Aetna, our Medicaid plans, and they may be able
6 to flip their commercial networks.
7 The other advantage is the Medicaid is actually
8 trickling into commercial much faster than we anticipated.
9 So Virginia is really using Medicaid as an incentive to
10 bring in all these providers, and we're finding that our
11 commercial plans are tired of sending their members out of
12 state, so they're actually already starting to use our
13 providers as well.
14 And then our Medicare Advantage plans are also
15 using these providers, and then many of the public
16 providers will accept uninsured. So it's Medicaid that is
17 a leverage to transform a delivery system for everyone,
18 regardless of payer.
19 And then I will say the problem with health
20 plans, from a provider perspective, is the confusion. You
21 can't have six different credentialing processes, six
22 different prior authorizations, because it will drive

1 providers insane. So what we did, for the first time ever,
2 was we brought all of our health plans in the room with
3 providers and said, "We're creating one system. We're
4 going to have one credentialing process. You're all going
5 to use the same application. Providers will submit one
6 form and the same information to every plan. We're going
7 to have one billing process for every provider. Here's
8 what we are going to do. We will all agree on it. We're
9 going to have one set of rates. The health plans have to
10 pay these fee-for-service rates as the floor, and we're
11 going to have one prior authorization form for every
12 service." And providers have absolutely loved that, and I
13 think that's been a game-changer for providers to come in.
14 You have to make it as easy as possible.
15 So what this has done for Virginia -- and I want
16 to -- Virginia is the third state to obtain the 1115
17 Substance Abuse Disorder Waiver after California and
18 Massachusetts. To my knowledge we are the first to do the
19 waiver completely in managed care. So what this does is it
20 allows us to waive the IMD exemption, so the biggest
21 challenge for Virginia was that we could not obtain FFP to
22 pay for residential treatment in the IMDs with more than 16

1 beds. So what that meant was we used to have a lot of
2 community detox in Virginia, and in the '90s, when Medicaid
3 started paying for residential crisis stays, 16 beds or
4 less, we actually had our public providers shut down whole
5 wings of detox and flip to crisis stabilization 16 beds,
6 because if they have more than 16 beds they couldn't --
7 Medicaid wouldn't pay them, because we don't get FFP.
8 So under our waiver that we were awarded in
9 December of 2016, which CMS gave us because of our
10 comprehensive benefit, we have that waived and Virginia
11 Medicaid will be able to draw down FFP and pay for services
12 provided in residential treatment facilities of unlimited
13 bed size, and that will significantly increase our
14 capacity, so we can pay for residential treatment for an
15 average of 30 days and for inpatient detox up to 15 days
16 max, because we will never solve this crisis with a bunch
17 of little 16-bed detox units. So we literally have a -- it
18 can be a public provider opening a 150-bed residential
19 treatment center across the -- south of the river, in
20 Richmond, with a 32-bed unit for pregnant women, including
21 beds for children, because before, those beds for their
22 kids counted against the 16-bed limit, so women couldn't go

1 into treatment and bring their kids with them.

2 So that's a game-changer. We have been told by

3 our providers they never could have done this without the

4 waiver. That was kind of the key linchpin to actually have

5 large treatment facilities.

6 The other key piece of this is the waiver

7 requires us to use ASAM, the American Society of Addiction

8 Medicine, as national evidence-based criteria. So before,

9 Virginia kind of had this home-grown system, really not

10 evidence-based guidelines. It was kind of chaos. So what

11 we were able to go is we went to the providers and said,

12 "To get our waiver we have to use ASAM," and we essentially

13 blew up our whole system, got authority from our general

14 assembly to redesign all of our services around ASAM.

15 So this just shows every one of these services,

16 the ASAM level of care, and the example, so we all know,

17 you know, that an ASAM Level 4 is an inpatient detox in a

18 medical bed. ASAM -- your know, our residential services,

19 we have different levels of care from detox in a psych unit

20 to detox in a community-based facility, to detox -- to

21 community-based settings group homes, halfway houses. We

22 have partial hospitalization, intensive outpatient, the

1 middle level of care, and then we also have opioid
2 treatment programs, methadone clinics, and office-based
3 opioid treatment. So it's that full continuum of care
4 that's been absolutely essential.
5 And I will say we spent the most time with
6 residential services. We actually brought in a contractor
7 to credential every one of our -- certify our residential
8 treatment centers, so we know that if Anthem says this is a
9 group home Level 3.1, Aetna will also say that, and we,
10 Medicaid, literally gave the health plans -- these are your
11 74 sites; credential these residential treatment providers,
12 so we don't have the chaos of one health plan says, "You're
13 a group home," the other says, "You're a community-based
14 detox."
15 And we've gone from three sites that took care of
16 pregnant women only in Virginia, for Medicaid, to now we
17 have 74 sites that have applied, so probably about a 20-
18 fold increase in capacity of residential treatment.
19 The other area we have put a huge amount of work
20 in, we learned a lot from Vermont. We had to figure -- the
21 office-based opioid treatment, the medication-assisted
22 treatment for us is the backbone of our delivery system.

1 This is the evidence-based combination of the methadone,
2 suboxone, and the counseling that we know is the most
3 important evidence-based treatment for opiate addiction.
4 We had a 6-12 month wait for methadone and suboxone. So
5 when we asked the family doctors, "How do we get you to do
6 medication-assisted treatment?" they said, "You have to pay
7 for the psychosocial supports. We need counselors in our
8 office."
9 So what we did was work with all of our health
10 plans, our addiction providers, and we designed this OBOT,
11 office-based opioid treatment providers, and we created all
12 of these new codes. So -- and we're paying unprecedented
13 rates. So for counseling in an OBOT we are paying $24 for
14 15 minutes, which is unprecedented. And then we even
15 created a new care coordination code. Virginia Medicaid
16 has never paid for care coordination, ever, at the provider
17 level, but we said this is so important, this crisis is so
18 severe, that for these special providers we are going to
19 pay $240 per member, per month. So that means in all of
20 our health -- Medicaid health plans will pay that. So what
21 that means is if you're a clinic and you have 30 Medicaid
22 patients, that's $84,000 a year. You can now hire a social

1 worker.

2 So once we -- and we also pay these clinics for
3 peer recovery supports, these other services. So we told
4 all of our providers to become an OBOT, you need to have a
5 buprenorphine-waived physician, co-located with a licensed
6 mental health professional. You need to apply to DMAS and
7 we will work with all of our health plan CMOs to all
8 approve you together. So we will have one network, if we
9 think about 30 to 40 OBOTs, who are going to work very
10 closely with the quality measures. We are going to turn
11 that care coordination payment into a value-based payment
12 in the next two to three years. The idea was we had to
13 offer money to build infrastructure first, and it's been
14 really fascinating. We have a variety of federally
15 qualified health centers becoming our OBOTs, that already
16 had behavioral health providers. We had outpatient
17 psychiatry clinics at our health systems, such as VCU. We
18 have private psychiatrist offices, primary care practices,
19 and we're really excited. We will know our final network
20 April 1.

21 And then the last piece, I mentioned how
22 important workforce is. Our general assembly also gave us

1 money for workforce training, which we gave to our Virginia
2 Department of Health. They have set up a really impressive
3 series of trainings, addiction disease management, one-day
4 training for physicians to get their buprenorphine waiver
5 and learn how to use it, and a parallel training for the
6 behavioral health providers to learn how to treat opiate
7 addiction. So we've had 700 professionals who are in the
8 process of -- signed up and registered and being trained at
9 28 different trainings across the Commonwealth. This is
10 going to double our addiction treatment workforce.
11 And then we also had -- Medicaid went out in the
12 field and did 12 in-person sessions that were attended by
13 over 1,000 providers, to teach them about our addiction
14 recovery treatment services benefit. Our secretary held an
15 opioid summit, which we think was key to getting the 74
16 residential providers, and our Virginia Department of
17 Behavioral Health trained over 400 providers in what the
18 American Society of Addiction Medicine is, so all of our
19 providers are using evidence-based best practice.
20 So this has really been, I think, an incredible
21 collaboration. We've had all of our agencies on deck. We
22 couldn't have done it without the governor's support and

1 the general assembly. And as I said, this is all -- we'll
2 start having outcomes in April 1, but I'm very excited to
3 hear from Vermont, who is actually even farther ahead of
4 us.
5 * MS. TANZMAN: Wow. So impressive what Virginia
6 is doing, and when I hear Vermont is farther ahead, it's
7 quite frightening, because we don't feel that we are out
8 from under this at all. We'd give ourselves probably like
9 about a C+ in terms of really addressing not only opioids
10 but substance use and mental health conditions, generally,
11 in our state.
12 I was asked to talk a little more about what
13 actually goes into medication-assisted treatment, which is
14 the gold standard for care, and to talk about some of the
15 barriers and challenges that state Medicaid plans might
16 encounter if they were really trying to scale a full
17 treatment response using medication-assisted treatment, and
18 then some of the strategies that we've used in Vermont to
19 address those barriers and challenges.
20 So obviously, addressing the opioid epidemic
21 requires a multipronged strategy. It isn't all treatment,
22 although treatment is central to it. Obviously, we need to

1 work on the opioid prescribing practices across the health
2 field, both for chronic and acute pain. We need to work at
3 it across different settings -- emergency room settings,
4 medical surgery departments, outpatient, and even
5 dentistry.
6 Prescription monitoring systems are an important
7 tool, particularly if they can cross state lines, and in
8 Vermont, we live close enough to other states that knowing
9 what's happening in New Hampshire or Massachusetts is also
10 important to having an effective prescription monitoring
11 system. And also having easy use for providers and
12 delegates to use these systems.
13 There is a huge role for law enforcement, both to
14 divert to treatment and then to actually manage and bring
15 the full force of the law to bear on dealers. There is an
16 incredible importance of peer support and recovery, family
17 support, in this whole area, and advocacy. Coming from a
18 mental health background, it's interesting how little voice
19 there is, really, of folks with substance abuse disorders,
20 and their families in an advocacy role. I think that the
21 shame and stigma still drive people underground, and
22 frankly, if you're still using you're probably engaging in

1 illegal activity, so it's not a time to come into a task
2 force and talk about, you know, how you are surviving.
3 Community organizing and prevention and messaging
4 has been incredibly important, and also in Vermont, we've
5 had strategies for all these things, but we've also done a
6 lot with Narcan, the overdose reversal, making that
7 available, widely available to first responders, to
8 addicts, to family members, and also changing some laws.
9 We have a Good Samaritan Law, so that if, in fact, you call
10 for medical assistance while a friend is overdosing you
11 will not be prosecuted yourself. So those are all examples
12 of broader strategies that are important in addressing
13 this.
14 What I want to talk about in a little deeper dive
15 is what happens, and can happen, in treatment systems. So
16 what goes into medication-assisted treatment? Well, it's
17 an evidence-based, long-term treatment using a combination
18 of medication, counseling, rehabilitation, psychosocial
19 supports, and really coaching to help people gain or regain
20 back healthy adult roles in our community. Generally, in
21 this discussion, the role of medication is over-emphasized,
22 at the expense of these more important psychosocial and

1 counseling supports that actually do more to build
2 recovery. We think of medication as sort of leg up, to get
3 someone stable enough to then be able to engage in the real
4 work of recovery, so I want to be careful to not
5 overemphasize the role of medication in this.
6 Important is frequency of contact. Typically,
7 with folks struggling with addiction, you need to monitor
8 them very closely. You need to monitor the treatment
9 response and see how people are doing with the medications
10 and the psychosocial interventions that you are providing.
11 You need to follow people over time, and not just in sort
12 of point-in-time episodes of care. And you need to attend
13 to the other consequences of the addiction, including,
14 often, extraordinary health complications, legal
15 involvement, disruption of family and parenting, and all of
16 the other sequelae that go along with sort of the
17 absolutely chaos and havoc that addiction wreaks in the
18 lives of families and communities.
19 What's interesting about this is that these
20 things that I just described -- close monitoring, following
21 over time, paying attention to the whole person -- are the
22 things that work in the management of other chronic

1 conditions. So this is not necessarily a new framework,
2 particularly for primary care providers. It tends to be a
3 little less typical of the framework in addictions
4 treatment, which outside of medication-assisted treatment
5 tends to be more episode-based. Typically, state Medicaid
6 plans do not have care management or case management in
7 their benefit. We do not follow people over time in a
8 continuous fashion. In fact, we often don't treat
9 addiction like the chronic relapsing illness that it is.
10 So medication-assisted treatment, I think, is actually an
11 important lead-in to a more comprehensive addictions
12 benefit plan in that it really sees the condition as long-
13 term and requiring more long-term supports.
14 One of the real barriers to scaling medication-
15 assisted treatment in our systems in the nation is a very -
16 - I'll just use the term "arcane" regulatory framework,
17 that governs the kinds of settings where medication-
18 assisted treatment can be provided. You probably heard
19 references to OBOTs and OTPs in this discussion that we've
20 just been having, but let me decode it just a little bit,
21 because I think it's important to understanding these
22 barriers.

1 OTPs, or opioid treatment programs, are a highly
2 regulated, particular kind of program that can only -- it's
3 the only environment in which methadone can be used, and
4 it's dispensed, for the treatment of addiction. It's the
5 only place that methadone can be used to treat addiction.
6 They tend to be -- they are governed by a very detailed set
7 of regulatory requirements, everything from the security
8 around the medication, the dosing schedule, and even a very
9 long, detailed set of regulations that actually set up the
10 clinical protocols by which you practice. This is unusual.
11 We don't really see this in other areas of the practice of
12 medicine or any other health care -- literally prescribing
13 how many times a person must be seen at the beginning of
14 treatment, when you can begin to back off and see them less
15 frequently, and so forth. It's all set out in federal
16 regulations.
17 What's happened with the opioid treatment
18 programs, with this heavy regulatory framework around it,
19 is they've tended to be extremely specialized, just
20 specializing in the provision of medication-assisted
21 treatment with methadone. They are often even operating in
22 isolation from the rest of the substance use treatment

1 system. They typically, at least in Vermont, were also
2 operating in considerable isolation from the general health
3 care system.
4 Just as a little diversion, in our opioid
5 treatment programs in Vermont, one in five of the folks
6 being served, the Medicaid beneficiaries being served in
7 these programs, have hepatitis C. So having a specialty
8 treatment program that operates in relative isolation from
9 the health care system, when you have a caseload, a client
10 base that has that much complicated other conditions, is
11 not a formula for good treatment.
12 That's on the OTP side. Also, typically, these
13 opioid treatment programs really only offer methadone.
14 They may use some Vivitrol or buprenorphine, but in the
15 case of Vermont they were doing none of the other
16 medications that are also FDA-approved for the management
17 of opioid addiction. So that's one framework. It drives
18 you into one kind of set of providers, in a very prescribed
19 fashion in our communities.
20 One other comment about it. It's not cost-
21 effective to do on a small scale, so it's very difficult to
22 scale opioid treatment programs in rural areas.

1 On the other side, beginning with federal
2 legislation in the early 2000s, is something called office-
3 based opioid treatment, or OBOT, and that is a set of
4 regulations that allow any MD, in any kind of medical
5 setting, to prescribe buprenorphine for the management of
6 opioid addiction. In those general medical settings,
7 however, what they can do is provide the buprenorphine, but
8 most plans and most service arrays do not have a mechanism
9 for embedding the psychosocial supports and the counseling
10 and all of the other things that are the necessary
11 components of medication-assisted treatment, what really
12 makes the medication-assisted treatment successful. The
13 ability to be waivered to prescribe buprenorphine in a
14 general medical setting doesn't get you all of that other
15 stuff there. So I'm not surprised that Kate learned, very
16 quickly, from her providers in Virginia, physicians saying,
17 "Hey, I can do this, but I need an embedded counselor. I
18 can't do this without a multidisciplinary team." But
19 there's nothing in the federal framework that cause or
20 units that part of the system.
21 So, essentially, in Vermont, before we began the
22 work that we were doing, the physicians who were

1 prescribing buprenorphine, some of them would say to me,
2 you know, "Beth, it's sort of like I'm flying blind. I
3 think this person is in counseling. I don't know how
4 they're doing in counseling, but yet I'm going to write
5 this prescription every couple of months -- or, you know,
6 twice a month, every two weeks, and I have difficulty
7 getting records and setting up a relationship with the
8 substance use treatment programs that would be treating
9 someone for counseling, because they say they can't
10 exchange information with us, and so forth."

11 So it was actually in Vermont. We were pretty
12 much requiring the addicted individual to go out and
13 coordinate their care, and make the evidence base come
14 true, so that they could get their medication and also get
15 the psychosocial support that they needed, and that's a bad
16 idea to ask the addicted person and their family to be
17 responsible for doing that. I think that one should be on
18 us.

19 So we -- the other thing, difficulties of scaling
20 in the system, I mentioned the OTPs tend be very
21 specialized, hard to do in a rural area. On the OBOT side,
22 we've been operating with caseload caps, so restrictions on

1 how many patients a physician can see. That has recently
2 been moved now to up to 275, but you still have to, in year
3 one, see only 30 people. I mean, it's -- so if you're
4 trying to actually bring a treatment response to scale, you
5 need -- every month you have to get new physicians willing
6 to participate, because of the nature of the caps.
7 Also, until, literally, this month, only MDs
8 could prescribe, so nurse practitioners, physician
9 assistants, mid-levels were not allowed to prescribe, which
10 used to make people kind of crazy. I've had folks say, you
11 know, "Beth, I can prescribe the opioids for pain. I can
12 get someone addicted, but I can't prescribe medication-
13 assisted treatment to my own patients, to actually manage
14 this." So that rule was changed by legislation this
15 summer, and so I think that some of what we're talking
16 about now is going to be significantly changing by the
17 inclusion of mid-levels. So that is a key opportunity for
18 systems across the nation in terms of being able to get the
19 provider force to do this work. So we have these two
20 different regulatory structures, OBOT and OTP, which sort
21 of force your medication-assisted treatment approach to
22 happen in two different provider settings, and so when

1 you're trying to scale a treatment response you need to
2 think about what are the interventions and supports you can
3 do in both sides of the continuum.
4 So what we did in Vermont was basically I did
5 everything the doctors said they needed. I mean, I really
6 took the physicians at their word. And what they said they
7 needed was more embedded counseling in order to be able to
8 do the services well and also that they needed specialized
9 nursing care because these patients are medically complex.
10 So I said, okay, we've got to get you nurses and embedded
11 counselors.
12 At the OTP side, they said they needed things
13 like consulting psychiatry because they actually were
14 relatively -- not as strong as they really should be in
15 treating the co-occurring mental health conditions that
16 occur with opioid addition. Right? This stuff travels
17 together. It rarely runs alone.
18 And, that they also needed more nursing and the
19 ability to actually have outreach into the health system to
20 organize care more broadly on behalf of their patients.
21 So we applied for -- the tool that we used to
22 grow our Medicaid program around this was the health home

1 under Section 2703 of the Affordable Care Act, and that was
2 really designed to treat Medicaid beneficiaries with
3 chronic conditions. And so we were the first to make the
4 argument to CMS that opioid addiction was a chronic
5 condition. What's kind of scary about this was that
6 actually in early 2012 I really was having to make that
7 case because they were not accustomed to thinking about
8 addiction disorders in that framework. It was,
9 fortunately, not a hard case to make.

10 So we applied for a health home that allowed us
11 to create an entitlement on the behalf of Medicaid
12 beneficiaries with opioid addiction in Vermont to things
13 like care coordination and attention to transitions of care
14 and health promotion services and consumer-and-family
15 support and referral to community services, all of the
16 things that you would do to manage a chronic condition but
17 that had not been available in our previous substance use
18 plan.

19 We also built on the infrastructure of our
20 statewide patient-centered medical home initiative, the
21 Blueprint for Health, that had been working with primary
22 care practices of all stripes and sizes in all different

1 kinds of settings to become patient-centered medical homes.
2 And that Blueprint provides additional payment, quality
3 payments to practices for meeting those standards, and also
4 has an all-payer approach to supporting a community health
5 team to work with the primary care practices. That
6 community health team was multi-disciplinary staff embedded
7 in all of our primary care practices.
8 So what we did was wrote a health home to link
9 the OTP programs, which we renamed "hubs," to the OBOT
10 programs, which we renamed "spokes."
11 We hired, through the Blueprint community health
12 teams, one FT nurse and one FT licensed mental health
13 addictions counselor to work with every 100 Medicaid
14 beneficiaries across all of the OBOTs in our state.
15 We hired -- additionally, we augmented the
16 bundled rate of the OTP programs, the "hubs," to include
17 consulting psychiatry, care management, additional nursing
18 supports.
19 And we also developed a buy-and-bill approach
20 that the OTP programs could use to also be able to dispense
21 buprenorphine. So now we have our OTP programs not only
22 using methadone but dispensing buprenorphine, and we

1 actually paid them to provide specialty addictions
2 consultation to the general medical providers who are
3 prescribing buprenorphine.
4 So we set up a sort of reciprocal relationship
5 where if a patient is having a very severe course of
6 addiction in a general medical office setting they can ask
7 for help from their specialty addictions provider, that
8 opioid treatment program, and vice-versa, and patients
9 could begin to flow.
10 So since we've done that, we've found that by
11 offering the embedded nursing and counseling staff it's
12 much more possible to engage physicians and medical
13 practices in becoming -- in offering medication-assisted
14 treatment because they actually have the multi-disciplinary
15 team support that they need to implement the evidence-based
16 model, which they'd like to be able to do.
17 And we've been able to really expand our
18 enrollment in the OTP programs in part because we're also
19 offering buprenorphine. So folks can start in the rigor
20 and daily dosing of an OTP program and have a hope of
21 transitioning to an outpatient program in the future.
22 We have almost tripled the number of people who

1 we're treating. We probably treat now more people per
2 capita than almost anyone else in the nation, and yet, in
3 some regions of Vermont we still have waiting lists. So we
4 don't feel out from under this.
5 We have dramatically expanded the number of
6 physicians and medical practices that are offering opioid
7 treatment, medication-assisted treatment. We're Vermont.
8 You know, we're tiny. We're the size of a county. But we
9 do have over 55 full-time nurses and licensed mental health
10 addictions counselors working in over 80 different general
11 medical settings now and have created this health home
12 framework to link what's happening in the OTP programs
13 programmatically with what's happening in the OBOT
14 programs.
15 CHAIR ROSENBAUM: We need time for public
16 comment, and I'm sure the commissioners have a lot of
17 questions.
18 MS. TANZMAN: Okay. Let me stop.
19 CHAIR ROSENBAUM: So if you could bring it to a
20 close so that we can have enough time for questions.
21 MS. TANZMAN: Certainly. Apologies for running a
22 little over.

1 CHAIR ROSENBAUM: It's okay. No. It's
2 fascinating.
3 MS. TANZMAN: I'm a little passionate about this,
4 yes, yes. At another point I'd be happy to share what
5 we're seeing in terms of results.
6 CHAIR ROSENBAUM: Please summarize the results,
7 actually give us a minute on the results.
8 MS. TANZMAN: Okay. So the elevator speech is
9 that we've been very successful in expanding access to
10 treatment, which is the number one goal that we were trying
11 to do. The second elevator speech is that we're finding
12 that Medicaid beneficiaries receiving medication-assisted
13 treatment have lower health care costs than Medicaid
14 beneficiaries with opioid addition who we are not treating
15 with medication-assisted treatment. So there's a good
16 return-on-investment argument for providing medication-
17 assisted treatment.
18 CHAIR ROSENBAUM: All right. Let me just start
19 at this end with Kit and Andy and Sheldon and Penny and
20 Peter.
21 COMMISSIONER GORTON: Thank you for investing so
22 much of your personal time and energy, your organization's

1 time and energy, on what is a very important topic.
2 Fascinating work that you're doing. And I could ask a
3 thousand questions, but in the interest of time I will
4 limit myself to two related questions, starting sort of,
5 Beth, where you left off.
6 It would be interesting that the commission takes
7 a much more population-level view. It's great that people
8 like you are out there in the fields doing the work, but we
9 sort of look at things from a population level. So I would
10 be interested in as you've set up your programs both in
11 Virginia and in Vermont as well -- Kelly, in the states
12 that don't start with V -- about what are the outcome
13 metrics that people are trying to move with these programs
14 so that as we look at population health data we can look
15 for the signal.
16 And then related to that, how do you think the
17 data is? I was a little anxious when Kate started talking
18 about nontraditional coding. And I just sort of wonder
19 what kind of data you think is out there, what data do you
20 use to shape these programs, what do you think are good
21 data sources, what do you think are weak data sources, if
22 you have a point of view about T-MSIS or those kind of

1 things, are your data getting into the Medicaid data sets.
2 That would be helpful. Thank you.
3 MS. TANZMAN: So the data on substance use
4 treatment is pretty poor from a population health point of
5 view if you're trying to look across a whole population
6 because it really doesn't flow into any of the systems
7 other than -- none of the clinical data does -- 42 CFR Part
8 II and also because, frankly, as we onboarded EMR programs
9 through the meaningful use program we did not include
10 behavioral health providers or other long-term care
11 providers. So they're not typically -- they haven't been
12 resourced, even developed the clinical EHR systems and the
13 connections with the health information exchanges, et
14 cetera, that would even allow clinical measures to flow to
15 the extent that they can.
16 The -- so we use -- the data that we use a lot in
17 Vermont is just our all-payer paid claims. So I'm looking
18 to find what we can find in claims that is pretty good in
19 terms of overall health utilization and expenditure kind of
20 information but poor in others. We have recently
21 negotiated to get a crosswalk with all of our corrections
22 data, and we're going to look and see what kind of impact

1 we're having on incarceration. And we also plan to match
2 this to labor data to see about impact on employment.
3 The only real gold standard population-level
4 measures, if you can call them that, that we see being used
5 that we're adopting in our new all-payer waiver are the
6 initiation and engagement in drug and alcohol treatment
7 measures after an index event. And it's quite distressing
8 to see actually how poorly the national benchmark is on
9 those measures, and we do poorly in Vermont on them.
10 CHAIR ROSENBAUM: Yes.
11 DR. NEUHAUSEN: Can I address that real quick?
12 CHAIR ROSENBAUM: Mm-hmm.
13 DR. NEUHAUSEN: Because I do think that's really
14 important. So we have, in Virginia, partnered with VCU
15 health system, with academic researchers, for an
16 evaluation. And so under the 1115 waiver, CMS actually
17 requires that we track ED visits, hospitalizations, and
18 readmissions to the same level of care or higher. So
19 that's the demonstration is does expanding access to the
20 full continuum of addiction treatment result in decreased
21 ER visits, hospitalizations, readmissions.
22 CMS also requires kind of the core measures, core

1 Medicaid adult. I think they're from the core Medicaid
2 adult measures set -- initiation, engagement, and substance
3 use disorder treatment, follow-up after seven days within
4 the ER visit. And we modified a care transition measure
5 from CMS.

6 There are some really good PQA (Pharmacy Quality
7 Alliance) measures on opioids that we're tracking. One is
8 multiple prescribers, patients with multiple prescribers
9 who don't have cancer, another is patients on more than 120
10 morphine ml equivalents without cancer, and one is multiple
11 prescribers and high doses that align well with CDC. We're
12 tracking those.

13 And I think most importantly we're linking with
14 our Virginia Department of Health data to look at opioid
15 overdose rates by region, fatal overdoses, and then looking
16 at neonatal abstinence syndrome.

17 I'd love to get incarceration data. I think
18 that's a long-term aspirational goal.

19 And then our researchers are also looking at our
20 workforce and looking at the -- really tracking, you know,
21 of course, access, volume of services, but looking at
22 whether we increase our workforce.

1 We do have the nontraditional codes, but that's
2 also how we're able to increase our rates without -- it's
3 really hard to -- we couldn't go to the E and M codes. But
4 I think that level of rigorous measurement and evaluation
5 is going to be essential for our general assembly to
6 continue to invest in the treatment.
7 CHAIR ROSENBAUM: [Off microphone] -- from eight
8 pending commissioners here, enlightening answers. Andy.
9 COMMISSIONER COHEN: Thank you so much. Really
10 interesting presentation and incredibly important topic.
11 Relates more broadly, I think, to a body of work that we
12 have touched on at MACPAC, but I hope we'll do more on in
13 the future with respect to how Medicaid cannot just allow
14 when you have incredibly motivated, dedicated individuals
15 and leaders, and a whole bunch of other factors aligning,
16 and lightening striking, but how to really incentivize
17 evidence-based practice for Medicaid beneficiaries. And I
18 think that that is just like a huge area to explore.
19 So, my question for you. And I guess really it's
20 probably mostly to Kelly. You talked a little bit about
21 sort of what can Medicaid do better to encourage or really
22 I think you framed it as like allow evidence-based

1 treatment models. And what I really want to understand,
2 thinking about where we sit as MACPAC, is we don't want to
3 just allow it. We want to make it easy to happen, and we
4 might even someday want to say, you know, we really want to
5 make it hard for states not to be using -- you know, paying
6 for evidence-based treatment. And, of course, there isn't
7 an evidence base on everything, but where there is.
8 So can you talk a little bit about -- and I
9 understand you come -- you're representing states who want
10 flexibility in a variety of ways and may be closer to
11 problems than the federal government is, but I just -- I
12 want to understand. What are things that the federal
13 government can do, policy changes that can make this switch
14 to pushing for evidence-based treatment easier?
15 MS. MURPHY: So it's a great point, and I'll be
16 really quick and happy to follow up with you more
17 afterwards. I definitely think that we certainly are
18 trying to incentivize evidence-based practices with
19 everything that we recommend with states to the extent that
20 there is evidence -- you noted that there isn't in
21 everything -- trying to uncover those promising practices.
22 States really want to know what works. They want to know

1 what has return on investment, which was mentioned earlier,
2 and to incorporate it.
3 We, last year, put out a set of priorities, and I
4 am happy to share those with you, to the federal government
5 about what the federal government broadly, broader than
6 CMS, could do to incentivize this work in the state, and
7 we're hoping to update that. So actually, I think we're
8 going to be coming out soon with some really clear,
9 hopefully from all of the governors, thoughts on what you
10 guys can actually do or what you can promote.
11 We're working pretty closely with NAMD to think
12 about Medicaid broadly and where Medicaid directors are
13 running into barriers, too, at the federal level. I had a
14 state anecdotally say the other day that even coming up --
15 even though -- even with Medicaid expansion, coming up with
16 those extra dollars from a state perspective is just still
17 really difficult and that that is top of mind for them,
18 too.
19 So let me take that back to NGA. Hopefully, we
20 are going to come up with some very concrete priorities,
21 and I'll make sure to highlight the ones -- the Medicaid
22 ones for you guys when we come up with those collectively

1 through our process.

2 CHAIR ROSENBAUM: Thank you. Sheldon.

3 COMMISSIONER RETCHIN: Is this?

4 CHAIR ROSENBAUM: It's on.

5 COMMISSIONER RETCHIN: You think it's on?

6 CHAIR ROSENBAUM: Yes. It is on eternally.

7 COMMISSIONER RETCHIN: How come mine doesn't
8 light up right?

9 So first, in full disclosure, I recruited Kate to
10 Virginia. Actually, maybe it wouldn't surprise people that
11 after our first meeting I realized that I was actually
12 being interviewed. So, welcome back.

13 I have just -- I have a comment and then maybe
14 even a suggestion on what I'm going to bring up, and that
15 is -- I think, Beth, only you touched on this, but it's the
16 different -- we have two different diseases here, and so
17 I'll characterize it as urban addiction and rural
18 addiction. Different drugs. Different demographics.
19 Different population. So in the rural areas they're using
20 non-heroin opioids and stimulants like meth, and it is just
21 a completely different -- and to even -- there's also a
22 cultural underlay. If you haven't read "Hillbilly Elegy,"

1 you should.

2 So your concentration in Appalachia is really
3 spot-on, but as I hear this, your discussion, I don't hear
4 much in terms of what to do about that. It's very, very
5 different and very difficult access.

6 So I'll just bring up two suggestions, and maybe
7 this really is for you, Kelly, because I'm sure there are a
8 lot of states that are bringing this up.

9 So one is whether -- is on telehealth and
10 reimbursing for it and determining how you're going to be
11 able to -- this is a different telehealth to involve teams,
12 and I think that that's an important part of a
13 demonstration.

14 The second one is an interesting one that we're
15 actually going to approach, and that's the extension
16 program. Land-grant universities in many states have these
17 extension programs for agriculture. Then you have -- it's
18 like the Maytag repairmen. They don't do what they were
19 supposed to do 100 years ago. And yet they have some
20 public health training background and wondered whether that
21 might not be a platform to get out into the rural areas in
22 a public health strategy.

1 Just, I wanted your comments.

2 MS. MURPHY: I am open to suggestions. I have
3 actually never heard about the extension program as an
4 option. It hasn't been brought up by states, but very
5 happy to look into it. I think we always hear that states
6 want resources pushed down to the community level just for
7 this reason, so that the communities have the flexibility
8 and they can allocate their resources according to what
9 their community-based needs are.

10 The reimbursement for telehealth. We've
11 certainly had states asking us all about different
12 telehealth, telemedicine, teleconsultation, strategies to
13 increase access in rural areas. So point taken, and we'll
14 certainly continue to look into these.

15 VICE CHAIR GOLD: That program is a model for the
16 REC program.

17 MS. MURPHY: Okay.

18 VICE CHAIR GOLD: But it was more successful.

19 MS. MURPHY: Okay. That's great. Thank you.

20 CHAIR ROSENBAUM: Great. Penny.

21 COMMISSIONER THOMPSON: Fantastic presentation.
22 Really found it fascinating from beginning to end. So also

1 could ask a thousand questions. Just to focus on a couple,
2 one is -- and maybe, Kelly, this is for you. Across the
3 country, we've talked about connecting to -- and Beth, you
4 mentioned this as well -- the corrections system and the
5 number of people that have received coverage through the
6 Medicaid expansion. So my question for you is: What
7 happens in the states without a Medicaid expansion? What
8 are the treatments and services, and how are they funded
9 and financed?
10 CHAIR ROSENBAUM: Yeah, I have the same question.
11 MS. MURPHY: Yeah, it's -- I know it is really
12 tough, and definitely they are playing with a lot less
13 funding and a lot less flexibility but no real less of a
14 problem. So we are trying to help them pick strategically
15 the, you know, places they want to put those limited
16 dollars. What we're really trying to do is help them look
17 at their data and figure out, you know, where their problem
18 is, where their issue is, so that they can target their
19 limited resources better.
20 It's certainly, certainly a concern. I don't
21 know that I have a great answer for it, but great question.
22 CHAIR ROSENBAUM: Well, it would be interesting.

1 I just want to note because it's right on Penny's point
2 that as I was sitting listening to you I would -- I'm sorry
3 we don't have the time for today, but some dialogue between
4 an expansion state and non-expansion state about things
5 that are happening or may be able to happen in Vermont that
6 do not happen in Virginia.
7 COMMISSIONER THOMPSON: And then a second quick
8 question Kate, also connected to some other conversations
9 that are going on, which is: So, very exciting what you're
10 launching in Virginia. Other than the IMD exclusion, what
11 other federal authorities had to be waived for you to
12 create that program?
13 DR. NEUHAUSEN: So, yeah. And I am not the
14 expert on the authority. I'm the expert on the clinical.
15 So I'll go back to our clinical.
16 So in the 1115 we also had to waive some of the
17 statewideness in the OBOT network specifically to limit the
18 care coordination payments to the OBOTs because that's a
19 big -- you know. Every practice is going to want that.
20 So, to say, we only are paying $240 per member per month
21 for a member with opioid use disorder in an OBOT, getting
22 the counseling and the buprenorphine, so the -- that was

1 really important in our waiver.

2 I think we just had a lot of flexibility because

3 it's under managed care, too. I mean, I think that's the

4 other. So we did a lot of -- some of the -- a lot of the

5 services are actually under our state plan amendment and

6 then under our 1915(b)(c) waiver.

7 COMMISSIONER THOMPSON: Right.

8 DR. NEUHAUSEN: So that allows a lot of the

9 flexibility with the networks.

10 COMMISSIONER THOMPSON: Yeah.

11 DR. NEUHAUSEN: And then really we used -- so all

12 the services are now in our state plan amendment.

13 COMMISSIONER THOMPSON: Yeah.

14 DR. NEUHAUSEN: And the waiver is really used for

15 the IMD exemption. I think some of the peer -- well, peer

16 is a new service. And then the care coordination and

17 limiting some of the payments, too, yeah.

18 COMMISSIONER THOMPSON: Okay. I think just to

19 sort of where Andy was going a little bit initially --

20 DR. NEUHAUSEN: Right.

21 COMMISSIONER THOMPSON: -- in terms of

22 identifying those places where maybe there are some federal

1 authorities that are barriers. I mean, I think in most of
2 these cases what we see is there is a state commitment,
3 state funding, state willingness to raise the rates, state
4 willingness to engage in some of these supporting services.
5 And then I think the question is: How does the federal
6 government come and meet those states, and what are the
7 steps that can be taken to make that easier and simpler for
8 states to take access of?
9 DR. NEUHAUSEN: I will say 42 CFR is a huge, huge
10 issue because our health plans have been told they can't
11 have their care coordinators call members with addictions
12 with 42.
13 COMMISSIONER THOMPSON: No, no [inaudible.]
14 DR. NEUHAUSEN: I mean, it's a huge issue for our
15 Medicaid considering our members are in managed care.
16 CHAIR ROSENBAUM: I should note -- I mean, again
17 just as a caveat, and then we can move on. I don't want to
18 interrupt the flow. That what it requires is an informed
19 consent, and so it's not a total barrier. It is a problem
20 that requires some thinking about how to encourage people
21 to give informed consent and how do you consent an entire
22 treatment team.

1 So this is -- it's very complicated, and of
2 course, I mean, I totally appreciate the concern about
3 modifying Part II or the need to rethink Part II. But I
4 just want to be clear that we're dealing here with a
5 question of consent. So.
6 DR. NEUHAUSEN: So that would be great guidance
7 because with the health unit how do we proactively reach
8 out to a member.
9 CHAIR ROSENBAUM: Right.
10 DR. NEUHAUSEN: You know. We've seen that they
11 were in ER --
12 CHAIR ROSENBAUM: Exactly.
13 DR. NEUHAUSEN: -- from their medical claims data
14 with a non-fatal overdose. I want to call them and to
15 screen them and get them referred to treatment.
16 CHAIR ROSENBAUM: A number of people have --
17 right. That it requires the high energy of thinking about
18 informed consent.
19 DR. NEUHAUSEN: Yeah. So any guidance from the
20 commission would be wonderful.
21 CHAIR ROSENBAUM: Totally. Peter.
22 COMMISSIONER SZILAGYI: Just very briefly, I had

1 a question and comment about costs and dollars.

2 And first of all, congratulations for -- as a
3 clinician, I was so impressed with how deep and thoughtful
4 your programs are, and to me there were kind of three
5 themes that really linked all this. One is that you really
6 listened to the experts and the providers on the ground for
7 what is needed for this patient population. Secondly, that
8 you implemented, and you sort of focused the program to
9 evidence-based and incentivized evidence-based care. And,
10 thirdly, that you recognized the non-medical component for
11 this population. And I don't think that's that different
12 from whether you talk about children with special health
13 care needs --

14 DR. NEUHAUSEN: No.

15 COMMISSIONER SZILAGYI: -- or adults with other
16 chronic disease. And this is sort of the complexity of
17 Medicaid because so much of Medicaid has the overlap of the
18 non-medical.

19 My question about costs was: Do you have any
20 estimates right now for what the cost per patient or per
21 Medicaid -- total Medicaid enrollment is going to be? And
22 the suggestion is I would really not -- I would spend the

1 effort trying to estimate what your outcomes and savings
2 are, not just in the medical component but the non-medical
3 component, in the evaluation component.

4 And this isn't just incarceration, but this is
5 anything from working with the law. As an anecdotal
6 example, my son is a policeman up in Seattle. He tells me
7 80 percent of his work has to do with opioid or addicted
8 individuals or people with mental health problems. Eighty
9 percent of his time.

10 So linking with academic institutions to try to
11 model what the savings are, and a lot of the savings are
12 not going to be in the traditional health sphere but
13 outside the health sphere.

14 There have been efficacy studies, small studies,
15 but you guys are scaling this up in a big term. And so the
16 costs will be different, and the savings or the model
17 savings might be different.

18 CHAIR ROSENBAUM: So I have Chuck, Sharon, Toby,
19 Norma.

20 COMMISSIONER MILLIGAN: I had one question, and
21 it's really about 42 CFR. I still want to ask it, I think.

22 So, a couple of just comments first. A lot of

1 individuals with behavioral health issues and addiction
2 issues are also neglecting other parts of their health
3 care. They're not getting other prevention and all of that.
4 So that's sort of premise one.
5 Premise two is the long-term cost effectiveness
6 is going to -- the business case, if you will, is going to
7 be based on avoiding other health costs in the health care
8 system in terms of the sustainability of these programs,
9 especially when some of the enhanced funding goes away
10 under the health home model, Section 2703, and so on.
11 So my question -- and I think, Kelly, I'm putting
12 to you, but -- I think I'm putting it to you. I'm not as
13 sensitive, Sara, to whatever the downsides are of modifying
14 42 CFR because I see the barrier side very clearly in terms
15 of clinical management and data-sharing that helps make the
16 business case about how the hospital avoidance or the
17 primary care provider or getting into other
18 prevention/preventive services, et cetera, et cetera.
19 My question: Are there any discussions around
20 modifying 42 CFR and to try to address the barrier part
21 without losing the benefit of it to whatever extent there's
22 a stigma issue about maintaining confidentiality?

1 MS. MURPHY: So we've mentioned 42 CFR in our
2 previous recommendations that we came out with as a
3 collective organization. We've talked with SAMHSA about
4 it. We've asked them about it about a million times. I
5 don't think we've ever avoided a question when we've
6 convened states about 42 CFR Part II. It definitely comes
7 up.
8 I know that there was a final rule, I think late
9 last year, where they modified it a little bit.
10 COMMISSIONER MILLIGAN: Not much.
11 MS. MURPHY: But we've really heard from states
12 that it's not enough. It's a step in the right direction,
13 but it really needs to go further and be a real
14 comprehensive fix that aligns with HIPAA. So we'll
15 continue to take that message to SAMHSA, and you know, open
16 to other suggestions, too.
17 COMMISSIONER MILLIGAN: Well -- and I just -- one
18 of the reasons I flag it is in terms of our role. That is
19 a federal issue that affects Medicaid.
20 CHAIR ROSENBAUM: Huge. It's a huge effect.
21 Sharon.
22 COMMISSIONER CARTE: A follow-up on the issue of

1 telehealth and specifically Project ECHO that Kelly
2 mentioned. I'd like to hear from the two model states if
3 you're contemplating that. It seems to have so much
4 potential in terms of workforce, targeting locale, whether
5 it's incarcerated centers or whatever. I'd just like to
6 hear from both.
7 MS. TANZMAN: So we've been incredibly impressed
8 by Project ECHO, and I've, on three times in the last five
9 years, brought forward a request to develop Project ECHO
10 for co-occurring mental health conditions, for folks with
11 complex trauma, for management of chronic pain, for a whole
12 host of them. Participated to some degree in the learning
13 collaborative, statewide learning collaborative for this.
14 We've not been successful in Vermont in engaging
15 academic medical centers and get traction of interest
16 around it. I worked really hard last year to do with our
17 federally qualified health center network. There's a
18 wonderful ECHO replication in Connecticut that's coming out
19 of the FQHC network. That's another place to do it, but it
20 requires seed money and mostly resources for the clinical
21 time to do the expert work. So we've not had success in
22 implementing although I would highly recommend the

1 approach.

2 CHAIR ROSENBAUM: Great. Toby.

3 DR. NEUHAUSEN: Can I? Virginia actually --

4 CHAIR ROSENBAUM: Oh, of course.

5 DR. NEUHAUSEN: So NGA actually has a Project
6 ECHO collaborative around addiction medicine that Virginia
7 was selected for that we're using for ongoing support of
8 those, that new workforce of 700 buprenorphine-waivered
9 physicians and behavioral health professionals. So we
10 actually had our academic institutions, our two major ones,
11 UVA and VCU, competing to be the academic hub. So we're
12 excited, but again that's six months. And it's a great way
13 to have a warm touch and to mentor these new providers so
14 they don't get overwhelmed and kind of have someone to
15 call.

16 But I will say we need -- I think a challenge to
17 us is going to be figuring out the ongoing support, and
18 probably I don't know if any state has created that
19 Medicaid payment for the physicians' consult time.

20 CHAIR ROSENBAUM: An interesting sidebar is that
21 HRSA, as I understand it, did set some of the health center
22 expansion fund aside to capitalize addiction programs. And

1 the question is: In doing so and then underwriting them on
2 an ongoing basis, what--you know, what policy guidance have
3 they given around how those funds should be used or could
4 be used in concert with these larger initiatives? That may
5 be something for us to follow up on.

6 Norma -- oh, Toby. I'm sorry.

7 COMMISSIONER DOUGLAS: Great presentations.

8 A question that I wanted to ask is around the
9 opioid treatment providers in California called "methadone
10 clinics," and just knowing that they have been really a
11 longstanding part of the substance use system and pre-
12 Medicaid assistance treatment, but you saw -- and this is
13 both for Beth and Kate -- of their ability to really change
14 their model and willingness -- clearly, it was great with
15 the health home, but the question we struggle in California
16 is really bringing them into the fold of really seeing the
17 MAT model and what you've seen in results and outcomes in
18 that and movement away from actual methadone.

19 MS. TANZMAN: This is a work in progress, and
20 it's primarily cultural. It's really not something that
21 can be addressed through, I think, regulation or funding,
22 that the tools are different to use.

1 We've had, I would say, our best experience with
2 our newest program that is actually operated by one of our
3 community hospitals, and in part, because it's sponsored
4 and operated by a hospital, they get it. And they built it
5 sort of with collaboration across the health and human
6 services network in their DNA.
7 One of the companies that's very active in
8 Vermont, actually, comes from California, BAART Behavioral
9 Services. I think they do a little better with this.
10 They've enjoyed the Vermont context, where we actually ask
11 them repeatedly to keep coordinating care, and we have
12 started to actually measure them on the amount of activity
13 that happens between hubs and spokes and things like that.
14 But I would say it first really became clear to
15 me when we began to ask them to dispense buprenorphine.
16 What a big change we were even making, because even that
17 was a big change over what the clinical practice had been.
18 And it's also hard to get people to talk in a
19 more positive way. I can't tell you how much of the
20 language, particularly in the traditional programs, is
21 around things like dirty urines rather than positive labs
22 or requiring patients to be completely organized and clear

1 and not recognizing that's the addiction.

2 Our primary care providers have been so helpful,
3 actually, in this discussion with our OTP programs, because
4 they will say things like, "I don't kick someone out of my
5 diabetes programs because they had two Big Macs over the
6 weekend." So that's been helpful, bringing them into
7 context with the general medical profession. I think it's
8 been helpful.

9 DR. NEUHAUSEN: And I'll say in 30 seconds, we're
10 using financial incentives. So we brought the best OTPs
11 into the room to develop our OTP payment model, which looks
12 very similar to our OBOT. They wanted daily payments, but
13 we said, "Look, you can make a lot more money if we
14 unbundle, and look, we're going to give you all this money
15 for counseling." So now they're hiring counselors, "And
16 we're going to give you all this money for care
17 coordination." So they're bringing in RNs.

18 This is what I love about Medicaid. We've
19 created the incentives to support the practice we want, and
20 we currently have 5 of our 35 methadone clinics to accept
21 Medicaid, and I think we're up to 20 that are coming in
22 under ours, but I think it's having them in the room to

1 design the incentives to support the practice we want.

2 COMMISSIONER DOUGLAS: Are there other policies

3 from a federal or CMS to drive it?

4 MS. TANZMAN: If I may, on the federal policy,

5 one of our big issues is that Medicare will not reimburse

6 for services in an opioid treatment program.

7 DR. NEUHAUSEN: Or for methadone.

8 MS. TANZMAN: That's a problem.

9 DR. NEUHAUSEN: Yeah. We're having an issue with

10 our duals, where we've having to wrap around on Medicaid

11 side. We learned Medicare Part D doesn't pay for

12 methadone, so we're trying to wrap around and cover. But,

13 yes, it's a big problem.

14 MS. TANZMAN: In fact, Medicare beneficiaries are

15 some of our hardest to place in medication treatment.

16 CHAIR ROSENBAUM: All right. Norma, you close us

17 out.

18 COMMISSIONER ROGERS: Okay. Thank you very much

19 for a wonderful presentation.

20 I'm wondering if in your outpatient, when you're

21 planning, doing our outpatient treatments, are you planning

22 group therapies? Do you do group therapy, and are you

1 separating men from women?

2 My research is in post-incarcerated female
3 offenders, who are under community supervision, and we
4 found that we separated the women from the men because many
5 times men are the ones who influence them to do whatever it
6 is. As we well know, 87 percent of the women who go to
7 prison are influenced by men.

8 So are you all working on that or doing that?
9 I'm just kind of curious about that.

10 DR. NEUHAUSEN: We actually created a special
11 code for our OTPs and our OBOTs for group counseling, and
12 we actually set the rate pretty high to incentivize it. It
13 is like $7.25 for 15 minutes. If you have four members,
14 you make more with the group than individual. Because,
15 again, we realized if we set the group rate too low,
16 everyone will do individual counseling.

17 So we build in a financial incentive for groups.
18 We set a maximum of 10. We're encouraging our OTPs and
19 OBOTs. We're not mandating segregated. I think some are
20 focusing on pregnant women and doing groups for pregnant
21 women, and we can encourage that when we hold their hand.

22 But I do want to say I think the other most

1 important thing we did was we did an OTP summit, and we
2 brought in all of our methadone clinics. And we showed
3 them the financial model, and we talked about clinical best
4 practices, like group visits and like dispensing
5 buprenorphine, and we're paying them more for
6 buprenorphine. They have more of a margin than methadone.
7 So it's a mix of financial incentives and encouraging
8 clinical best practices, but we're doing that for groups.
9 COMMISSIONER BURWELL: Well, what we did was we
10 separated -- well, we also included family therapy with
11 that because what we found was that the kids were really
12 mad at their mothers, and so separating them, but we kept
13 them in treatment for a year. It's a long time. It was a
14 long time. We started off with a shorter period of time
15 but realized it needed to be longer, and it was in order to
16 prevent relapse and recidivism. We did it for seven years,
17 and in those seven years, we only had one woman relapse.
18 DR. NEUHAUSEN: That's amazing.
19 CHAIR ROSENBAUM: Thank you. Thank you so much.
20 We do have time now for public comment before we
21 break for lunch.
22

1 **### PUBLIC COMMENT**

2 * MR. GORDON: Stuart Gordon with the National
3 Association of State Mental Health Program Directors.
4 On the issue of 42 CFR Part 2, when SAMHSA
5 proposed the proposed regulations and the final
6 regulations, they emphasized in each case that they didn't
7 feel they had the discretion within the existing law to
8 modify the regulations. So the previous SAMHSA
9 Administrator indicated she would be more than willing to
10 look at a change to the legislation, and a coalition of
11 about 29 organizations, of which we are a part, and a
12 couple organizations who have lent their support but are
13 not a part have been working the Hill.
14 There is legislation about to be filed in the
15 Senate and the House, and the Senate by the West Virginia
16 Senate delegation and the House by a previous champion of
17 mental health, who you may guess. That would attempt to
18 address this issue, and it would be very helpful if MACPAC
19 could make the recommendation to Congress that the
20 underlying statute has to be changed.
21 We are not attempting to change the prohibition
22 and the current statute against sharing information with

1 criminal justice system. That would remain. That is the
2 area that the advocates are most vehement about, and we
3 think that the legislation would enable providers to
4 integrate care better. And you know all the arguments for
5 this, so thank you.
6 VICE CHAIR GOLD: Can I just ask you a question?
7 One of the things that we always heard was that one of the
8 reasons for the prohibition was, aside from the legal
9 system, there was a concern that people might lose their
10 jobs or have other personal bad things happen to them if it
11 became known that they had a problem.
12 So is that not as big a concern now, or do these
13 fixes deal with that? Because they always seem like, from
14 a public health point of view, you always want to recommend
15 that information be shared, but I had heard these other
16 issues, because it came up in the HITECH Act, the
17 limitations on electronic medical records. And I've never
18 been clear on exactly what the counter-arguments are.
19 MR. GORDON: I don't want to speak for the
20 opponents to the legislation. There is nothing directly in
21 the legislation that addresses that particular issue, other
22 than the fact that this limits the sharing of information,

1 the disclosure and re-disclosure to payment and treatment.

2 CHAIR ROSENBAUM: And it aligns up with HIPAA.

3 Yes, yes.

4 VICE CHAIR GOLD: Right.

5 CHAIR ROSENBAUM: I mean, HIPAA itself has been

6 criticized on this ground, but HIPAA is certainly a more

7 modern statement of management of personal health

8 information. That's been the tension all along. On the

9 other hand, it is important to note that informed consent

10 plays a crucial role in society, so it's a very difficult

11 issue.

12 Any other public comments?

13 [No response.]

14 CHAIR ROSENBAUM: All right. We are adjourned

15 until one.

16 * [Whereupon, at 12:07 p.m., the meeting was

17 recessed, to reconvene at 1:00 p.m., this same day.]

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1 AFTERNOON SESSION

2 [1:07 p.m.]

3 CHAIR ROSENBAUM: All righty. I think we are
4 ready to go this afternoon. Welcome back, everybody, to
5 the afternoon MACPAC session. It is like this morning,
6 jam-packed and interesting. So why don't we -- oh, well,
7 now they're just getting here. Got it. So we will start
8 in a second with Martha's overview.

9 MS. HEBERLEIN: Sorry. Technical difficulties.

10 CHAIR ROSENBAUM: No problem.

11 [Pause.]

12 CHAIR ROSENBAUM: Thank you, Martha and Kayla.

13 MS. HEBERLEIN: Sorry about that.

14 So we're going to spend a little bit of time
15 today talking about state flexibility.

16 [Pause.]

17 MS. HEBERLEIN: All in suspense.

18 [Pause.]

19 **### STATE FLEXIBILITY OVERVIEW**

20 * MS. HEBERLEIN: So I am going to start today by
21 providing a little brief summary on some of the work we've
22 done to date as well as previewing some upcoming analysis

1 that looks specifically at state flexibility, so this
2 includes a focus on the Medicaid state plan requirements
3 and options, state responses to budget pressures, and
4 mandatory and optional enrollment and spending.
5 So since MACPAC's inception, much of our work has
6 touched upon state variation and flexibility across a
7 number of areas, including program design, state financing,
8 and delivery systems. For example, our payment landscapes
9 show how individual states set their payment rates and the
10 various adjustments and supplemental payments they made.
11 We've also cataloged state policies for dental
12 and behavioral health benefits under the state plan.
13 However, our first foray into how states use this
14 flexibility specifically to control program cost was last
15 year's June chapter addressing growth in Medicaid spending.
16 This chapter provided an overview of the current
17 authorities that allow states to reduce spending in
18 designing and administering their programs.
19 States take advantage of this flexibility when
20 deciding whether to cover optional eligibility groups and
21 services and determining the scope of those benefits. They
22 also exercised their options when establishing provider

1 payment methods and rates, determining whether to use fee-
2 for-service or managed care, and they also exercised these
3 options when designing their program integrity efforts to
4 be effective and efficient.
5 A number of us have been working on a reference
6 document that catalogs state plan requirements and options
7 that they can exercise under current law. This work
8 expands on what was in the June chapter and provides a more
9 in-depth analysis of the existing flexibilities.
10 This document is a compilation of tables that
11 provides a description of the parameters as well as
12 statutory and regulatory references for each requirement
13 and state option. It looks across a number of dimensions
14 of the Medicare program, including eligibility, enrollment
15 and renewal procedures, benefits, cost sharing, delivery
16 system design, premium assistance, and provider payment.
17 Each section includes an introductory section
18 that describes the overall requirements and then goes into
19 detail, more detail in the table. It also includes
20 information, where available, of state adoption of various
21 options.
22 So, for example, the eligibility section

1 describes categorical eligibility, income and immigration
2 requirements, as well as options to cover individuals with
3 high health needs.
4 Then the table goes into more details about the
5 pathways for low-income children, children and youth in the
6 child welfare system, pregnant women, parents and caretaker
7 relatives, adults without dependent children, individuals
8 age 65 and older, individuals with disabilities, and other
9 individuals. So each of the sections is sort of set up
10 that way with introductory section that sort of describes
11 overall the state plan requirements and options and then
12 far more detail in the table itself.
13 So this document is currently under technical
14 review, and we hope to publish it in the near future.
15 Our next line of work is looking at state
16 responses to fiscal pressures. As Congress and the new
17 administration are considering significant changes to the
18 federal financing, a commonly voiced criticism of
19 Medicaid's current financing structure is that it does not
20 create incentives to control -- for states to control
21 spending.
22 Again, sort of building off of what we did in

1 last June's report, the analysis that Kayla will present
2 next highlights how nine states have responded to recent
3 budget shortfalls. It shows the range of options that they
4 considered when trying to balance their budgets. It
5 describes all the specific changes that states proposed,
6 the amount of money that was estimated to be saved, the
7 revenues raised, as well in the policies that were
8 ultimately adopted.
9 And finally on our list of ongoing work is a
10 congressionally requested study that will examine the
11 mandatory and optional enrollment and spending in Medicaid,
12 and I will spend more time this afternoon talking about
13 this.
14 So just to remind you all, this analysis was
15 requested in a January letter from the chairs of MACPAC's
16 congressional committees of jurisdiction, and we're going
17 to be presenting it over the next two meetings.
18 At today's meeting, I will go over the request in
19 more detail, the findings from prior analysis on the topic,
20 and then I will provide a brief overview of our methods and
21 discuss a few key assumptions for your input.
22 We will also try to begin a discussion of what we

1 might expect to learn from the findings as well as what the
2 findings might suggest for policymakers.
3 And then at the April meeting, I will come back
4 with findings for your discussion and interpretation.
5 So, with that, thank you, and we look forward to
6 any feedback you have on this current work and your
7 suggestions for future endeavors.
8 COMMISSIONER Thompson: I wanted to ask a
9 question about how we're presenting just the narrative
10 information on options and mandatory groups and optional
11 groups and mandatory benefits and optional. It is going to
12 relate to a comment that I have about the later material
13 too, but it's recognizing that this statute has evolved
14 over time, and it's evolved over time in certain directions
15 for certain reasons. And giving people a flavor of some of
16 that evolution and why certain benefits were structured in
17 the way that they were and how they are used as a
18 descriptive matter, I think would be very useful as
19 context.
20 Some of the benefits that we look at, one is that
21 there is this issue of fungibility of the benefits. You
22 can take a certain service, and you could potentially place

1 it under multiple benefits, so giving people a sense of
2 that. And different states at different moments may put
3 certain kinds of services inside of certain benefit designs
4 or certain benefit definitions and giving people an
5 appreciation for the fact that there's a little fungibility
6 in some of these benefits that we should recognize.
7 And then the second is that some of the benefits
8 are intended to substitute for other benefits. So they are
9 intended to create alternatives to more efficient settings,
10 for example, for other kinds of benefits, and so I think a
11 little bit of that context and understanding about how
12 benefits relate to one another and how they evolved over
13 time to reflect a desire to move to certain kinds of
14 settings and services to complete care for people and to
15 provide alternatives and more efficient settings, I think
16 is a useful piece of context.
17 CHAIR ROSENBAUM: Good. And this will come up
18 all afternoon, I think, as we begin, so thank you very much
19 for that sort of table-setting for us. And I am sure that
20 we are going to come back to this theme of what kind of
21 context do we create for the information we're going to
22 give Congress.

1 So, Kayla, why don't you take us through the
2 "State Medicaid Responses to Fiscal Pressures"
3 presentation.
4 **### STATE MEDICAID RESPONSES TO FISCAL PRESSURES**
5 * MS. HOLGASH: So good afternoon. To reiterate
6 the overview from Martha, growth in the aggregate spending,
7 in aggregate spending has led the Medicaid program to
8 account for an increasing share of federal and state
9 budgets, and some policymakers have expressed concerns
10 about the sustainability of Medicaid. Thus, Congress and
11 the new administration are considering significant changes
12 to the federal financing.
13 This presentation first provides an overview of
14 the state budget process. Then it looks at the recent
15 experience in nine states as they considered adjustments in
16 Medicaid spending to achieve budget targets. This
17 information is intended to eliminate the breadth of changes
18 that states consider within their Medicaid program, not
19 just final budgetary solutions.
20 We can get more systematic data from the 50-state
21 Medicaid budget surveys done by Kaiser and HMA on final
22 policy actions around eligibility and enrollment, provider

1 rates, taxes and fees, benefits and more. However, the
2 work presented here should serve as a complement to that,
3 taking note of all the options states considered in order
4 to tell a more full story of how states might respond to
5 cuts in the future.
6 States are routinely engaged in evaluating their
7 Medicaid spending due to balanced budget requirements and
8 other incentives to limit growth in overall Medicaid costs.
9 In state fiscal year 2016, the program accounted
10 for 28.2 percent of spending from all state and federal
11 sources. When only the state-funded portion of Medicaid is
12 considered, that is, general funds raised through income,
13 sales, and other broad-based state taxes, the program's
14 share of state budgets is much lower, 19.7 percent of
15 state spending.
16 Most states finance Medicaid through a
17 combination of state general funds, bonds, local
18 contributions, and other sources, such as dedicated health
19 care-related taxes, and when these sources of funding are
20 considered, Medicaid spending accounted for 15.8 percent of
21 the state budget.
22 This graph, although a little small, depicts the

1 information I just shared, and as you can hopefully see,
2 under any of these methods, the overall share of Medicaid
3 and state budgets has generally increased over the past 30
4 years. This is an updated version of the graph in Chapter
5 1 of MACPAC's June 16, 2016, report, where you can find
6 more details on trends in Medicaid spending.
7 The state budget process is similar to the
8 federal process but unique in a few notable ways. While
9 the process can vary by state, generally state agencies
10 submit budget requests to the governor. The governor's
11 office reviews those request and submits an executive
12 budget to the state legislature. The legislature is then
13 responsible for developing and approving a final budget.
14 For all but four states and D.C., the state fiscal year
15 begins on July 1st as opposed to the federal fiscal year
16 which begins on October 1st.
17 Twenty states also differ from the federal
18 government by utilizing a biennial budget cycle versus an
19 annual cycle.
20 All states have balanced budget requirements or
21 standards that limit carrying deficits, and facing these
22 requirements, states consider a number of factors when

1 determining how to spend resources such as competing
2 funding priorities, the ability to raise additional
3 revenue, and views on the appropriate role of Medicaid.
4 States regularly scrutinize their own budgets,
5 including revenue and spending components. Also noted in
6 the June report, current authorities allow states to use
7 many different policy levers to reduce spending and achieve
8 other program efficiencies. In designing their programs
9 and responding to changing economic conditions, states take
10 advantage of this flexibility to decide whether to cover
11 optional eligibility groups and services, determine
12 provider payment methods and rates, define parameters for
13 covered services, or adopt strategies to address the volume
14 and intensity of services.
15 The choices they face differ not only in the
16 amount of spending or revenue affected, but also in their
17 political sensitivity.
18 Different approaches have different effects on
19 the magnitude and direction of spending as well as on other
20 aspects of the program. Typically, states seek first to
21 minimize direct effects on beneficiaries; for example,
22 keeping Medicaid provider payments low compared to other

1 payers rather than rolling back eligibility.

2 For this analysis, we selected a mix of states to
3 reflect differences in political leadership, expansion
4 status, size of the Medicaid budget, and geographic
5 regions. While we have highlighted only changes within the
6 Medicaid program, states make budget cuts to other programs
7 or in state health departments that work with the Medicaid
8 program.

9 Also note that while we incorporated official
10 state sources and governors submitted budgets, many of the
11 sources are local news outlets, press releases, and reports
12 of discussions between the governor and state legislators.

13 As I go through each state, you will see
14 different themes and details on the slides and in your
15 materials, such as changes to provider rates or introducing
16 new or increased provider taxes. I won't verbally mention
17 each idea, but I will point out some of the more unique and
18 notable considerations to highlight the range among states.

19 Governor Bentley and the Alabama State Medicaid
20 agency determined that $785 million would be needed to
21 fully fund the Medicaid program in 2017. In the face of
22 statewide deficits, the legislature appropriated $700

1 million, leaving the governor to find $85 million in cuts
2 or revenue.
3 Notable here is that the governor and Medicaid
4 commissioners said the state would need to eliminate a
5 large number of optional benefits, some of which you see
6 here, such as prescription drugs and outpatient dialysis,
7 among other changes.
8 Outside of the program, the governor proposed
9 establishing a statewide lottery as a method of raising
10 funds for Medicaid, but the legislature voted it down.
11 Ultimately, the legislature decided to utilize money from
12 the BP oil spill settlement to fill the funding gap for
13 2017 and the projected gap for 2018.
14 More than $56 million were cut from the Kansas
15 State Medicaid program in 2016, and more cuts are planned
16 moving forward, including reducing provider payments by 4
17 percent across the board and increasing provider taxes.
18 Plans were set to implement the capable person
19 policy, which limits the duties home support workers are
20 allowed to do if the beneficiary lives with a nondisabled
21 person. CMS has since notified the state that this policy
22 is not allowed.

1 The governor's budget for Maine's 2018-2019
2 biennium reduces health department spending by nearly $140
3 million, a 4.5 percent reduction from the previous cycle,
4 including almost $70 million in cuts directly to Medicaid.
5 The proposed reductions would increase provider
6 taxes, decrease payments, and reduce eligibility, including
7 eliminating Medicaid coverage for parents above 40 percent
8 FPL, whereas they currently cover parents up to 100 percent
9 FPL.
10 In Ohio, Governor Kasich proposed $47 million in
11 Medicaid savings in 2016 to 2017 and at least another $1
12 billion in his 2018-2019 budget. This included methods of
13 adjusting eligibility by eliminating coverage for non-aged
14 or disabled adults above 138 percent FPL and eliminating
15 spend down as well as raising eligibility for those with
16 disabilities from 64 to 75 percent FPL and increasing the
17 asset test from $1,500 to $2,000.
18 The governor also implemented a tax on Medicaid
19 managed care companies that was subsequently deemed
20 impermissible by CMS. He has since proposed an alternative
21 tax on all health insurance plans, not just the Medicaid
22 insurers, that is estimated to garner $615 million in

1 fiscal year 2018.

2 Oklahoma faced a statewide record deficit of $1.3
3 billion for fiscal year 2017. While a dollar amount that
4 would come from Medicaid was not specified, lawmakers and
5 the Medicaid director proposed several cuts within the
6 program. For instance, the agency proposed a 25 percent
7 payment rate cut to all providers, including hospitals,
8 physicians, pharmacies, DME suppliers, and nursing
9 facilities, among other changes in eligibility cuts.

10 Ultimately, they scaled back and instead cut
11 provider payments by about 3 percent. Revenue was added by
12 introducing and increasing taxes outside of the Medicaid
13 program, and legislators are currently considering a law
14 that would increase the cigarette tax to raise an estimate
15 $254 million for health care funds, 45 percent of which
16 would go to Medicaid service.

17 The state Medicaid agency in Oregon projected a
18 program deficit of $500 million in the 2017-2019 fiscal
19 biennium. In addition to other ideas, the agency proposed
20 cutting certain low-priority medical services, including
21 treatment of collapsed lungs, hearing loss, neonatal eye
22 infections, gallbladder cancer, and a significant portion

1 of mental health and dental coverage. The governor,
2 however, did not include these in the executive budget.
3 Pennsylvania faced an overall deficit of about
4 $1.3 billion in 2016-2017, of which $600 million could have
5 come from the Medicaid program. In the governor's opening
6 salvo, he warned that prescription drug assistance, home-
7 and community-based services for seniors, and services for
8 individuals with mental illness or intellectual
9 disabilities could be cut. The governor's official budget
10 proposal, however, recommended a host of new or increased
11 state taxes outside of the Medicaid program, such as
12 increasing the income on cigarette taxes and implementing
13 taxes on promotional plays at casinos.
14 Virginia Medicaid was forecasted to require an
15 increase of $255 million during the 2016-2018 biennium.
16 The governor has proposed expanding Medicaid to the new
17 adult group in every executive budget since taking office,
18 in addition to a number of provider payment changes. In
19 advance of the executive budget, the governor opted to
20 eliminate raises for state employees and utilize money from
21 the state's rainy-day fund to begin filling the budget
22 hole.

1 Finally, state officials in Wyoming are planning
2 for a reduction of $90 million to help department funding
3 in the 2017-2018 budget cycle, and the governor has
4 proposed that about $55 million of that be from Medicaid.
5 Included in the governor's proposal are various provider
6 changes, as well as changes to beneficiaries, including
7 reducing eligibility for breast and cervical cancer
8 treatment and decreasing the income standard for the
9 Employed Individuals with Disabilities program from 300
10 percent of the SSI payment level to 100 percent FPL.
11 This work should provide the Commission with helpful
12 background information to be used in conjunction with other
13 staff analyses on financing restructuring options and state
14 flexibility. I look forward to your discussion.
15 Thank you.
16 CHAIR ROSENBAUM: Thank you. Okay. Let's see.
17 We have Marsha leading us off. Who else? Toby.
18 VICE CHAIR GOLD: Hi, Kayla. I wonder if you can
19 give us a sense of the proportion of the Medicaid budget
20 that these shortfalls are, and I know there's three ways of
21 calculating it. And let me just say the reason I'm asking
22 is I was just looking back, and it struck me that these are

1 kind of -- it looked to me that these might be the kind of
2 garden variety changes at the margin that many states go
3 through, and for those kind of things it struck me that
4 they have some more ability to look outside the program or
5 do other things, than if it was a 25 percent cut in the
6 program or a 50 percent cut.

7 And so I think while this money is real money,
8 and it sounds big, it would be helpful if you could sort of
9 give a percentage, in terms of the state budget or
10 something like that -- I mean, the state -- you know, how
11 much of Medicaid savings they're really trying to save here
12 and what that implies for how we might learn something from
13 here about a really bigger change in financing.

14 MS. HOLGASH: I don't have a specific percentage
15 for each state, but we did include, in the table of the
16 states included in the analysis --

17 VICE CHAIR GOLD: Right.

18 MS. HOLGASH: -- the amount of spending for each,
19 so --

20 VICE CHAIR GOLD: Right. I was doing a rough --
21 is it right that I'm thinking it's maybe 2, 3 percent, at
22 most 5, or --

1 EXECUTIVE DIRECTOR SCHWARTZ: On some of these
2 it's hard to say because the numbers aren't directly
3 attributable to Medicaid. For example, $1.3 billion in
4 Oklahoma, is the gap in their entire state budget.
5 VICE CHAIR GOLD: Right.
6 EXECUTIVE DIRECTOR SCHWARTZ: We don't have a
7 share of those funds.
8 VICE CHAIR GOLD: Right. I know that.
9 EXECUTIVE DIRECTOR SCHWARTZ: Obviously I think
10 Oklahoma was one of the bigger ones, like many other oil
11 and gas states are seeing some real challenges.
12 VICE CHAIR GOLD: Yeah.
13 MS. HOLGASH: And to your point, there were
14 states that weren't necessarily facing an overall deficit
15 but they were continually searching for program
16 efficiencies and to reduce the budget.
17 CHAIR ROSENBAUM: Toby.
18 I actually had a question, also, along Marsha's
19 line of questioning, which is, I'm interested in knowing,
20 you know, what the precipitating events were, and whether
21 the precipitating events tended to be an overspending
22 against projections versus a shortfall of revenue. So, you

1 know, for example, Oklahoma, I assume that they're in
2 crisis across every single kind of service that the state
3 finances. But I think it would be helpful -- again,
4 echoing Marsha's point -- to know whether what's happening
5 here is that spending is out of control versus spending is
6 actually, you know, controlled but the revenues just are
7 not there.

8 MS. HOLGASH: That is a great question. We
9 didn't look at those in particular but we can definitely do
10 that.

11 CHAIR ROSENBAUM: Okay. So I have Kit, Penny,
12 Sharon. Okay.

13 COMMISSIONER GORTON: I guess I would ask the
14 obverse of the question they're asking, which is, for those
15 of us who live in this environment and watch what happens
16 there's a lot of horse-trading that goes on. And so I
17 think it's equally important to characterize what didn't
18 get funded, right? So Alabama or, you know, several of
19 these proposed fairly draconian changes and then backed off
20 of them. My hypothesis is the draconian change was to
21 allow funding for infrastructure, K-12 education, local
22 aid, all of the other stuff that state government has to

1 pay for, and I suspect, but I think it's worth testing,
2 when the money got put back into Medicaid, somebody else
3 was left with less than a full glass.
4 And so I think that -- I agree that the issue of
5 the revenue environment -- and, you know, another piece of
6 it is revenue shortfall versus, you know, overly rosy
7 projections, you know. So I think if you can give us a
8 little more qualitative color around what were the
9 tradeoffs that went on between the governor and the
10 legislature, and where they ultimately ended, you know,
11 that helps give a full picture in terms of -- I think when
12 you're talking to the governors, what they always talk
13 about is the stuff that they don't get to pay for because
14 Medicaid crowds it out. I don't think that necessarily
15 implies that Medicaid is unmanaged, but I think it suggests
16 that the current structure of Medicaid is such that the
17 governors can't necessarily -- and legislators can't always
18 fund things which are also of importance to the taxpayers
19 in the states.
20 CHAIR ROSENBAUM: Good. I have Penny, Sharon,
21 Chuck.
22 COMMISSIONER THOMPSON: Or they can't withstand

1 the proposed cuts that would otherwise be required in
2 Medicaid, right? They can't take either one of them.
3 The state budget process, I think it's important
4 to bring budget scoring into this picture, because also
5 what happens is that I've got to solve for that equation
6 within a period of time that looks like this. I don't have
7 an opportunity to make an investment to create a change for
8 which the return on investment happens over a longer
9 window. So that's why I end up having to default to
10 something that is pure math. I'm cutting these provider
11 payments, I'm cutting these people, I'm cutting these
12 benefits. And I think that's also part of the picture of
13 constraints that a state is dealing with when they're
14 trying to figure out how to respond to some of these
15 issues, which is they're not doing it over a multi-year
16 period, which would allow them, perhaps, to search for
17 efficiencies or transformations that will really allow for
18 a better outcome, and they end up defaulting to a tried-
19 and-true scorable list of reductions.
20 CHAIR ROSENBAUM: Sharon.
21 COMMISSIONER CARTE: I'm not sure if we have some
22 previous data, but because Medicaid is countercyclical,

1 perhaps it would be helpful if we would look at per capita
2 income nationally. You know, there's always the perception
3 that Medicaid is growing because more people just aren't
4 working, and if we could just look at -- track that from,
5 say, 2007 to the present. And then also to look at these
6 particular states, that might help get to some of the
7 questions that people are asking, like what is the
8 individual state situation, economically, and how does that
9 influence Medicaid growth or participation?
10 CHAIR ROSENBAUM: Chuck.
11 COMMISSIONER MILLIGAN: Thank you, Kayla. I
12 guess I want to make a couple of points. I think the first
13 point I want to make is this seems to be kind of like
14 another year in the life of Medicaid.
15 [Laughter.]
16 VICE CHAIR GOLD: Right. Yes.
17 COMMISSIONER MILLIGAN: This seems to be --
18 VICE CHAIR GOLD: That's what I meant by garden
19 variety.
20 COMMISSIONER MILLIGAN: Yeah. No, and to me the
21 garden variety part is there's always going to be state
22 variations about, you know, where they draw revenue, the

1 oil and gas states. There are always going to be
2 variations based on state economies. There's always going
3 to be a desire to fund new things, or cut taxes, or other
4 things.
5 I think that this list -- I guess the point I
6 want to make is to me it seems pretty representative of a
7 pretty typical year, a pretty typical non-national
8 recession year.
9 VICE CHAIR GOLD: Right.
10 COMMISSIONER MILLIGAN: I guess the main other
11 comment I wanted to make is -- and I'm going to sort of
12 draw out a couple of points that you made for a few of the
13 states, and then add one point -- a lot of times -- and
14 I've had to shepherd a Medicaid budget through a state
15 budget process seven times. Toby probably has -- but seven
16 times is plenty for me -- and the -- when a state has a
17 budget crisis, there is often an inclination to draw from
18 more federal funds, and that happens in a couple of forms.
19 You mentioned provider tax-related ideas, and, you know,
20 there continues to be legitimate ways of doing that.
21 And the response states often do is to look for
22 those programs that are not matched, that are 100 percent

1 state funded, and pull them into Medicaid, and draw match.
2 And so you've seen a lot of efforts over the years about
3 bringing into Medicaid various kinds of social services
4 and, you know, programs for kids in foster care, and
5 school-based things, and, you know, all kinds of stuff.
6 So I guess one of the -- the point I want to
7 make, and I'll wrap it up here, is a lot of times when
8 states are in a budget crisis they respond not only by
9 cutting Medicaid or cutting other state programs but they
10 also respond by growing Medicaid, that kind of the middle
11 line of your chart, as a way of reducing, otherwise, 100
12 percent state-funded programs. So I wanted to make that
13 comment.
14 CHAIR ROSENBAUM: Alan.
15 COMMISSIONER WEIL: Yeah. I'm not sure how to
16 say this but I'm going to try. I think more context is
17 always interesting, but I worry about the reason, what we
18 would do with that additional context and whether it would
19 really add much to our understanding. My reaction is very
20 much along the same lines as Chuck's, which is, yeah, this
21 is what happens, and it's some combination of rate cuts
22 and, you know, things you can delay, and ways to get new

1 money, and refinancing. And I think it's really important
2 for us, to be able to show the variety and range of things
3 that states do, but I'm not sure this can be -- I'm not
4 sure this analysis can be pushed any further than it has
5 been.

6 And so getting a sense of what didn't happen, you
7 know, what happened outside the Medicaid budget, I am not
8 sure that would actually add much understanding, so I want
9 to just offer that reaction.

10 COMMISSIONER DOUGLAS: [Off microphone.] There's
11 not much new here. I don't think there's any -- and a
12 great job, but --

13 CHAIR ROSENBAUM: It just gives us --

14 COMMISSIONER DOUGLAS: -- it wouldn't give us --

15 CHAIR ROSENBAUM: It sounds like sort of our
16 sentiment is that this gives us a sense of the kind of to-
17 and-fro that happens in the Medicaid program pretty
18 routinely. I was sitting thinking that I go all the way
19 back to 1974, when adult eyeglasses got on the -- it was
20 the first time I saw them on the cut list, and adult
21 eyeglasses have been on the cut list for 43 years, ever
22 since.

1 So this is very good and useful information to
2 have, but it feels rather routine. Yeah.
3 COMMISSIONER GORTON: Just at the risk of being
4 the outlier, yet again, it's routine to us because we've
5 all been doing Medicaid for 30 years.
6 CHAIR ROSENBAUM: Yes. Yes. Of course.
7 COMMISSIONER GORTON: And so to the extent that
8 what we want to do is illustrate for people who are new to
9 the conversation, or the people who we heard about in this
10 morning's session who didn't -- maybe it wasn't this
11 morning. I don't know. It all blurs together -- who
12 weren't clear what's the difference between Medicaid and
13 Medicare, I don't think it's wrong to share. I agree --
14 there's nothing particularly exciting here. We could all
15 pull out examples from 15 other states. We could talk
16 about one-time accounting tricks, where we pay the
17 providers in the next fiscal year, right, because states
18 operate on a cash accounting basis. So there's all sorts
19 of stuff that goes on.
20 But at the end of the day, I don't know that the
21 people who are talking to their members of Congress about
22 changes they would like to see in the Medicaid process have

1 visibility into this. And so with all due respect to Alan,
2 I do think that a little more context would be helpful in
3 advancing the national discussion.
4 CHAIR ROSENBAUM: Yes, and I do think that giving
5 people a great sense of the routine, significant issues
6 that Medicaid programs face, you know, and they confront
7 them in the face of a lot of events, some specific to
8 Medicaid and others extraneous to Medicaid, is a very
9 important role that we can play here, as long as we are
10 able to continually put it in context for people, that
11 these are -- what you're presenting -- what is being
12 presented to us is the things that happen in a very
13 important, sophisticated program that's got to be managed.
14 Yeah, Norma.
15 COMMISSIONER ROGERS: Well, believe it or not,
16 Kit, I'm agreeing with you.
17 [Laughter.]
18 COMMISSIONER ROGERS: I agree with Kit, because I
19 do think that for people to fully understand what is
20 happening, or what will happen with the Medicaid program,
21 need to have this information. So I agree with you.
22 VICE CHAIR GOLD: But I think the one caveat I'd

1 put on that is the what will happen. I mean, this is a
2 good illustration of -- that's why I asked about the
3 percent, and I think that would be a valuable addition, to
4 sort of understanding what these are. I mean, once -- if
5 you get to a 25 percent or 50 percent cut, or something
6 different, then the paradigm probably shifts and the
7 options to make up for it become different. That's when
8 you start talking about changes -- really changes in the
9 program.
10 And so I don't think -- I mean, in a lot of these
11 states they've kind of managed to finagle, and that's my
12 experience with Medicaid too, they work around things. But
13 depending upon how big the cliff is, you know, sometimes
14 you can go over it.
15 CHAIR ROSENBAUM: Okay. Stacey and Toby.
16 COMMISSIONER LAMPKIN: Yeah, I think just the
17 context here, that maybe draws the two opinions together,
18 is that this is partly a response to people who think that
19 the current financing structure doesn't put pressure on the
20 states to manage their expenses, and what this shows is
21 that even with the current financing structures, states
22 have to balance their budget and have to have these hard

1 discussions about where they find the money, or what they
2 do if they can't find the money. So that's where the value
3 comes from this, I think.
4 CHAIR ROSENBAUM: And I was also struck, I should
5 note, by the similarity between the expansion and the non-
6 expansion states, in terms of both the techniques they turn
7 to, the services they zeroed in on, and I think that that
8 may be also a point to draw out, that whether you cover all
9 adults, or certain categories of adults, you confront, in
10 any situation, the same kinds of issues.
11 Toby.
12 COMMISSIONER DOUGLAS: I was just going to
13 suggest -- I mean, maybe we -- so the staff don't have to
14 do kind of the work -- this has been done by Medicaid
15 directors with HMA, and kind of family foundation for every
16 year, kind of laying out, and maybe we have them present or
17 do something that --
18 CHAIR ROSENBAUM: Right.
19 COMMISSIONER DOUGLAS: -- presents all that
20 information.
21 VICE CHAIR GOLD: Yeah, and I think -- I mean, in
22 some ways, it might help to sort of understand how the

1 Medicaid budget gets put together initially, in that -- I
2 mean, every state, they have to figure out what -- how many
3 people, of what types they think they'll enroll, how much
4 the hospital utilization will be, how much various costs
5 are. They project it some number of times in advance, and
6 it's very hard to be right, especially, you know, getting
7 the enrollment, getting the hospital use. I know when I
8 was in Maryland, I knew the budget secretary pretty well,
9 and he had a simple chart on his wall that tracked the
10 hospital utilization in Medicaid, and he knew when that
11 sort of went off-cycle with what the projections had been
12 that there was likely to be a problem. And it would be
13 impossible for a state to be on target all the time.
14 So, you know, the fact that you're doing it two
15 years in advance, for things that you're not quite sure,
16 with the enrollment mix, how that's going to be, makes it
17 inevitable that you have these tradeoffs, even in a
18 relatively stable environment. And then when it gets crazy
19 is, you know, if you have shocks to the system it's harder.
20 CHAIR ROSENBAUM: Well, thank you very much,
21 Kayla. This is very helpful. It was a good discussion.
22 And now we're going to turn matters back to Martha, to talk

1 with us about the staff approach to the Congressionally
2 mandated study on mandatory and optional benefits.
3 [Pause.]
4 ### **CONGRESSIONALLY REQUESTED STUDY ON**
5 **MANDATORY/OPTIONAL BENEFITS AND POPULATIONS:**
6 **REVIEW OF METHODS, LIMITATIONS, AND POLICY ISSUES**
7 * MS. HEBERLEIN: That's what I get for having two
8 presentations.
9 So going back to the congressionally requested
10 study on mandatory and optional benefits and populations.
11 As we all know, states are required to cover certain
12 populations that are eligible through mandatory pathways
13 and certain benefits, such as inpatient hospital and
14 physician services. However, states have a great deal of
15 flexibility to cover both optional populations as well as
16 optional services.
17 In this analysis that I am going to talk through
18 today, we are examining Medicaid enrollment and spending on
19 mandatory and operational enrollees and services at the
20 specific request of the chairman of MACPAC's committees of
21 jurisdiction.
22 As I just mentioned, for today we're going to

1 focus on the methods and limitations, and in April, we will
2 come back with some numbers to share.
3 So I already sort of said what I'm going to do
4 today, so I will move right along.
5 As I said, this analysis was requested by the
6 chairman of our committees of jurisdiction in a letter
7 dated January 11, 2017. The letter begins by describing
8 Medicaid as an important safety net program that provides
9 health coverage and long-term services and supports to the
10 nation's most vulnerable patients. As the program extends
11 its reach, both as a result of legislative and demographic
12 changes, the requesters note their worry about Medicaid's
13 ability to meet the needs of these individuals and that the
14 strains to the system will further erode access and
15 quality.
16 So, for example, they discuss the difficult
17 decisions that states face in balancing their budgets in
18 determining which populations and services to cover,
19 highlighting the use of waiting lists for home- and
20 community-based service waivers.
21 So it's within this context that the requesters
22 see the need to have a better understanding of the optional

1 eligibility groups and optional benefits that states are
2 covering and the resources associated with these.
3 Specifically, the letter requests that MACPAC
4 determine the following for each state -- the intersection
5 of the coverage of optional eligibility groups and the
6 receipt of optional benefits for those groups to show the
7 extent to which optional populations in a given state are
8 receiving optional benefits.
9 They asked the number of benefits covered by each
10 state -- sorry -- the number of people covered by each
11 state who qualify for Medicaid through an optional
12 eligibility category and the federal and state expenditures
13 for each category of optional populations and optional
14 benefits in each state.
15 The letter requests that this analysis be
16 completed in a six-month time frame, or by July 11, and
17 MACPAC issues a response to this letter on January 23rd,
18 2017, saying that we would complete the analysis in the
19 time frame requested, and both of the letters are included
20 in your materials today.
21 So the Kaiser Commission on Medicaid and the
22 Uninsured and the Urban Institute have previously

1 undertaken similar analysis, the most recent of which was
2 published in 2012, using fiscal year 2007 Medicaid
3 Statistical Information System, or MSIS data, and CMS-64
4 reports.
5 They used these reports to estimate the
6 proportion of enrollment and spending that was attributable
7 to mandatory or what they referred to as federal core and
8 optional or referred to as state expansion enrollment
9 spending.
10 Using the MSIS eligibility codes, they assigned
11 beneficiaries to either a mandatory or optional status for
12 the four major eligibility groups: for the elderly,
13 individuals with disabilities, nondisabled adults and
14 pregnant women, and nondisabled children. And also using
15 the MSIS service codes, they allocated spending as either
16 mandatory or optional.
17 So here is what they found. This analysis found
18 that in fiscal year 2007, 70 percent of enrollees were
19 mandatory, with the largest share of those being children,
20 43 percent. Individuals covered at state option accounted
21 for about 30 percent of enrollment.
22 In terms of expenditures, the researchers found

1 that almost 60 percent of spending was on mandatory
2 enrollees, with 40 percent of spending on mandatory
3 services and 19 percent on optional services.
4 Forty-one percent of spending was on optional
5 enrollees, with about 27 percent of mandatory services and
6 14 percent on optional services.
7 So to the fun part, building on this prior Kaiser
8 and Urban analysis, we are examining enrollment and
9 spending on mandatory and optional individuals and services
10 using the MSIS and CMS-64 data for fiscal year 2013.
11 Because these data sources do not specifically
12 identify individuals and services as mandatory or optional,
13 we have determined the mandatory or optional status based
14 on review of statutory and regulatory citations, as I was
15 talking about before, and the data dictionaries that are
16 available to describe the MSIS data.
17 Note that we have sent out a proposed methodology
18 to experts for review and have incorporated the feedback we
19 have received so far.
20 I also want to note that in assessing whether an
21 individual or service is mandatory, we are referring only
22 to the federal requirements and do not attempt to take into

1 account any state-specific requirements, such as state-
2 mandated benefits, and we do not attempt to account for
3 state variation in benefit limitations or eligibility
4 criteria, such as defining what constitutes an
5 institutional level of care.
6 So beginning with eligibility, states must cover
7 certain individuals, but others can be covered at state
8 options. So a person must fall into a specific population
9 group, which is often referred to as categorical
10 eligibility, and must also meet income thresholds in order
11 to be eligible for Medicaid.
12 While there are a number of discrete eligibility
13 pathways, states generally must cover children and pregnant
14 women up to specified income levels, parents with dependent
15 children with incomes up to the state’s 1996 Aid to
16 Families with Dependents Children, AFDC, or the old welfare
17 standards, individuals who are elderly and disabled and
18 receive supplemental security income, and certain Medicare
19 enrollees.
20 To classify individuals as mandatory or optional,
21 we rely on their Medicaid Assistance Status/Basis of
22 Eligibility, also known as MAS/BOE designation.

1 When making this classification, similar to what
2 Kaiser did, individuals remain in their larger eligibility
3 group, and therefore, children would be classified as a
4 mandatory child or an optional child.
5 Similar to enrollees, states are required to
6 cover mandatory benefits and may choose to also cover
7 operational benefits.
8 For adults, states may also limit the extent to
9 which a covered benefit is available by defining both
10 medical necessity criteria and the amount, duration, and
11 scope.
12 For children, however, the Early and Periodic
13 Screening, Diagnostic, and Treatment, or EPSDT
14 requirements, limit the extent to which states may apply
15 criteria, other than medical necessary, to covered
16 benefits. As such, almost all of the services for
17 children, including those received through managed care,
18 are going to be considered mandatory in our analysis.
19 We are classifying these services as mandatory or
20 optional, using the MSIS type of service, or TOS code, and
21 spending that is not directly related to services,
22 including supplemental payments and Section 1115 payments

1 for costs not otherwise matchable will be classified
2 separately using CMS-64 data, similar to how we account for
3 that in MACStats.
4 So moving on to some of our key assumptions, as I
5 just mentioned, assignment as mandatory or optional
6 population was done using a combination of MAS/BOE. The
7 MAS/BOE groups contain eligibility -- multiple eligibility
8 pathways, some of which are uniform in their mandatory and
9 optional categorization, while others include both
10 mandatory and optional eligibility groups.
11 And the data dictionary is in your appendix in
12 case you care to read along.
13 [Laughter.]
14 MS. HEBERLEIN: So there is no way to associate a
15 particular pathway within these MAS/BOEs to a particular
16 individual. So we have to make some assumptions about the
17 distribution.
18 For example, children's mandatory and optional
19 status will be randomly assigned on a state-by-state basis
20 based on the state distribution of family income relative
21 to the state eligibility thresholds. For some other aged,
22 blind, disabled, and adult MAS/BOEs with mixed mandatory

1 and optional eligibility pathways, we randomly assign
2 individuals so that half are mandatory and half are
3 optional because approximately half the pathways are
4 optional and half the pathways are mandatory.

5 We are proposing to do a sensitivity analysis,
6 and when I say proposing, we hope to have T-MSIS data
7 available from between 10 to 20 states that will have more
8 granularity related to eligibility. In the new transformed
9 MSIS, there will be a code that shows whether the person is
10 a mandatory or optional individual, and so our hope is to
11 use these data to sort of benchmark our assumptions and see
12 whether or not what we're doing is accurate.

13 For managed care, MSIS includes records of each
14 capitated payment made on behalf of an enrollee to a
15 managed care plan as well as records for each service
16 received by the enrollee from a provider under a contract
17 with managed care plan, which are also known as encounter
18 data, but because the amount paid by the managed care plan
19 for a specific service is not available from the encounter
20 data and we don't really have another source to benchmark,
21 we are assuming that the distribution of managed care
22 spending on mandatory and optional services mirrors that in

1 fee-for-service arrangements at the state level.
2 However, it may be the case that the differences
3 in populations covered, services provided in managed care
4 mean that using the fee-for-service proportions is not an
5 accurate reflection of the distribution of mandatory and
6 optional spending in managed care.
7 I would like to make a quick note that simply
8 because there is a shift in the type of service, say from
9 inpatient hospital to physician services, that doesn't
10 necessarily mean there is a shift from mandatory to
11 optional, because in that example, both would be mandatory
12 services.
13 So here we have a number of proposed
14 alternatives. Currently, we’re going to apply the
15 mandatory and optional shares in fee-for-service by
16 population, so looking specifically at MAS/BOEs instead of
17 using the distribution from the entire population, and this
18 might help address some of the different service mix by
19 population questions.
20 We could also do a couple other things. We could
21 establish a threshold for states that use predominantly
22 managed care arrangements and instead use the -- decide

1 whether we would use the in-state fee-for-service
2 distribution or some other distribution of
3 mandatory/optional spending.
4 For example, in a state that has more than 75
5 percent of its enrollees in managed care, we could apply a
6 national mandatory/optional split in instead of the state-
7 specific, thinking that the individuals who are left in
8 fee-for-service are not representative of the managed care
9 population. And we would just need to decide whether --
10 not just, but we would need to decide what that threshold
11 would be and whether we would apply that sort of
12 universally across the state or by population.
13 We could also apply the distribution of mandatory
14 and optional spending for predominantly fee-for-service
15 states instead of using a national average, and this might
16 also help address some of the case mix issues as well, so
17 some things to think about.
18 And finally, while a number of states have moved
19 to managed long-term services and supports, the share of
20 enrollees receiving long-term services in a managed care
21 setting remains a small share of the overall managed care
22 population, and furthermore, the spending on managed long-

1 term services and supports, represents a small but growing
2 share of spending as well as overall managed care spending.
3 However, this varies by state, as some have
4 implemented LTSS statewide. But as distinguishing managed
5 LTSS from managed care more generally would be difficult,
6 we assume all managed care spending is acute. However, we
7 could in states that have MLTSS statewide or a large
8 proportion of MLTSS, we could apply different distributions
9 of mandatory and optional spending to either the acute
10 services and the long-term care services separately.
11 Again, some of the same decisions about how we would apply
12 that threshold for the other managed care, we'd have to
13 think through.
14 So in addition to your input on these assumptions
15 I just walked through, we would like to start the larger
16 conversation of what these findings might mean to
17 policymakers as they consider changes in the Medicaid
18 program, so specifically how does categorizing Medicaid
19 enrollment and spending as either mandatory or optional
20 help us determine who is in most need of services and
21 assess the value of the different types of services, and
22 what do the current data on mandatory and optional

1 enrollment in spending tell us about the choices that
2 states are currently making.
3 So, with that, I look forward to your discussion
4 and suggestions.
5 CHAIR ROSENBAUM: Okay. Here is what I suggest
6 we do. Before we have a drink --
7 [Laughter.]
8 CHAIR ROSENBAUM: -- I think maybe, because
9 everybody has so many questions, I would say -- well, let's
10 just start with a list and see where we get. So we'll
11 start down this way. So we have Kit, Andy, Chuck, Marsha,
12 Toby, Stacey --
13 VICE CHAIR GOLD: And the rest will have them
14 later.
15 CHAIR ROSENBAUM: Yes. We reserve our rights for
16 Round 2 here. Okay. So, yes, let's start with the
17 methods.
18 COMMISSIONER GORTON: So do you want to go do all
19 the methods, or just do you want me to go --
20 CHAIR ROSENBAUM: I think there are so many
21 questions on the table, it might -- I don't know, Martha.
22 You tell us what would be the most helpful to you to have

1 us give you input on each distinct category of queries
2 you've put out, and start with the methods?
3 MS. HEBERLEIN: Sure.
4 CHAIR ROSENBAUM: Yeah. So rather than sort of
5 trying to think randomly, we'll do that and we'll go around
6 again. Okay.
7 COMMISSIONER GORTON: Okay. So my methods
8 question or observation is that there are a number of
9 optional services which states use to replace mandatory
10 services, and I understand that will be difficult to
11 characterize quantitatively, but I think it's important to
12 at least qualitatively indicate to decision-makers that if
13 we've got a lot of home- and community-based services being
14 offered that that's probably in lieu of institutional
15 services, which would have been much more expensive.
16 CHAIR ROSENBAUM: Exactly.
17 COMMISSIONER GORTON: And so it is an obvious
18 thing. You just eliminate those optional services, because
19 what you're doing is just moving the mix to segregated and
20 more restrictive environments, so that's my methodology
21 question.
22 CHAIR ROSENBAUM: Good.

1 Andy, why don't we do that, and then we'll keep
2 going round and round until we're done. Yes.
3 COMMISSIONER COHEN: Oh, okay. So my methodology
4 question is around the definition of services, and I've
5 always been like a little sort of focused on this. I
6 always use the same example to clinic services. Like what
7 is a clinic service? Does every state define that the same
8 way? Does every provider who bills on it define it the
9 same way, and how much of an issue is that in these
10 analyses? And are there particular areas where it's a
11 bigger issue than others?
12 MS. HEBERLEIN: My guess would be that there are
13 instructions on how to report your claims and where to file
14 them, but as with all things Medicaid, I would assume that
15 there is a degree of state variation in how states are
16 actually reporting their claims and where things sort of
17 get bucketed in.
18 I don't know whether there are more -- there are
19 certain areas where that's more or less. I know we talked
20 a lot about the home- and community-based services, which
21 have a flag if they're a waiver service, but there's also
22 an "other" bucket that states can report in, and from prior

1 work here that other people have done, they have found that
2 a lot of states report the HCBS services in that other
3 bucket. And so we don't really know what constitutes
4 "other." We know that they are HCBS services because they
5 have that flag, but we don't know what "other" means. So I
6 think the "other" category would certainly be one that
7 might give me pause, but we can look into are there other
8 known areas where the reporting is --
9 CHAIR ROSENBAUM: Sure, sure.
10 COMMISSIONER THOMPSON: Let me just jump on that
11 point because both what Kit and Andy have said is a little
12 bit of what I was trying to say on the outside about
13 describing these benefits about fungibility and
14 substitution.
15 CHAIR ROSENBAUM: Right, right.
16 COMMISSIONER THOMPSON: And so it's rehab. It's
17 clinic. It's -- I think there's one that's other
18 practitioner.
19 CHAIR ROSENBAUM: Other practitioners, remedial.
20 COMMISSIONER THOMPSON: Right.
21 CHAIR ROSENBAUM: What's another remedial?
22 COMMISSIONER THOMPSON: So I think there's a

1 number of places -- I don't know from a provider's
2 standpoint. All they care about is code and payment.
3 CHAIR ROSENBAUM: Right, exactly. They don't
4 care what class it's under.
5 COMMISSIONER THOMPSON: Right. How it's being
6 reflected in a state plan or waiver and under what
7 authority, you know, lots of times the conversation between
8 a state and a federal government is "I want to pay these
9 people to do this. How can I fit that under some kind of
10 Title 19 category? Where does it fit best? And what are
11 the implications of fitting it under one benefit structure
12 versus another benefit structure?"
13 So I do think -- I'm not sure how we get at this
14 issue in the methods, but I at least think that like
15 understanding there are not these black lines between some
16 of these services and sometimes they exist because they're
17 a more efficient setting or approach to delivering a set of
18 -- meeting a set of needs for a set of beneficiaries, I
19 think, are both very important to kind of initial --
20 CHAIR ROSENBAUM: Yeah. Okay. Chuck.
21 COMMISSIONER MILLIGAN: So focusing on the
22 methodology part -- and God bless you, Martha. One of my

1 comments is going to be similar to what's been said. I
2 think that -- and you reflected it in your opening
3 comments, Martha. I think there is in some ways an
4 artificial distinction between mandatory and optional, and
5 you mentioned a couple.

6 I was going to mention the nursing facility level
7 of care being kind of state flexibility, and so some of
8 it's optional. Some of it isn't. Amount, duration, and
9 scope, do you cover everything, or do you have limits on
10 amount, duration, and scope? So there's some flexibility
11 around mandatory things, and that's all fungible.

12 I guess the question I want to pose here -- and
13 you didn't really focus a lot on it -- is how we are going
14 to deal with dual eligibles, and I want to mention a couple
15 of things about dual eligibles.

16 The first is when you said MLTSS might just be
17 treated like managed care in general and acute, MLTSS has a
18 lot more dual eligibles, and I think that confounds what we
19 mean by looking like acute managed care for TANF-type
20 populations.

21 The second thing I want to mention about dual
22 eligibles is that you had mentioned that various kind of

1 supplemental funding might be treated discretely and sort
2 of a separate bucket of state spending. For things like
3 Part B premiums on the Medicare side, as we've seen Part B
4 premiums rise at a rate faster than health inflation or any
5 kind of normal index, that is a kind of increase in state
6 spending over time that isn't discretionary, but it isn't
7 typically captured in claims data. So I'm interested in
8 knowing how you want to deal with the duals, and I want to
9 conclude with one other comment.
10 I think the reference point to the Kaiser and
11 Urban work from the past is helpful, but looking at sort of
12 fiscal 2007 as reported in 2012, that was before a lot of
13 the country discovered dual eligibles existed. And as we
14 see, demographically, a lot more Medicaid beneficiaries
15 aging into Medicare, otherwise getting Medicare, this is a
16 growing feature of the whole state budget and state program
17 design aspects. So I want to make sure we don't neglect a
18 focused discussion in the methodology around duals.
19 CHAIR ROSENBAUM: Thank you.
20 Marsha.
21 VICE CHAIR GOLD: Yeah. I had two areas I want
22 to focus on. The first, just to pick up, it's sort of a

1 mixture of what it means and where it goes, but to pick up
2 on what Kit and Penny and Chuck were saying, I had that
3 same reaction.

4 I think that in the beginning, before we get into
5 the analysis, we need to just describe a little bit as
6 context what these optional benefits are, and maybe have
7 also a chart showing what share of total spending they each
8 are and maybe how many states have each of them, because
9 some of them, I think a large share may be pharmacy.
10 That's been historical. I mean, pharmacy now would be in
11 the mandatory, but it happens to be there.

12 Some are the usual acute care services that may
13 or may not be in employer plans or typically are newer.
14 Some are the long-term care services that substitute for
15 the others, and I sent comments on some of this, some
16 efficient-related things that pack on mandatory benefits,
17 like targeted care management, the case management fee for
18 primary care case management.

19 And then I sent some of these to staff, but I
20 think just helping to understand that, because it looks
21 like there's so much money that's optional, but I'm not
22 sure it's in that context is optional, even though that's

1 where the bucket is. So I think that would help a lot in
2 terms of understanding things.
3 CHAIR ROSENBAUM: Well, you're drawing the
4 distinction between legislative structure and --
5 VICE CHAIR GOLD: Right.
6 CHAIR ROSENBAUM: -- operations of a health
7 insurance program.
8 VICE CHAIR GOLD: Legislative structure, and it
9 affects later what we do to interpret it.
10 CHAIR ROSENBAUM: Right.
11 VICE CHAIR GOLD: I mean, so we need to
12 understand some of that to help interpret it, and I think
13 an easy way to do that is just setting the context in the
14 beginning.
15 CHAIR ROSENBAUM: Right.
16 VICE CHAIR GOLD: The methods thing I wanted to
17 bring up -- and I want to say how great you guys have done.
18 I mean, this is complicated. I looked through the draft,
19 which was pretty solid to begin with. You have gotten
20 comments there and lots of things one could quibble about,
21 and I'm sure people in the world will, but you do the best
22 you can with what you have. And so it's good work.

1 The managed care stuff, what I was trying to
2 figure out, I'm uneasy with using like states that don't
3 have managed care to get other people because they're
4 rural. They're different in a lot of ways, and I'm
5 wondering if there's an easy way to use what we know of the
6 managed care programs in each state to do a better or more
7 refined breakdown of optional and mandatory.
8 Especially like with carve-outs, if we know that
9 pharmacy is carved out and paid for in inpatient services,
10 we don't have to allocate any of it to the managed care
11 side. It's all in -- well, maybe we do. I don't know, but
12 that's a question.
13 And the same way, if you know that this program
14 doesn't have long-term care services, then the home- and
15 community-based services don't have to.
16 So I know you're stuck with what you have, but I
17 was wondering at the state level if there's just something
18 about the programs that in heavily penetrated managed care
19 states that you could use to make a somewhat refined
20 estimate that would allow you to improve things.
21 CHAIR ROSENBAUM: Good.
22 Just quickly, one request and actually one -- two

1 requests. One is if you could just amplify a little bit on
2 what you do plan on doing about duals, going to Chuck's
3 point.
4 And the other -- and this could only come from a
5 lawyer who knows nothing about research methods -- can you
6 give us a sense of what the spread is here? I mean, in
7 other words, if you tune the dial a little bit more this
8 way or this way, depending on all the input that you're
9 getting, is it a 10-percentage-spread? Is it a 5-
10 percentage-point spread? Without in any way suggesting
11 that we don't have to worry a lot about the methodology,
12 I'm trying to get a sense of what --
13 VICE CHAIR GOLD: I think what you're asking is,
14 Is it important?
15 CHAIR ROSENBAUM: What's the range here? Yeah.
16 MS. HEBERLEIN: Is the juice worth the squeeze?
17 Is that what you're looking for?
18 CHAIR ROSENBAUM: Yeah.
19 MS. HEBERLEIN: I think it depends on what we're
20 looking at. I think the managed care, especially depending
21 upon the state and the managed care penetration, I think
22 how we decide to deal with that could have larger

1 implications. Not having done all these data yet, I think
2 some of it is probably at the margins, and I always
3 advocate for stronger methods that we can be fairly
4 confident in. But I think on the managed care side, I
5 think that's probably where our refinements would make the
6 biggest change.

7 As for the duals, there is a dual eligible flag
8 that we are pulling out to categorize the duals. So
9 partial duals, we're considering mandatory, and then all
10 other individuals with the dually eligible flag will fall
11 into their MAS/BOE as they would otherwise, so they may be
12 mandatory, may be optional, depending on what other
13 category they come into.

14 And then in our adjustment sort of after the
15 fact, which sounds wrong, but like using the CMS-64, we can
16 get at the premiums that they are paying on behalf of those
17 individuals, and so we are going to include that. That's
18 not in MSIS data, but it is in the CMS 64 data, and we are
19 going to include that, and that would be mandatory
20 spending.

21 CHAIR ROSENBAUM: And one last thing, other than
22 the services that are covered, that are federally fundable

1 services, but do not fall within the definition of medical
2 assistance under 1905(a), other than those very small
3 number of services, is there anything for a child that
4 would not be mandatory spending?
5 MS. HEBERLEIN: How we are defining it, no. The
6 only thing that we are defining as not mandatory are HCBS
7 services.
8 VICE CHAIR GOLD: So outside of 1905.
9 MS. HEBERLEIN: Everything else, we are defining
10 as mandatory under EPSDT.
11 VICE CHAIR GOLD: And because of the year, your
12 data are -- it was in our material but not here. It also
13 excludes the new eligibility group because they're not in
14 this data.
15 CHAIR ROSENBAUM: I have Toby. I have Alan. I
16 have Stacey, Alan, and Brian.
17 COMMISSIONER DOUGLAS: So building on some of the
18 points Sharon made, first on the context, I think it would
19 be good -- when I think back to this, the state
20 perspective, there was always cost shifts involved. So
21 giving some context on some of these options, there's the
22 in lieu of, as Kit said, but there's also just

1 understanding like DME, for example, that what are the
2 implications of likelihood on inpatient. So putting that
3 versus podiatry was an example. Well, that should shift
4 probably just to another clinician where there isn't --
5 there isn't the savings, too, for some of these. So that's
6 one piece.
7 On the managed care, a couple comments that I
8 have on that. One, I do think since these optional
9 benefits vary considerably on populations, they're not
10 evenly distributed, the thought I had was breaking it down
11 into populations within managed care of taking the children
12 and the medically needy adults and looking at that compared
13 to fee-for-service, and then the same with age, blind, and
14 disabled. Are you saying you already did -- or if that was
15 already what it was, I think that's --
16 MS. HEBERLEIN: That's our plan.
17 COMMISSIONER DOUGLAS: Okay, good. Okay. That
18 level of funding --
19 MS. HEBERLEIN: Good.
20 COMMISSIONER DOUGLAS: Okay.
21 CHAIR ROSENBAUM: Good. Stacey.
22 COMMISSIONER DOUGLAS: Well, I've got one more.

1 I'm sorry.

2 CHAIR ROSENBAUM: Oh, sorry.

3 COMMISSIONER DOUGLAS: No, no, no.

4 CHAIR ROSENBAUM: No, no. Go right ahead.

5 COMMISSIONER DOUGLAS: The only other thing is
6 also just in terms of implications, and Stacey can correct
7 me if I'm wrong. The optional benefits within managed
8 care, the other piece of that, which is not at the case in
9 fee-for-service, is the actuaries would -- even if this
10 eliminates it, there would be an actuarial change in the
11 rates to account for the cost shift. From an actuarial
12 standpoint, they would have to take that into account. I
13 mean, it's just really important to understand the
14 implications. Some of these benefits might be optional,
15 but from a delivery of care and then rate-setting, it's
16 just going to kind of -- some places wash out.

17 CHAIR ROSENBAUM: Stacey.

18 COMMISSIONER LAMPKIN: So I definitely agree with
19 that comment. I don't think it's unique to managed care.
20 I mean, if the optional substitute of services are
21 eliminated, whether in fee-for-service or managed care,
22 those medical needs go somewhere and the costs have to be

1 covered.

2 COMMISSIONER DOUGLAS: It was just for service,
3 the state can get away with not having to budget that. The
4 managed care, they can --

5 COMMISSIONER LAMPKIN: So I had a couple of
6 comments related to managed care. The managed care,
7 there's no question about it, tricky, and the challenge is
8 it can get weird in so many different ways because of the
9 way that the states have their programs structured so
10 differently, especially dropping that to fiscal '13. My
11 sense is that we've moved to more comprehensive programs
12 pretty steadily since that time, but they were more
13 fragmented back then, which adds to the challenge.

14 So I definitely support the comment that the
15 distributions need to be looked at, at the population
16 level, and it's not at all a bad idea to go to something
17 like you mentioned, where you're looking for threshold
18 enrollment in managed care to move out from the state look
19 with a high enough penetration rate. I do think you need
20 to do that at the population level as well because of a
21 number of states that might be mandatory for one population
22 but optional for another, especially back in '13, so that's

1 going to be important.

2 The other thing I would say about this is I think
3 we need to make an explicit decision about how we handle
4 nonmedical cost associated with managed care, so your
5 fairly comprehensive managed care program, you're talking
6 about roughly 10 percent. I mean, I think that's a round
7 number that's different, depending on the populations
8 covered, but it's probably reasonable for comprehensive.
9 It's probably reasonable to take that and allocate it in
10 the same mandatory/optional split because it supports the
11 service delivery, but I think we need to acknowledge it
12 some way that it's the administrative cost that the health
13 plans incur to deliver the services and abide by the
14 contract term.

15 VICE CHAIR GOLD: Stacey, on that, can I just ask
16 you, did you have any reaction on carve-outs? Is that
17 practical?

18 COMMISSIONER LAMPKIN: When you say that, I'm
19 thinking of TennCare, but then I am also remembering that
20 this was before the states were able to get rebates on the
21 managed care utilization, fiscal '13. So they're probably
22 -- I've forgotten how many states had carved-out drugs, but

1 that's the biggest risk area right there for the typical
2 managed care-covered populations at '13. Looking at those
3 optional services, prescription drugs is probably the most
4 important of those.
5 So if you've got a state that has it carved out,
6 certainly that can affect the results, but I don't know
7 that it's practical to try to go state to state. Maybe the
8 largest states just take kind of a gut check on the
9 structure of the managed care program, and any benchmarks
10 that are published, compare that for the largest states,
11 because it just doesn't seem practical to go state to state
12 to try to refine this.
13 CHAIR ROSENBAUM: On this point?
14 COMMISSIONER GORTON: So I would agree with that.
15 I think behavioral health is the other elephant in the
16 room, in terms of material carve-outs, because whether
17 they're in or out really does shift, and I think that plays
18 into this idea of can you use benchmarks from other parts
19 of the country, because what's carved in and what's carved
20 out, that gets tricky.
21 The one other thing I wanted to say about MLTSS,
22 and then I'm done, is there are states that budget for it

1 separately. Texas, I think, is the most noteworthy of
2 them. But they have a long history of accounting for the
3 MLTSS program separately. They have studied it. And, you
4 know, it won't illuminate what happens everywhere but it
5 might. I think Tennessee, also, may call out in their
6 reporting. They budget -- it's segregated, so it might be
7 useful color commentary.
8 CHAIR ROSENBAUM: Alan.
9 COMMISSIONER WEIL: Two things. One is I had a
10 very similar reaction to Sara's with respect to
11 sensitivity. I mean, you are already, and have to make
12 hundreds of, in some sense -- in some instances arbitrary
13 but hopefully, in many instances, evidence-based decision
14 rules about where to classify things. I think most of the
15 time you just do it, but for the few, and managed care and,
16 in the broader sense it's just been discussed, I think is a
17 good example. You know, in the few places where you're
18 having to make those decisions and it really swings, the
19 numbers a lot, I think those should be called out and the
20 rest should be in that appendix that, you know, others
21 won't read.
22 And then my second comment is really about the

1 context in which this analysis arises, and I think there
2 are two, but there are probably others. One is sort of
3 part of the picture of state flexibility. Well, if there
4 are options then states can or can't do it, and this sort
5 of gives you a sense of the scale of that. I think with
6 respect to that topic, it's important to put it in the
7 context that amount, duration, and scope is also a form of
8 state flexibility isn't mandatory or optional. Payment
9 rates are a form of state flexibility.
10 So, you know, to the extent that we're talking
11 about what this means with respect to how states can and
12 can't design their programs, I think it needs to be put
13 into context.
14 The other narrative -- and I remember this from -
15 - you know, from all the other times we've done this
16 analysis -- not at MACPAC but all the other times I've been
17 part of organizations doing this analysis, is, you know,
18 mandatory equates with important and optional equates with
19 unimportant. And I think that is, in my view, the more
20 dangerous narrative because anyone who's, you know, been
21 involved with the program knows that that's not the case.
22 And so the more this captures, as some of the

1 other documents that have been done on this topic have
2 attempted to do so, not just some of the substitution
3 issues that have already been discussed by the group here,
4 but also the reality of who we're talking about, I think
5 that that's got to be part of this picture, because at the
6 end of the day, you know, if you have a pie chart with four
7 slices on it, with mandatory, mandatory, mandatory,
8 optional, mandatory --
9 CHAIR ROSENBAUM: Yeah.
10 COMMISSIONER WEIL: -- there's no prior on that.
11 I mean, I don't know whether it should be 10 percent or 20
12 or 30. The real question is who is in each of those, and
13 what services are in each of those, and how, then, does a
14 policymaker evaluate the importance of providing those
15 services to those people? And that's, I think, in the end,
16 more important than whether it's a 20 percent wedge or a 23
17 percent wedge.
18 CHAIR ROSENBAUM: Penny.
19 COMMISSIONER THOMPSON: So great comments. I
20 just want to go back to a couple of narrower issues on the
21 methods. On managed care, I just want to understand. You
22 slide says because the amounts paid for specific services

1 are not available, we are assuming distribution of
2 spending. There is that and fee-for-service. So I'm
3 trying to distinguish between utilization of pricing. Is
4 the point that we have utilization but not pricing, or we
5 have neither utilization or pricing, or --
6 MS. HEBERLEIN: We have encountered data which
7 basically says I went to the doctor --
8 COMMISSIONER THOMPSON: Yeah.
9 MS. HEBERLEIN: -- but it doesn't say how much
10 the managed care plan paid that doctor.
11 COMMISSIONER THOMPSON: so when you say you're
12 assuming the distribution is the same as in fee-for-
13 service, do you mean on the price paid --
14 MS. HEBERLEIN: The spending, yes.
15 COMMISSIONER THOMPSON: -- against the
16 utilization you're seeing in the actual data, or that
17 you're also assuming the utilization is the same as in fee-
18 for-service?
19 MS. HEBERLEIN: Sorry. I'm going to look to my
20 managed care partner. I'm going to, like, call a friend.
21 [Laughter.]
22 MS. HEBERLEIN: Lifeline, please.

1 MR. PARK: So we would -- we have the amount that
2 the state paid the managed care as a capitation payment.
3 Right now we're going to assume that the proportion that,
4 you know, the state paid overall on, like, fee-for-service
5 services, say, is like 30 percent mandatory, whatever, 40
6 percent optional. Things like that would apply to that
7 capitation payment. So we wouldn't try to, say, reprice
8 the managed care encounters to reflect fee-for-service
9 payment. We are just going to take this--
10 COMMISSIONER THOMPSON: So we are not using any
11 managed care data, is the --
12 MR. PARK: In terms of the utilization, right.
13 We are not.
14 COMMISSIONER THOMPSON: Absent pricing. So we're
15 --
16 MR. PARK: Right.
17 COMMISSIONER THOMPSON: I mean, that -- I mean,
18 the capitation payment is based on, generally, an
19 assumption that those things look different. So I think
20 that's just a square that -- that's just a circle we have
21 to square somehow.
22 EXECUTIVE DIRECTOR SCHWARTZ: But, Penny, also,

1 they may look different but not necessarily in a mandatory-
2 optional way. They look different --
3 COMMISSIONER THOMPSON: That's fine, but --
4 EXECUTIVE DIRECTOR SCHWARTZ: That's the thing.
5 [Simultaneous discussion.]
6 CHAIR ROSENBAUM: So there is a bias in those
7 definitions too.
8 EXECUTIVE DIRECTOR SCHWARTZ: I think the point
9 that Martha made earlier is that you would be assumed
10 reduced hospitalizations --
11 MS. HEBERLEIN: Yeah. Right.
12 EXECUTIVE DIRECTOR SCHWARTZ: -- but outpatient
13 care would be mandatory as well. So you are not seeing the
14 same sort of substitution across mandatory-optional that
15 you would think about when you think about --
16 COMMISSIONER THOMPSON: I don't know that --
17 COMMISSIONER GORTON: Well, except pharmacy is
18 optional and so is ambulance. So, you know, to the extent
19 that you're --
20 COMMISSIONER THOMPSON: I don't have answer. I
21 know how --
22 EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

1 COMMISSIONER THOMPSON: -- how -- I'm just want
2 to be clear about the fact that we are basically saying
3 managed care is a black box and it looks like fee-for-
4 service, and just that that's a difficult thing to say --
5 CHAIR ROSENBAUM: We will just have to --
6 COMMISSIONER THOMPSON: -- with respect to
7 mandatory and optional.
8 EXECUTIVE DIRECTOR SCHWARTZ: Right.
9 COMMISSIONER THOMPSON: Right. Which is exactly
10 why you need it.
11 The second is about eligibility pathways. I just
12 want to understand this too. There is a point at which we
13 talk about, in those places where the MAS/BOE has a
14 distribution above mandatory and optional, we are
15 distributing by number of pathways?
16 MS. HEBERLEIN: It depends on the MAS/BOE.
17 COMMISSIONER THOMPSON: Okay.
18 MS. HEBERLEIN: So what we did for kids is we
19 classified all the MAS/BOEs that had low-income children,
20 and we said, okay -- because there's some mandatory
21 populations and there's some optional populations, and what
22 we did is we looked at the distribution by income of where

1 Medicaid fell above and below the threshold in that
2 particular state and then we said, okay, well, then, 80
3 percent were below the threshold and 80 percent were
4 mandatory, and 20 percent were optional.
5 And then, in other circumstances where, you know,
6 there was -- where most of the MAS/BOEs, or the eligibility
7 pathways were mandatory, we called the whole group
8 mandatory because the one that remained was very small, or
9 I should give you a different example because we did that
10 with an optional group where it was all medically needy
11 except the newborns born from medically needy pregnant
12 women, and the deemed newborns would be mandatory but
13 everybody else would be optional, and we just made an
14 assumption that that whole group would be optional.
15 So it depends upon which MAS/BOE you're talking
16 about, how we made sort of the next step that we took.
17 COMMISSIONER THOMPSON: All of that seems like,
18 to me, to make sense. I just was a little concerned if we
19 didn't have any sizing of the pathway and we were
20 distributing by the simple number of pathways.
21 MS. HEBERLEIN: We were in some cases. So there
22 are several sort of other categories that include other

1 eligible adults, for example, and it includes pathways like
2 TMA, and it includes emergency Medicaid pathways, and then
3 it also includes adults who would be eligible under a home-
4 and community-based waiver. And so there's -- but we don't
5 know --
6 COMMISSIONER THOMPSON: So there's three
7 different pathways, and we don't know anything about --
8 MS. HEBERLEIN: There's 14 different pathways,
9 right, and so we don't know, sort of, what the distribution
10 in that MAS/BOE is of those particular pathways. And so in
11 that case, we randomly assigned people based on -- so that
12 half were mandatory and half were optional, because we had
13 nothing else to really go on. And so that's where we're
14 hoping, especially in those categories, where we didn't --
15 COMMISSIONER THOMPSON: And the T-MSIS data will
16 give you that. Okay.
17 MS. HEBERLEIN: Yeah.
18 COMMISSIONER THOMPSON: Thank you.
19 CHAIR ROSENBAUM: Brian.
20 COMMISSIONER BURWELL: Just two things. I just
21 want to -- I think this is just building upon what other
22 people have said. I do not think that the assumption used

1 in MLTSS programs should be the same as the rest of managed
2 care. They are totally different. In 2013, there are not
3 that many states that had statewide MLTSS, and I think it
4 would be fairly feasible to treat those states different,
5 where there is very low penetration in MLTSS, so I can see
6 that. It's not going to make a big difference. But in
7 states like Arizona, you know, Minnesota, et cetera, it
8 would make a big difference. And you're going to have a
9 problem with Arizona since it was all managed care, so --
10 that's a separate issue.

11 I guess I would like to have good transparency
12 about the magnitude of the assumptions and the data, so
13 rather than just showing the data and footnoting the
14 assumptions that were used, I would -- it would be nice to
15 be able to see how many people were placed in categories
16 based on the codes -- the MSIS codes versus those that were
17 randomly assigned, so you could just get some sense of, you
18 know, the impact of the assumptions on the results.

19 CHAIR ROSENBAUM: Marsha.

20 VICE CHAIR GOLD: On methods, just a couple of
21 things. I think one way of dealing with what Brian said,
22 and some other people -- and I had this as a comment when I

1 looked at the original draft -- was sort of helping people
2 to distinguish which assumptions are really critical and
3 which aren't, how big, how much of a difference it is. And
4 if you're not sure, being able to do some sensitivity test,
5 like if you -- instead of half and half it was three-
6 quarters and one-quarter, or vice versa, would it make a
7 difference? And just as a footnote, just to help people,
8 you know, understand both what's important and what isn't,
9 and what might change and what doesn't.
10 The other that I was going to suggest, when
11 people were saying about managed care, is I think there's
12 two kinds of places where things are worse. I mean, one is
13 on the big states that have a lot of people in managed
14 care. That could change the whole national total. So one
15 wants to look at those top five or something like that
16 more. The other is states like Arizona, where everyone is
17 in managed care, because the other reason Congress asked us
18 for state-specific estimates, because they'll want to look
19 at it.
20 So if we can sort of look at the, maybe, top five
21 states in size and top five in -- you know, where it might
22 be most sensitive, or specific long-term care stuff, I

1 think those are the ones we really need to worry about,
2 because we're most likely to be potentially giving a
3 misleading sense.
4 CHAIR ROSENBAUM: Well, and that sort of leads
5 into your last set of questions, the policy issues. You
6 know, the construct, the legal construct of the Medicaid
7 statute is, you know, 50 years old and it's been updated
8 many ways. But, I mean, the biggest phenomenon in the
9 context of this study, I think, to have happened, is that
10 today, for three-quarters of the population -- and it's,
11 you know, we're heading toward almost everybody -- the
12 questions that state Medicaid programs are now asking has
13 to do with the delivery of health care in an efficient
14 fashion.
15 And so the -- once you rephrase the crucial goal
16 of Medicaid as delivering, you know, good quality health
17 care in an efficient a fashion as possible, and you then
18 realign your payment and provider structures to go along
19 with that, it essentially makes a hash out of the
20 mandatory-optional dividing line, because you couldn't
21 possibly do business with entities that are designing
22 systems that are going to deliver care for people and

1 achieve certain results for you if you didn't have certain
2 benefits, whether they're in the cap rate, out of the cap
3 rate, accompanying the cap rate, a carve-out. I don't
4 care. The fact is -- and I think we've all sort of been
5 circling this issue now for an hour and a half -- is that
6 the way to think about the core purpose of Medicaid today
7 is somewhat different from the way we thought about it when
8 it was sort of a strange parallel to indemnity insurance,
9 and, you know, was operating in a much less unstructured
10 manner.

11 And so I think, you know, when we get to both the
12 context setting apart we talked about, but the policy
13 question you draw at the end, you know, are -- I think we
14 have a very important set of tasks from Congress. And then
15 I think in addition to trying as best we can to answer the
16 question, is sort of also identifying for our committees of
17 jurisdiction, the other kinds of questions that might be
18 asked about Medicaid spending today, which I think the room
19 has talked about a lot.

20 Brian.

21 COMMISSIONER BURWELL: So on the first policy
22 question on the last page -- how to categorize in Medicaid

1 enrollment and spending as either mandatory or optional
2 will help us determine who is in most need and assess the
3 value of different types of services --
4 CHAIR ROSENBAUM: It does.
5 COMMISSIONER BURWELL: -- is that specifically in
6 the letter, because my response to that is it doesn't say
7 anything. I mean, it says very little.
8 CHAIR ROSENBAUM: Well, I think that's what we
9 are all struggling with here.
10 COMMISSIONER BURWELL: I mean, but is that a
11 question that they asked us?
12 CHAIR ROSENBAUM: No. I think what we're trying
13 to do is take a step back, as the Commission now, and say
14 what do we -- when we produce this very complicated
15 analysis for Congress, what kind of context and
16 implications do we want to draw for lawmakers as we answer
17 their questions.
18 EXECUTIVE DIRECTOR SCHWARTZ: But the letter --
19 the letter --
20 COMMISSIONER BURWELL: And there's no short
21 answer to that. That's a long answer.
22 EXECUTIVE DIRECTOR SCHWARTZ: Yeah, and the --

1 while not phrasing it this way, the letter goes on quite a
2 bit about what is crowding out --
3 CHAIR ROSENBAUM: Yes.
4 EXECUTIVE DIRECTOR SCHWARTZ: -- what or who is
5 crowding out what or who. So it's -- I think it's fairly
6 easily implied from the examples.
7 CHAIR ROSENBAUM: Yes. No. I think we are -- I
8 think the way the letter is phrased, while those questions
9 are not literally in the letter, I think the letter is
10 asking for this information because it rests on a series of
11 assumptions about how states spend Medicaid funds, and it
12 rests on the assumption that the statutory structure of
13 benefits and eligibles is a basis for drawing implications
14 about the necessity of certain kinds of care. And I think
15 it -- I think because the committees themselves are
16 searching for this kind of direction from us, it's
17 important for us to tell them what we -- what one can see
18 in what we give them and what one cannot see.
19 Yeah, Andy.
20 COMMISSIONER COHEN: I think one thing that would
21 be really helpful here is to just provide a little history.
22 When were these definitions set? I mean, they weren't -- I

1 don't think they were all set at one time but most of them
2 were set at one time, and it was a long time ago, for most
3 of them, I believe. And to talk a little bit about how --
4 maybe what those definitions meant then, in the context of
5 the way health care was delivered and what they -- how
6 health care has changed and what they mean today, and
7 whether or not, in today's world, do commercial -- you
8 know, do other kinds of health care payers make
9 distinctions and categories and decisions based on those
10 criteria, or to what extent they do. But just a little bit
11 of context around relevance and history, like when they
12 were created and whether that is -- whether they are as
13 relevant today as when they were created.
14 CHAIR ROSENBAUM: Yep. Kit.
15 COMMISSIONER GORTON: And I think building on
16 what Andy said, there is a real question in people's minds
17 about equity, that we created a Medicaid program with such
18 a rich and comprehensive benefit that the best insurance
19 you can have, laying aside the access questions, is
20 Medicaid, because it covers everything. And I think you
21 can argue after OBRA ‘89 and expanded EPSDT, at least for
22 children, the answer to that is yes.

1 And so I do think that we hear people struggle
2 with, well, is that right? And I don't necessarily embrace
3 this point of view, but people then make the argument,
4 well, are there then some people who make economic choices
5 in their lives based on their perceived need for health
6 care, that they might choose to be in Medicaid rather than
7 choose to be working at a relatively low-paying job with
8 little or no employer-sponsored coverage or a high-
9 deductible health plan and an HSA that they can't afford to
10 contribute to? You know, have we pushed the balance too
11 far? And in the interest of making sure that low-income
12 people and people with disabilities have the best possible
13 coverage, have we, in fact, pushed too far, and should the
14 balance -- and not -- I see, when I read the questions in
15 the letter I see them searching for, is the balance point
16 in the right place.
17 And so I think that to the extent that we can
18 address that, understanding that, you know, for people
19 above 138 percent of poverty, this is simply not an option.
20 And so are the benefits equivalent? Are the -- you know,
21 the actuarial value is obviously much higher because it's
22 100 percent. But I do think that people are interested in

1 those value judgments, and I think that's what draws them
2 to, you know, have we expanded these optional categories to
3 the point where there's so much fluff in the program. And
4 I don't happen to think that's the case, but I do think we
5 need to demonstrate how the word "optional" misleads
6 people.
7 CHAIR ROSENBAUM: Marsha.
8 VICE CHAIR GOLD: Yeah. I mean, that was, in
9 part, behind what I was thinking about in the beginning, if
10 we talk about these services. I mean, there are a whole
11 bunch that if you looked at what commercial coverage
12 usually covers, would be in that package. I mean, there's
13 pharmacy, there's the, you know, occupational speech
14 therapy, hospice, maybe chiropractor -- I don't know -- we
15 have -- whatever those are, they're acute care medical
16 benefits, and that's -- but I think we then have to come
17 back and say -- and draw on some of what we've done before
18 and some of the reports to Congress, is what is Medicaid.
19 Well, Medicaid is the program we've used to deal with a lot
20 of things that regular insurance doesn't deal with, and
21 that are problems otherwise. So that it seems like there's
22 a whole bunch of home- and community-based services, ICF/MR

1 that are making up for restrictions in the other services,
2 and sometimes are substitutes for mandatory services.
3 People can debate whether Medicaid should do
4 that, but if you're going to have a Medicaid program that
5 treats disabled people, then you better have some of the --
6 or, you know, or these very aged people, you better have
7 some of these services. You also have -- some of them are
8 efficiency enhancing, just to get better payoff on the
9 mandatory benefits, like home health targeted case
10 management. Maybe that exists in commercial too. I don't
11 know. But those things.
12 And then there are ones that maybe aren't part of
13 insurance, but you have a low-income population, and these
14 maybe are the ones you're thinking that people are talking
15 about. We have eyeglasses, dentures, adult dental care,
16 and maybe -- I don't know where TB and sickle cell fit in.
17 But -- and the issue is these were deliberately put there
18 because you have a low-income population, and these are
19 important things that help people stay healthy, maintain a
20 good quality of life, keep a job. One can debate whether
21 you should cover them or not. I suspect they're a tiny
22 piece of the optional sliver, which is a -- because partly

1 they're already covered for children as mandatory, so
2 you're only talking about adults.
3 But I think making them real, and sort of talking
4 not just as a laundry list of a bunch of benefits but the
5 different functions these benefits are performing in the
6 Medicaid program, can result in a better discussion of to
7 what extent are they are or are they not valued. Because I
8 agree -- I think we have to make the point clearly that, to
9 the large extent, the mandatory-optional distinction is
10 more historical artifact than it is something that's going
11 to help the policy today, but if there are issues within
12 that, you know, like should Medicaid take care of the
13 developmental disabled and mentally retarded people, that
14 one could debate.
15 CHAIR ROSENBAUM: Okay. Let's let Stacy close us
16 out.
17 COMMISSIONER LAMPKIN: So just reacting to the
18 comments that the two of you have just made, would it be
19 useful to us, in the course of commenting on this, to talk
20 about which of the benefits are -- which of the acute care
21 benefits are commonly covered in employer-sponsored health
22 insurance, where employers, the payer over there, have

1 decided this is an efficient set of value-based --

2 VICE CHAIR GOLD: BLS has that.

3 COMMISSIONER LAMPKIN: Yeah, and then for the

4 services that are not, they're specialized services that

5 target individuals with high needs, and kind of put it in

6 that context, that that's another role that the Medicaid

7 program plays. Provide that context around the issues.

8 CHAIR ROSENBAUM: I think very useful.

9 Well, thank you, Martha. I'm so -- I feel so bad

10 for you.

11 [Laughter.]

12 CHAIR ROSENBAUM: Our condolences. But really, a

13 wonderful job, and we look forward to the work itself.

14 All right. We are on a break. We will reconvene

15 in 15 minutes.

16 [Speaking off microphone.]

17 CHAIR ROSENBAUM: Oh, I'm sorry. Do we have

18 public comment now?

19 EXECUTIVE DIRECTOR SCHWARTZ: You can have public

20 comment whenever you want.

21 CHAIR ROSENBAUM: Let's see if we have public

22 comment now. My apologies to the public. Yes, we have

1 public comment.

2 **### PUBLIC COMMENT**

3 * MR. BRUEN: Brian Bruen from George Washington

4 University. First, my condolences to the MACPAC staff who

5 have to do this mandatory-optional thing, because I did it

6 20 years ago and then three times since then, and every

7 time it got harder, because there were more and more people

8 in managed care to deal with.

9 One point on that that I would suggest is that

10 there are some states that have good data published on

11 their websites or hidden, that you have to ask God for and

12 beg for, that do have some breakouts of spending for their

13 managed care populations. Look particularly at states that

14 require, as part of their contracts with plans, to submit

15 both utilization and expenditure data, because they have

16 the data; they can run it.

17 On the budget option analysis that we talked

18 about a while ago, one of the things I thought might be

19 helpful is to also try to assess some of the motivations

20 behind some of those proposals. For example, prescription

21 drugs are increasingly being put on that list, and I, like

22 Marsha, don't really view those as being sort of really a

1 true attempt. They don't really think they're going to cut
2 drugs, because of the immense pushback they would get.
3 But, at the same time, it reflects their frustration with
4 the high cost of drugs, some of the limited options that
5 they have to manage their drug benefits, in terms of
6 limiting access or dealing with the fact that you may have
7 a very high up-front cost for a benefit that you, as
8 Medicaid, may or may not recoup down the line.
9 And so those things go into those proposals just
10 to get attention to them, more so than as legitimate budget
11 options. And so I think that's at least worth a
12 discussion.
13 CHAIR ROSENBAUM: Thank you.
14 All right, we are on break until three.
15 * [Recess.]
16 CHAIR ROSENBAUM: All right. Everyone has
17 assumed his or her places. We seem to have our
18 Commissioners back.
19 So we are starting up, and this is the session on
20 Alternative Approaches to Medicaid Financing and Setting
21 Per Capita Caps. Take it away.
22 MS. FORBES: Is this close enough?

1 CHAIR ROSENBAUM: Yes.

2 ### **ALTERNATIVE APPROACHES TO MEDICAID FINANCING:**
3 **SETTING PER CAPITA CAPS**
4 **CURRENT MEDICAID PARALLELS TO PER CAPITA**
5 **FINANCING OPTIONS**

6 * MS. FORBES: So, thanks. This session is a
7 follow-on to the January session we had on alternative
8 financing proposals and illustrative examples of design
9 elements. A lot of the focus recently has been on per
10 capita caps and block grants, and as Commissioners and
11 other staff pointed out, capitation rate setting and 1115
12 budget neutrality calculation methodologies have parallels
13 to some of these alternative methodologies. They both
14 estimate a total cost of care for beneficiaries and they
15 both put an upper limit on state or federal spending.

16 While there are a lot of commonalities and
17 parallels, there are also some differences that are
18 important to understand.

19 So we conducted an examination of the current
20 methods that state and CMS are using, which raise some
21 implications for consideration of alternative financing
22 models that you may wish to discuss further. We are also

1 happy to answer any questions or provide more technical
2 details as best we can, as we go along.
3 So first I will discuss managed care rate
4 setting, which some have noted as a close analog to the per
5 capita cap approach. There is a lot of experience with
6 this. Forty-three states make at least some capitated
7 payments. These are per-member, per-month payments,
8 calculated to cover the services provided by managed care
9 organizations to enrolled beneficiaries. Since 1981,
10 federal Medicaid law has required managed care capitation
11 rates to be set on an actuarially sound basis, which means
12 they must be developed in accordance with generally
13 accepted actuarial principles and certified by qualified
14 actuaries.
15 There is a Medicaid actuarial soundness standard
16 that says that payments must cover reasonable, appropriate,
17 and attainable costs in providing covered services to
18 enrollees in Medicaid managed care programs. In
19 determining whether to implement or continue a managed care
20 program, states consider whether the actuarially sound
21 rates that meet the standard are adequate to attract
22 qualified health plans but are also fiscally prudent.

1 So I'll quickly walk through the steps that
2 states and their actuaries follow in setting managed care
3 rates. States follow accepted actuarial methods and the
4 specific requirements that are described in federal
5 Medicaid regulations and guidance. States use fee-for-
6 service claims and health plan financial and encounter data
7 to determine historical costs and utilization and establish
8 a baseline. States can use multiple years of data to
9 smooth out variability, but they don't use baseline data
10 that's more than three years old. Actuaries can make
11 adjustments for things like missing data, claims lags, and
12 the effects of differences between the covered group and
13 the baseline.
14 To help make sure MCO payments reflect the health
15 status and expected costs of the actual enrolled
16 population, actuaries develop many rate cells to segment
17 the population into groups with similar cost
18 characteristics. This means you could have different rate
19 cells based on age, gender, county, eligibility category,
20 institutional status, and other factors.
21 Actuaries project future cost for the coverage
22 period, taking into account medical cost inflation rates

1 based on actual experience, changes in utilization
2 patterns, and program changes. Trends can vary by service
3 or population. Actuaries can take into account the effect
4 of cost-savings initiatives such as payment cuts, but can't
5 set rates to achieve an arbitrary savings amount.
6 Actuaries adjust rates to account for expected
7 savings through managed care efficiency factors, such as
8 assumptions regarding the potential lower use of emergency
9 rooms. They also calculate an allowance for administrative
10 costs. Actuaries may also apply risk adjustment techniques
11 or make other adjustments for certain high-cost services.
12 States must submit all of the capitation rates as
13 well as the underlying data used to develop the rates, an
14 explanation of the rate-setting methodology, and copies of
15 the MCO contracts to CMS for review and approval before
16 they can start making payments. The state's actuary must
17 include in the rate submission documentation of compliance
18 with all of the actual soundness requirements.
19 CMS staff review the rates for adequacy and
20 appropriateness. For example, CMS staff, or an actuary
21 applying generally accepted actuarial principles, may
22 evaluate the trend factors to determine their

1 reasonableness. Medicaid rates are certified for a 12-
2 month period. States can make minor adjustments within 1-
3 1/2 percent, without federal re-review.
4 And now I will turn it over to Rob to discuss the
5 methodology for calculating Section 1115 waiver budget
6 neutrality limits.
7 * MR. NELB: Thanks, Moira. So I'm going to review
8 Section 1115, budget neutrality.
9 As you know, Section 1115 is one of the broadest
10 waiver authorities available in the Medicaid program, and
11 it provides the Secretary with the ability to authorize
12 spending that furthers the objectives of the Medicaid
13 program. Budget neutrality provides a benchmark for
14 ensuring that any additional spending authorized through a
15 waiver does not exceed expected federal costs without the
16 waiver. Budget neutrality is not defined in statute or
17 regulation, but it has been a long-standing practice since
18 the late 1970s.
19 States can demonstrate budget neutrality in a
20 variety of ways. Today I'll be talking about the per
21 capita method. Currently, 26 states use the per capita
22 method in Section 1115 demonstrations for some or all of

1 their Medicaid populations. More information about the
2 particular populations covered is in your materials.
3 Under the per capita method, a benchmark of per
4 enrollee spending is established for broad Medicaid
5 eligibility groups included in the demonstration, such as
6 children, adults, or the disabled. Baseline costs for each
7 eligibility group are established based on the most recent
8 year of spending, for which data are available, and then
9 future costs are projected by trending forward per capita
10 costs by the lower of the President's budget or the state's
11 historical growth rate during the five years prior to the
12 demonstration.
13 States can include some hypothetical costs in
14 their budget projections for populations that could have
15 been covered without the demonstration but are not in the
16 historical baseline. However, savings from hypothetical
17 populations cannot be used to offset the cost of other
18 expenditures under the demonstration.
19 A good example of this is the new adult group,
20 added by the Affordable Care Act's Medicaid expansion.
21 States can now cover these low-income adults without a
22 waiver, but states d0 not have historical costs for this

1 population to put into their budget neutrality baseline.
2 So for demonstrations that include the new adult group,
3 states have estimated what their costs are. However, they
4 are not allowed to use savings from the new adult group to
5 offset other costs under the demonstration. In future
6 years, per capita limits for this group will be re-based,
7 based on actual expenditures.
8 Budget neutrality is enforced over the entire
9 period of the demonstration, which is typically five years.
10 State spending can exceed projections for one eligibility
11 group as long as spending for the demonstration overall is
12 below the budget neutrality limits.
13 Historically, when states renew their
14 demonstrations, they have been able to carry forward
15 savings from prior years. However, in 2016, CMS revised
16 its budget neutrality policy to phase down some of these
17 accumulated savings and begin to rebase per capita spending
18 at renewal. Although CMS has a process for budget
19 neutrality, GAO has expressed concern in the past that CMS
20 has approved budget neutrality limits that may have
21 increased federal spending, and as a result GAO has
22 recommended that CMS provide more transparency about its

1 budget neutrality methods and assumptions.

2 Although managed care rate setting and Section
3 1115 budget neutrality have different goals, they do share
4 some common challenges when establishing per capita
5 spending limits, so I'll talk about some of these common
6 challenges and then I'll turn it over to Moira to talk
7 about some of the implications for broader discussions
8 about Medicaid financing reform.

9 So our first common challenge is determining
10 which populations or services to include. So although many
11 states have some experience with managed care or Section
12 1115 demonstration, for some portions of their Medicaid
13 population, many states often exclude complex populations
14 and services, the costs of which are more difficult to
15 project. In addition, as the experience of the new adult
16 group shows, it's difficult to account for populations or
17 services that are not part of the historical baseline.

18 In some legislative proposals for per capita
19 caps, they have included a broader range of populations and
20 services, including some that states do not have as much
21 experience managing, and that they traditionally excluded
22 from managed care or waivers. In Chris' presentation to

1 follow, he is going to walk through some examples of the
2 effects of including or excluding some of these
3 populations, such as duals or partial benefit enrollees.
4 A second common challenge is just the data that's
5 used. So for managed care and Section 1115 demonstrations,
6 the data comes from states, but just like the federal data
7 it's often incomplete and subject to some data lag.
8 Because both managed care and budget neutrality rely on
9 state data, it's also important to note that they reflect
10 states' current policies in terms of eligibility, covered
11 benefits, and payment rates, so they're not making any
12 adjustments based on the differences in spending between
13 states.
14 Contrast the national per capita cap models that
15 have been proposed, which primarily rely on national data,
16 which is, of course, less detailed than the data available
17 to states and subject to more data lag. As you know, CMS
18 is currently working through the T-MSIS initiative to
19 improve the timeliness and quality of data available at the
20 national level, but it's still a work in progress.
21 The third challenge I wanted to highlight is
22 trend rates. So when you're accounting for future costs it

1 involves making a number of assumptions about future cost
2 growth, for which there may be a range of appropriate
3 responses. So in Section 1115 budget neutrality, there are
4 some broad assumptions made about aggregate trends for
5 eligibility groups as a whole, whereas in managed care,
6 actuaries make more specific assumptions using a more
7 sophisticated process to estimate costs for particular rate
8 cells and for particular services. This method provides
9 more precision but it also requires more data about
10 enrollees and the services that they use.
11 A final point to note about trend rates for both
12 managed care and waivers is that under the current
13 mechanism they are often negotiated between states and CMS
14 or between states and their plans. In contrast, under some
15 proposals for national per capita caps, there may be less
16 opportunity for state-by-state negotiation about
17 assumptions and trend rates.
18 And the last common challenge I wanted to review
19 today is about methods for accounting for savings. So
20 managed care and Section 1115 budget neutrality have
21 different processes for accounting for future savings,
22 which reflects, in part, the different goals of these

1 processes. So in managed care, rates are adjusted to
2 account for anticipated savings, in part because any
3 savings that are achieved by the managed care plan are
4 retained by the plan. Actuaries have a process for
5 estimating attainable savings for particular services, and
6 then adjust rates through various efficiency factors, while
7 at the same time having to ensure that rates are sufficient
8 to meet the actuarial soundness test and provide health
9 plans opportunities to achieve a reasonable medical loss
10 ratio.
11 For Section 1115 demonstrations, however, the
12 budget neutrality benchmark is not adjusted to account for
13 anticipated savings, and this is, in part, because states
14 cannot spend savings from a demonstration without CMS
15 approval for those additional expenditures.
16 Now I will turn it over to Moira to just
17 summarize some of these key distinctions with per capita
18 caps.
19 MS. FORBES: Thanks. So having reviewed the
20 basic components of these two parallels to the per capita
21 cap development process, we have developed a few
22 distinctions that you may want to keep in mind.

1 First, the mechanisms that have been developed to
2 establish capitation rates and budget neutrality limits may
3 not translate to a national per capita cap model.
4 Different goals require different methods. When paying
5 private MCOs, states develop many specific rate cells to
6 help payments be as precise as possible, but CMS generally
7 uses broad eligibility categories to establish limits for
8 federal contributions to state health care demonstrations.
9 A national per capita cap financial model has its own
10 goals, and policymakers will need to establish guidelines
11 to support those goals.
12 Also, rate setting and budget neutrality methods
13 are state specific and do not need to account for different
14 state policies, as Rob mentioned. The process in each
15 state is developed and adjusted to account for the unique
16 characteristics of that state's program design, data
17 availability, and program goals. Each state develops its
18 rates or limits independently, without reference to other
19 states, so these approaches do not tell us much about how
20 to adjust for the significant differences among states, in
21 terms of coverage and provider payment.
22 Another key difference is that managed care

1 programs and Section 1115 demonstration waivers are
2 voluntary programs. Health plans can decide whether or not
3 to contract with states and states can decide whether or
4 not to pursue waivers, and so there is often some
5 negotiation of both performance requirements and payment
6 terms, and then periodic renegotiation or rebasing. The
7 national per capita cap models that we have seen anticipate
8 an automatic formula that would be applied to all states
9 going forward.
10 So that completes our review of these two current
11 Medicaid parallels to the per capita financing options. As
12 I said, we can answer any technical questions that you
13 have, and we look forward to your discussion.
14 CHAIR ROSENBAUM: Questions? Comments? Alan.
15 COMMISSIONER WEIL: So I just want to start by
16 saying I think this analysis is brilliant, and I don't know
17 whose idea it was to do it, but I -- my hat -- not that I
18 have one on, goes -- is off to you. It's brilliant because
19 it is trying to do what you all have said, which is to look
20 inside the program for analogs for what's being described
21 as a macro approach. So I just -- it is a -- for me, it
22 changes the way I think, which is wonderful.

1 What I want to try to do is, because it's a
2 mapping of two very different concepts -- or maybe three
3 because you've got two examples and per capita caps -- but
4 because it's a mapping of things that, as you, Moira, noted
5 at the end, different goals, how that map occurs feels very
6 important to me. So I just want to take a moment, if I
7 could, to say that I think the unique contribution here,
8 from my perspective, is akin to something I went through,
9 having been part of the debates over block grants two
10 decades ago, which is to elucidate the complexity of
11 concepts that sound simple. And I -- for me, as a member
12 of MACPAC, the strongest power of this analysis is in that
13 fact, that it shows that if you want to take an approach of
14 per capita caps, it turns out that there are a lot of
15 questions you have to answer that are very consequential,
16 and we know how hard they are to answer because we have two
17 examples of it in the program where we've tried to answer
18 them, and it's hard there, and, in fact, particularly on
19 the budget neutrality, there's been a lot of criticism
20 about that approach. There's been a challenge on the
21 managed care rates as well, but a lot of criticism about,
22 you know, transparency and data sources and the negotiated

1 nature of that.

2 So I guess what I would encourage as this work
3 continues is to spend less time sort of contrasting how
4 current per capita cap proposals do or do not line up with
5 what's been done in 1115s and managed care, because the
6 first half of that is a moving target, and the goals of
7 that endeavor are quite different than the goals here.

8 I think a more matter-of-fact presentation of the
9 number of decisions that have to be made and the
10 implications of those decisions when you adopt an approach
11 like this is a very powerful document. And so I would lean
12 more toward the descriptive elements of the features, the
13 challenges associated with timeliness, the use of national
14 versus state and things like that, and less on trying to
15 then map that onto proposal which, at this point, are still
16 very general.

17 CHAIR ROSENBAUM: Stacey.

18 COMMISSIONER LAMPKIN: Okay. So thank you. I
19 agree that I think this is really helpful to look at these
20 and understand where they line up and where they don't. I
21 think it is informative.

22 One other thing that occurs to me, as we walked

1 through this, in light of managed care rate setting, and
2 not necessarily that it provides a direct guide to the
3 issue in per capita caps -- so maybe there's something
4 there that's useful, which -- and we talked in the last
5 meeting about the variability in costs, state to state, and
6 how, over time, there might be a push to a mean with per
7 capita caps and so forth, and there's -- we spent some time
8 talking about what are the different things that produce
9 that variation. Well, to some extent, states have the same
10 issue in managed care rate setting. You may have multiple
11 MCOs that have very different cost levels. And so rate
12 setting has to think through where are the legitimate
13 variations that you want to leave in the system, and what
14 are perhaps -- not illegitimate variations, but variations
15 that you don't need to perpetuate, for example. And so
16 there may be something there, too, that translates to this
17 conversation.
18 COMMISSIONER THOMPSON: And just building on
19 that, the other piece, I think, is this issue of managing
20 risk and who owns risk, and how do you account for risk.
21 So I think in terms of going another level down, that's
22 another place where some of the complexity that Alan is

1 referencing, about -- you know, in both of these
2 circumstances, and you mentioned this, you know, you have
3 two parties coming together to voluntarily agree to
4 something. That's a really basic proposition here, is that
5 if I've decided I can't live with it, I don't have to live
6 with it. Whether it's the state and the federal government
7 or it's a plan and a state. And, you know, I have room to
8 negotiate and talk about what I think is fair or not fair,
9 or acceptable or not acceptable, and a lot of that has to
10 do with some of the underlying decisions that you're making
11 about what you want to pay for, and what you think is
12 legitimate, and what's been done in the past, and what you
13 want to perpetuate or not. But some of it is also how much
14 risk can I assume, how much risk do I think I can manage,
15 what are the safety valves if I can't meet that. So I
16 think that's another area where it would be kind of
17 interesting to dive down a little bit and talk about that
18 element, in terms of both how things have been done in the
19 past but also just how that is addressed going, in general,
20 in the industry.
21 CHAIR ROSENBAUM: I have Kit, Andy, Chuck.
22 COMMISSIONER GORTON: So I'll just build on that.

1 I agree with everything that's been said, including,
2 particularly, what Alan said, because I think this is
3 really important work, so congratulations.
4 A piece that I would add onto it is this is a
5 great treatment of programmatic costs. It doesn't talk
6 about administrative costs, and there's a whole long,
7 fraught history between CMS and the states, and between the
8 states and the plans about how you cover administrative
9 costs, and there's a lot less consistency there so it would
10 be hard to describe. But one of the challenges many states
11 have is constitutionally they budget their administrative
12 costs in a different bucket than they budget their
13 programmatic costs, and so their administrative costs may
14 be differently constrained than their programmatic costs,
15 and some of the failings that people have attributed to the
16 states over the years, in Medicaid, have come from the fact
17 that they simply have no administrative resources to deploy
18 to managing the program. Right? So why were we talking
19 about low uptake of T-MSIS? It's because states don't have
20 the administrative dollars to do that.
21 A similar conversation happens with the plans,
22 and some states do capitation with the admin rolled in and

1 some states do a separate admin computation. And so I do
2 think that -- and then if we think about how CMS pays the
3 states, there are different matching rates for IT
4 investments, there are different matching rates for
5 clinical infrastructure that the states put in place, and
6 so the CMS has, in fact, tried to drive states in the
7 direction of making certain investments.
8 And so I do think it's worth laying that out,
9 because to the extent that we are going to change the
10 financing construct, we're not only going to have to think
11 about how that maps to programmatic financing but we're
12 also going to have to think about how the administrative
13 component of it gets financed.
14 COMMISSIONER COHEN: Agreed. This was a really
15 neat and interesting analysis, and I think useful, and I
16 like Alan's suggestion about really focusing on sort of the
17 complexity of the elements of doing the two existing
18 processes.
19 One piece that just kept coming up in my mind as
20 I was reading about this, and I -- there are those who know
21 more about this than I do, but both with respect to waivers
22 and with respect to managed care rate setting, the thing

1 that kept coming up in my mind is these things are adjusted
2 a lot. You know what I mean? So waiver formulas kind of
3 get adjusted -- because it's a negotiation between
4 partners, and if both partners want it to work, it gets
5 adjusted.
6 And managed care rates, at least in my
7 experience, which is somewhat limited, are adjusted at
8 least every year, so that when you have -- you know, when
9 an assumption is made about what costs might be, and in
10 some year every plan in your state does extremely badly
11 because of an event that happens, or Harvoni comes out, or
12 whatever it is, the next year there's usually some sort of
13 compensating change in rates to sort of address that
14 problem. And I just think that's a really important
15 element that adds to complexity, that these arrangements,
16 in part, work -- and again, it goes to Penny's point about
17 who's holding the risk when you're sort of trying to, to
18 some degree, limit risk, but, in part, because there is an
19 awful lot of adjustment that happens along the way, that's
20 not automatic, and to require, say, federal legislation
21 every time that would need to be done is a terrifying
22 thought.

1 CHAIR ROSENBAUM: Okay. Chuck.

2 COMMISSIONER MILLIGAN: I echo the comments. I
3 wasn't prepared to think this afternoon, but you made me do
4 it, so congratulations.

5 I want to -- so where my thoughts took me was the
6 element of carryover from year to year about surpluses or
7 deficits, and I want to develop this for a second. In 1115
8 waiver -- and I've been on the state management side of
9 this -- you're kind of -- you have a trend over a period of
10 time, and you can be behind the trend or above the trend.
11 I mean, you can sort of be in deficit mode or in surplus
12 mode in a given year, but you're sort of carrying it over
13 the course of the five years. I mean, it's still matchable
14 inside of that, but you're sort of looking at, are you
15 above water or below water all along the way, and you're
16 carrying it over, over a period of time.

17 Not so much so in managed care rates, although
18 it's arguable that if a trend is set at 3 percent, let's
19 say, and the medical costs actually are below that, it's
20 margin to the health plans because maybe some drugs went to
21 generic and other kinds of things can happen, or maybe, you
22 know, it wasn't a bad flu season -- all kinds of things.

1 Or you can be behind and plans lose money, but you aren't
2 carrying it over quite.
3 And so the reason I think that I wanted to
4 develop that comment, as a point of distinction between
5 these two, is that, in a hypothetical per capita world, is
6 it like CHIP, where you're carrying over an amount over
7 time, or is it not like CHIP -- it's a one-year snapshot
8 per capita amount and whatever the state's actual
9 experience is against a per capita cap is just one year at
10 a time?
11 So I think that developing that distinction
12 between 1115 waiver budget neutrality and managed care rate
13 setting, I think, would be helpful.
14 COMMISSIONER BURWELL: So I have a question, and
15 the question, I think, is more towards Stacy and Penny
16 about managed care rate setting and 1115s. Are there -- in
17 those negotiations, generally, are there allowances for
18 adjustment factors related to programmatic changes between
19 the base year and the implementation year? For example,
20 opioid epidemic, or the introduction of specialty drugs.
21 Those -- I'm just thinking in this situation there may be
22 additional programmatic changes that would need to be taken

1 into account between whatever base year is used, and the
2 launch year. That's generally --
3 MR. NELB: Sure. So in Section 1115
4 demonstrations there is a clause that any -- there are
5 automatic adjustments for any change in federal law. So,
6 for example, when the primary care bump took effect, so
7 that that additional increase didn't count against states'
8 limits. But you described, though, if there's like a bad
9 flu season or something, that's not sort of automatically
10 dealt in. However, the state could always come in for an
11 amendment or something, like they sometimes do in cases of
12 disasters.
13 CHAIR ROSENBAUM: You know, I am sitting here
14 thinking, I mean, I really deeply appreciate this
15 presentation, as everybody does. I also think, though,
16 that it's very important to keep the distinctions clear
17 here. I mean, in 1115, we're talking about a state wanting
18 to pursue an experimental design in Medicaid, and because
19 it's -- otherwise, it's not an 1115. You can't use 1115
20 just because you want to run differently. You use 1115
21 because you're pursuing an experimental design, and that is
22 how the Secretary derives his authority to act.

1 And so you would imagine that all of the complex
2 methods that go into building an experimental design, and
3 adding in certain levels of cost accountability in the
4 design are there, but the -- whether you would ever use the
5 kinds of set rules, okay, for building an experimental
6 design, that you would use when we're talking about,
7 really, two sovereigns operating a massive federal program,
8 you know, based on a statute that assumed two sovereigns
9 coming together, and the current structure now is that
10 there is a tremendous amount of back-and-forth but the
11 edges are blurred, to the extent that you go to a -- you
12 start moving toward a much more structured negotiation, you
13 know, I think the question really becomes, for just
14 tremendous federalism reasons, how much advance negotiation
15 happens, how much the underlying assumptions about updates
16 can be, you know, sort of worked out in advance, challenged
17 in advance, how much room there is for -- as we were just
18 saying -- for 1115, or even for an experiment we allow it,
19 you know, but for real-time adjustments as the situation
20 warrants, where, you know, who could have predicted Zika?
21 I mean, nobody saw Zika coming.
22 And I think that it's very important in this

1 context to understand that the precedents give us a lot to
2 work with, but that in the end we are talking about a
3 program where it's really the standard operation of a
4 program insuring 74 million people. It's not an experiment
5 that's going to deal with 2 million people, which is a lot
6 of people, or a decision by one particular managed care
7 company, whether to be in a market or not. And the
8 question is when you are building an insurance system where
9 you've got two sovereigns having to run an insurance system
10 for 74 million people, what are the real-time and
11 prospective safeguards you build into the process of rate
12 setting, that may be very different from what you would,
13 you know, normally think is important when you're dealing
14 with something on a much smaller scale.
15 So I think the great thing about this exercise is
16 not only the analogies we can draw from, but also the
17 contrasts that we identify. You know, this is -- this
18 would be an unprecedented scale to essentially set a
19 mechanism for financing care for 74 million people.
20 So I think we are now ready for the next act.
21 **### ILLUSTRATIONS OF STATE-LEVEL EFFECTS OF PER**
22 **CAPITA CAP DESIGN ELEMENTS**

1 * MR. PARK: Thanks, Sara.

2 This presentation continues our work from January
3 to provide data examples to illustrate the impact certain
4 design choices may have under alternative financing
5 proposals.

6 Previously, you expressed interest in better
7 understanding how choices may have different effects on
8 states, so today, I am going to present data to illustrate
9 state-level effects of certain design elements in per-
10 capita cap proposals.

11 The examples provided today are illustrative and
12 are not intended to endorse any specific design decision or
13 a policy proposal on how Medicaid should be financed.

14 Another thing to note is that we prepared this
15 presentation before the draft bill language, which was
16 leaked last Friday. That draft bill language does include
17 a per capita cap; however, there are a few differences
18 between that bill language and the examples I am going to
19 present today.

20 For example, the draft bill does not make any
21 adjustments for state differences or attempt to reallocate
22 federal funds among states.

1 In terms of Moira's and Rob's presentations, it's
2 more like the 1115 waiver budget neutrality per capita caps
3 than capitation rate setting.
4 Because no bill or proposal has been finalized
5 yet, we still wanted to show you these examples, since
6 other proposals had included these elements.
7 Just a quick background on the data we used, to
8 create these illustrative examples, we used fiscal year
9 2013 Medicaid Statistical Information System, or MSIS data,
10 and we adjust the spending from MSIS to match state
11 spending, as reported on the CMS-64 financial management
12 reports. This is the same data that we used in our most
13 recent MACStats data book, and the numbers provided here
14 reflect the methodology used in MACStats. So this means
15 that it excludes DSH payments and certain supplemental
16 payments made under 1115 waiver authority.
17 We also used wage index data from the CMS
18 Medicare Acute Inpatient Prospective Payment System as a
19 measure to reflect differences in geographic costs.
20 This is the same list of design elements you saw
21 last month. The items with check marks are elements that
22 we talked about last month or we talked about earlier

1 today, such as state flexibility.

2 The ones that are circles are the ones that I

3 will focus on in today's presentation, and again, the draft

4 bill language largely takes each state spending and trends

5 it forward and does not make any adjustments for health

6 status, geographic cost, or attempt to reallocate federal

7 funds among states.

8 A quick high-level background on per capita cap,

9 the proposals generally have all established the base year

10 for historical spending for populations and services that

11 are going to be included under the cap. All of the

12 proposals to date have established individual spending per

13 enrollee caps for the four major eligibility groups of

14 children, adults, the disabled population, and the aged

15 population. The draft bill language from last week would

16 have added a fifth category for the new adult group.

17 The spending per enrollee for each group is

18 trended forward to a particular funding year by a growth

19 factor, and generally, these have been linked to a measure

20 of price or economic growth, such as the consumer price

21 index or gross domestic product.

22 Some proposals such as Cassidy's and Sessions'

1 World's Greatest Health Care Plan Act of 2016 reallocate
2 federal funding by compressing the federal spending caps
3 for each state toward the national average. Alongside this
4 compression toward the average, there may be other
5 adjustments normalized for differences across states, such
6 as age, institutional status, health status, and geographic
7 cost differences, similar to the way states use rate cells
8 and risk adjustment in setting capitation rates.
9 Populations and services not covered by the cap
10 continue to exist under the current financing structure.
11 For each of the following examples I'll present
12 today, we calculate a benefit spending for a full-year
13 equivalent by state for each of the four eligibility groups
14 using the fiscal year 2013 data. Each of the following
15 charts illustrates the magnitude and direction of change in
16 the spending per full-year equivalent for each state under
17 different scenarios.
18 The first set of charts showed the change in
19 state spending for full-year equivalent when certain
20 populations are excluded. The next set shows the impact
21 that certain adjustments for enrollee mix and geographic
22 cost would have on state spending per full-year equivalent,

1 and the last set shows the effect of reallocating federal
2 funds by moving states to national average.
3 These examples show benefit spending, so state
4 administrative spending is not included. Many proposals to
5 date have the state administrative spending outside of the
6 cap.
7 These are some of the potential populations
8 excluded that I discussed in a commission meeting in
9 January. Dually eligible enrollees could be considered for
10 exclusion because some of their spending is for Medicare
11 premiums and cost sharing, for which states are not in
12 direct control. This exclusion would primarily impact the
13 aged and disabled groups.
14 Because dually eligible enrollees are generally
15 higher cost than the overall Medicaid average, excluding
16 them would decrease the overall spending per full-year
17 equivalent in those states.
18 In fiscal year 2013, about 12.5 percent of full-
19 year equivalent enrollees were receiving limited benefits,
20 and we define that here as those receiving coverage for
21 only family planning services, assistance with Medicare
22 premiums and cost sharing, or emergency services only.

1 Limited-benefit enrollees may also be excluded
2 because their spending is typically less than the average
3 full-benefit enrollee within the same eligibility group.
4 This population exclusion would impact all four eligibility
5 groups, but the largest impact is on the adult group, from
6 those receiving emergency services and the aged group from
7 the partial dually eligibles.
8 The draft bill language from last week would
9 exclude the limited benefit enrollees, but would include
10 full dual eligibles under the per capita cap amounts.
11 This chart shows the change in overall fiscal
12 year 2013 benefit spending per full-year equivalent by
13 state if you were to exclude the dually eligibles, and so
14 this is the percent change from when you include everyone
15 to when you exclude dually eligibles.
16 The light blue bar shows an increase in spending
17 per full-year equivalent, and the green bar show a decrease
18 in spending per full-year equivalent.
19 As you can see, the majority of states show a
20 decrease of around 10 percent or more should dually
21 eligible enrollees get excluded. New Mexico is the only
22 state that had a slight increase in the spending per full-

1 year equivalent.

2 This chart shows the change in overall 2013
3 benefit spending per full-year equivalent by state if you
4 were to exclude limited benefit enrollees. The majority of
5 the states show an increase in spending per full-year
6 equivalent between zero and 10 percent. California has the
7 greatest increase, as they had a high proportion of limited
8 benefit enrollees. D.C. had very few limited benefit
9 enrollees and had a slightly decrease in their full-year
10 equivalent spending.

11 And then this chart shows the benefit spending if
12 you were to exclude both the dually eligible enrollees and
13 the limited benefit enrollees. The majority of states show
14 a decrease in spending per full-year equivalent, as the
15 decrease associated with the dually eligible enrollees
16 generally outweighs the increase in spending per full-year
17 equivalent related to the exclusion of the limited benefit
18 enrollees. The spending per full-year equivalent for two
19 states, California and New Mexico, would increase.

20 Proposals to date have generally set the per
21 capita caps at the eligibility group level. While a per
22 capita cap allows for changes in enrollment mix between

1 eligibility groups, they do not necessarily account for
2 changes in enrollment mix within an eligibility group.
3 This is important because there can be significant
4 variation in spending per enrollee within an eligibility
5 group.
6 As Moira mentioned earlier, capitation rate
7 setting addresses these population differences by
8 developing payment rate cells for subgroups of enrollees
9 with similar cost characteristics, which may include age,
10 gender, geographic residence, and institutional status.
11 Additionally, states may adjust payment rates between
12 health plans, through diagnostic risk adjustment to account
13 for differences in health status between their enrolled
14 populations.
15 A per capita cap could make certain adjustments
16 for certain things, such as age and health status, to
17 account for changes over time within a state or in an
18 eligibility group.
19 These adjustments become even more important for
20 individual states if a proposal sets the cap at a national
21 average or re-allocated federal funding in a different way,
22 such as moving toward the national average, as I will talk

1 about later. Making these adjustments makes the process
2 more like capitation rate setting.
3 To demonstrate the impact of age mix, we looked
4 at the distribution of children in the nondisabled child
5 eligibility group by age groups. Because spending for
6 newborns, as you can see here, is about three to four times
7 that of other age groups, the proportion of newborns within
8 a state can be a key driver in determining the overall
9 spending for full-year equivalent for children.
10 To normalize for age mix, we adjusted each
11 state's enrollment mix in the child eligibility group to
12 match the national mix, shown in the table to the right.
13 So, for example, we made each state's enrollment in a child
14 eligibility group to show 4.5 percent newborns, and then we
15 applied the state's average spending per full-year
16 equivalent within each age group to those new adjusted
17 enrollment counts.
18 Once you normalize for age, 34 states would have
19 an increase in your spending per full-year equivalent for
20 the child eligibility group. For the most part, states
21 that had a newborn share that was below the national
22 average saw an increase in spending per full-year

1 equivalent for the child eligibility group once you
2 normalized for age.
3 In a similar manner, the proportions of enrollees
4 using LTSS within a state can have a large impact on their
5 spending for full-year equivalent. On average, spending
6 for LTSS users are about 10 times that of those who do not
7 use LTSS. To normalize for LTSS, we adjusted each state's
8 LTSS user mix to match the national mix within each
9 eligibility group, and then we applied the state's average
10 spending per full-year equivalent for users and non-users
11 of LTSS to calculate a new overall spending per full-year
12 equivalent for each state.
13 This analysis excluded limited benefit enrollees
14 but kept full dual eligibles due to their use of LTSS.
15 Another thing to note on this particular analysis
16 is that we identify LTSS users through the presence of a
17 fee-for-service LTSS claim. So we excluded five states --
18 Arizona, Delaware, Hawaii, New Mexico, and Tennessee -- due
19 to a large proportion of LTSS users in those states that
20 were in managed LTSS.
21 Once we normalized for LTSS use, 25 states, over
22 half the states in the analysis, would have a decrease in

1 their spending per full-year equivalent, and 18 states
2 would have an increase in their spending per full-year
3 equivalent.
4 Spending variation across states can reflect a
5 variety of factors, including the type and level of
6 benefits covered, payment methodologies, and geographic
7 price differences, reflecting local market conditions and
8 underlying costs of delivering health care service in a
9 specific geographic area.
10 To normalize for regional cost differences, we
11 used local wage index data from the Medicare Acute
12 Inpatient Prospective System to estimate relative price
13 differences across states. The Medicare wage index won't
14 account for all the regional price differences that may
15 occur, but it does provide a standard methodology to
16 demonstrate the relative difference in geographic cost
17 across states.
18 For this chart, we exclude both limited benefit
19 and dually eligible enrollees, and because, as I mentioned,
20 the Medicare wage index doesn't completely account for all
21 the differences across states, I think it's more important
22 to kind of focus on the direction of change for a

1 particular state instead of the magnitude of change.

2 After making the geographic wage adjustment,

3 spending per full-year equivalent for about half the states

4 go up and about half go down, and generally speaking, you

5 can see that spending per full-year equivalent for states

6 with high cost, such as Alaska and California, have a large

7 decrease, while spending for states for full-year

8 equivalent with lower cost, such as Alabama and

9 Mississippi, have a large increase after making this

10 adjustment.

11 Another potential design element in alternative

12 financing proposals could change how federal funds are

13 allocated to states. Similar to DSH, basing future per

14 capita caps at the state level on current spending locks in

15 existing differences across states. Alternatively, a

16 proposal could base per capita caps on the national

17 average, which would reallocated some funds to low-spending

18 states.

19 As I mentioned before, the draft bill language

20 from last week did not set the caps for each state on the

21 national average or reallocate federal funds in a different

22 ways; however, because there are many proposals that have

1 been discussed and the World's Greatest Health Care Plan
2 Act of 2016 does include this reallocation, we wanted to
3 provide some examples of what that may look like.
4 The World's Greatest Health Care Plan Act of 2016
5 has this reallocation by moving states toward the national
6 average by taking federal funding and compressing it to a
7 corridor of 10 percent above or below the national average.
8 For example, if federal spending per full-year equivalent
9 in a state was 20 percent above the national average, they
10 would decrease the state to 110 percent of the national
11 average. If a state was 5 percent above or below the
12 national average, then their federal spending per full-year
13 equivalent wouldn't change. Our analysis assumes that the
14 non-federal share in each state would remain constant.
15 These next few slides show the change in total
16 spending per full-year equivalent, including both federal
17 and non-federal spending of this compression toward the
18 national average in each state. The chart shows the effect
19 of compression toward the national average when all -- this
20 chart shows the effect of compression toward the national
21 average when all populations are included.
22 Because the compression is on the federal share,

1 the magnitude of change in spending per full-year
2 equivalent for each state reflects both the amount of
3 spending per full-year equivalent and the matching rate.
4 For example, D.C. has both a high spending per full-year
5 equivalent as well as a high matching rate, leading to a
6 high federal spending per full-year equivalent compared to
7 the national average, and thus, a large decrease once you
8 start compressing toward the national average.
9 This next chart shows the effect if you exclude
10 the limited benefit in dually eligible enrollees, and
11 compared to the previous example where everyone is
12 included, six states -- Pennsylvania, Iowa, Maryland, New
13 Hampshire, New Jersey, Wyoming -- go from a decrease to an
14 increase, and three states -- Kansas, Texas, and Virginia -
15 - go from an increase to a decrease.
16 And this chart builds on the prior two charts and
17 shows the effect if you exclude limited benefit and dually
18 eligible enrollees and also make a geographic wage
19 adjustment.
20 From the example that just excluded limited
21 benefit and dually eligible enrollees, two states --
22 Connecticut and New York -- go from a decrease to an

1 increase, and four states -- Georgia, Iowa, South Carolina,
2 and Tennessee -- go from an increase to a decrease.
3 There are additional design elements to consider
4 that we did not cover in today's examples and can be
5 explored in further work. Financing proposals could change
6 the split between federal and non-federal share by changing
7 the matching rate, or they could reduce or eliminate
8 certain sources of non-federal share, such as provider
9 taxes, intergovernmental transfers, and certified public
10 expenditures. For example, the World's Greatest Health
11 Care Plan would bring the matching rate for each state up
12 to at least 75 percent and eliminate the use of the IGTs
13 and CPEs.
14 The draft House bill from last week did not
15 address either of these first two elements on the level
16 sources and non-federal share or changes the federal match.
17 Similar to rate setting, the level of complexity
18 involved in establishing per capita caps highlights the
19 need for accurate and timely data, both to establish the
20 initial caps and to make the necessary adjustments.
21 The draft House bill did address some of the data
22 requirements by penalizing states that do not report the

1 required data elements.

2 Additionally, once more detailed language for any

3 upcoming bill or proposal settles down, we can provide

4 examples and model specific elements from those proposals

5 for the next Commission meeting.

6 And with that, I will open it up to any

7 questions.

8 CHAIR ROSENBAUM: All right. Let's start with

9 Marsha and take it from there.

10 VICE CHAIR GOLD: Yeah. I hope I can ask this

11 question so it will make sense. It's a point of confusion

12 over how one interprets these tables.

13 Let me start with the one that -- I understand

14 the compression to the average. That is an explicit

15 attempt to get states to go closer. I don't think anyone

16 would ever attempt to move people from one state to

17 another. So they're not going to have the average

18 demographic mix there.

19 So I think what you're showing us on some of

20 these is the effect of not adjusting for the child's age or

21 long-term care services, and as a result, it's an error in

22 some ways, in one way or another, that the data is going.

1 And in fact, if you took it the other way, if you wanted to
2 be sensitive to long-term care, you'd turn it around and
3 maybe indirect standardization versus direct.
4 So the data show you how important these are, but
5 I'm not -- they are slightly different. It's like apples
6 and oranges. Maybe you can help me out and sort of think
7 about it. If I was in Congress and I was thinking about
8 how I'd write something given this, what does this imply
9 for rate setting? I would guess that it implies that if
10 you try and move people to the center, there is going to be
11 a big -- there's going to be some shift across states.
12 How about the others? What does it imply about
13 the age and the dual mix and --
14 MR. PARK: Sure. I think some of this was to
15 show -- and this becomes particularly important, as you
16 mentioned, if you start trying to push people toward a
17 national standard, like the national average or --
18 VICE CHAIR GOLD: Right. But you're not going to
19 move people, so they're not going to --
20 MR. PARK: Right. And so I think this is trying
21 to show that if you're going to do that, there are like
22 certain considerations that are very important to try to

1 make this -- as Stacey pointed out, there are certain
2 variations that you want to control for and certain
3 variations that you might not want to. So things like the
4 age-sex mix in a particular state, you might want to try to
5 control for that by making adjustment to account for a
6 greater percentage of newborns or on LTSS, a greater
7 percentage of either LTSS users or a greater percentage of
8 institutionalized users versus home- and community-based
9 waiver users.
10 And so I think not only do we want to show the
11 impact on this kind of like national average methodology,
12 but also even if you just kind of trend -- look at each
13 state separately and just kind of develop their own per
14 capita cap without trying to move them toward the national
15 average, it does show how like an increase in LTSS use or
16 an increase in newborns or any change of the enrollment
17 mix, whatever characteristics you want to use, within a
18 state, within a eligibility group, can still make a big
19 difference. And so that the trend might not only reflect
20 like a price increase over time, but it might actually
21 reflect a change in population.
22 CHAIR ROSENBAUM: Alan.

1 COMMISSIONER WEIL: I think this is sort of a
2 follow-up. I mean, in some sense, what you're capturing is
3 the notion that four eligibility categories to trend
4 forward is a tough cut. The more precise the cut, the more
5 precise the results. With all the challenges, then, of
6 data sources and trends and the like, I mean, at some
7 level, the tautology here is that an open-ended match is
8 the perfect risk adjustment, and so if the assumption here
9 is that Congress wants to get rid of the open-ended match,
10 the question is how much do they want to do a risk
11 adjustment, because we already have a way to do that. It's
12 called the current program.
13 [Laughter.]
14 COMMISSIONER WEIL: And that's what they're
15 rejecting.
16 So, I mean, I'm trying to figure out what -- I
17 think this is an important analysis, but I am trying to
18 figure out the policymakers' use of it.
19 I guess that then brings me to sort of the
20 compression issue. At some point, this is a formula fight,
21 and the question of what Congress will do depends on which
22 state they are representing, and how many green bars and

1 how many blue bars they look at will be as big a factor as
2 anything else.
3 So I guess I'd just leave it there. I think it's
4 very -- oh, I'm sorry. Just one other thought, which does
5 follow on Stacey's earlier point, and you picked it up in
6 the very beginning of your response to Marsha, which is a
7 lot of this is about what's under state control, what
8 should be under state control. So, again, how you think
9 about these is not just the distributional effect, but
10 whether you want to encourage certain behavior on the part
11 of the state to modify how care is delivered, so presumably
12 basic demographics are not modifiable.
13 But to the extent -- it's just like risk
14 adjustment and anything else. To the extent you're using
15 utilization as a measure for risk adjustment, that takes,
16 as the premise, that that utilization was warranted. You
17 try to use diagnosis to go upstream, but then you worry
18 about gaming of diagnosis.
19 So I think there's some things we could learn
20 here from the risk adjustment literature. Maybe there's
21 some language you could pick up from the risk adjustment
22 literature to try to help policymakers understand the

1 differences between a demographic difference that is
2 outside of control, a shock to the system that's un-
3 anticipatable, a care modality, or a diagnostic frequency
4 that -- or different points on a continuum, and that those
5 are different ways of thinking about what you might or
6 might not want a state to -- that you might or might not
7 want to reward a state financially for having higher or
8 lower numbers.

9 CHAIR ROSENBAUM: Chuck and then Brian.

10 COMMISSIONER MILLIGAN: I was going to make a
11 very similar point, and I'll try to be brief with it.

12 I think there's a descriptive piece, Chris, and I
13 think you've done a great job with that. And I'm going to
14 give two quick examples.

15 When I was in Maryland and we were doing managed
16 care rate setting, the health plans would argue that they
17 should be paid more for low-birth-weight babies because
18 those are very expensive, NICU, et cetera, et cetera.

19 If you pay for births as a group and you risk-
20 adjust based on data about low-birth-weight babies, are you
21 incenting prenatal care, and are you incenting good
22 outreach?

1 So there's a policy debate around whether you try
2 to use rate setting to drive behavior in the ways Alan just
3 said, or are you using it to kind of reflect the baseline
4 experience?
5 The other example -- and, Chris, this is really
6 when I raised my hand to comment -- was about LTSS. If a
7 given state has a mix between nursing facility utilization
8 and HCBS utilization and you set that state's per capita
9 cap based on their point-in-time mix, they might not have
10 an incentive to change that distribution, whereas if you
11 set their per capita cap below that rate, you might drive
12 them to move more people in community-based settings
13 because that's typically less expensive on a per-capita
14 basis.
15 So I think, to Alan's point, it's worth -- and to
16 Stacey's earlier point, it's worth, I think, unpacking that
17 rate setting has both descriptive or baseline fairness
18 elements, but it also often has policy-driving aspects.
19 And I'll just leave it at that.
20 CHAIR ROSENBAUM: Brian.
21 COMMISSIONER BURWELL: I think my comments are
22 similar because I see all this in terms of risk and risk

1 points, what you're putting states at risk for and what
2 not. So per capita cap to me over a block grant is
3 basically states are not at risk for the distribution of
4 their population across the four eligibility groups and for
5 enrollment growth of each of those groups. So they're not
6 at risk for the overall risk of the population and the
7 distribution.

8 Similarly, these other adjustments put states at
9 risk for various things or not. So like the age adjustment
10 or for birth, distribution by age, are you going to put
11 states at risk for birth rates? Those with higher birth
12 rates would be more at risk because they would have to
13 cover those costs themselves. States with declining birth
14 rates, the other way. Same with LTSS, do you put states at
15 risk for the ratio of institutional versus community-based
16 services?

17 So, to me, that's how I see these various policy
18 levers is the risk -- I mean, it is a behavioral incentive
19 too for states to change their programs into certain
20 directions as well, so that's just the framework that I see
21 these adjustments in.

22 CHAIR ROSENBAUM: Marsha.

1 VICE CHAIR GOLD: Yeah. I wanted to go back to -
2 - it's sort of on the same point but away from the
3 demographics and towards the compression issue and what
4 states can be at risk for.
5 So you might contrast long-term care services
6 where the states really has a monopoly on that population
7 and that setting, and so they could decide to move people -
8 - not move them literally, but they could -- if they had an
9 incentive to use community-based services or long-term care
10 services, you might think they had some broader control.
11 Maybe Brian will disagree with me on what reality is there.
12 I don't know. And that's fine. He's the expert on that.
13 But if we remember back to the debate on single
14 pay -- controlling cost through a single payer versus
15 multi-payer and medical care generally, there's a lot of
16 differences across the country and even within the same
17 city based in different practice groups on practice
18 patterns, on costs and all the rest.
19 A wage adjustment is a very small part of the
20 total variability there, and if I was a state, I'd probably
21 be nervous about my ability, even if I wanted to, to have a
22 dramatic change in aggregate per capita cost on some of

1 these total levels because it reflects a lot of payers and
2 how things are going. I have more sense that I could
3 control things that were more totally Medicaid, but even
4 then, a lot of it depends.
5 So I think in talking about the compression
6 issues, if they turn out to be an important part of the
7 federal debate, some of the debate that went on with
8 Medicare Advantage and to what extent the capitation rates
9 should be compressed or not compressed or how variable they
10 are, the IOM's report on geographic variation in medical
11 care, it's really important to break in, because states are
12 trying to move to a more all-payer basis on some dimension,
13 some more than others, to change things, but it's really
14 hard.
15 And so I would think that having strong
16 incentives, which assume that unless the state controls
17 costs -- they're going to get a lot less money -- might be
18 more theoretically valuable than in theory, and in fact,
19 you're saying you're going to have the higher-priced ones
20 get less and the lower-priced ones get a benefit that may
21 not have anything to do with what they themselves have done
22 or could do.

1 CHAIR ROSENBAUM: Kit.

2 COMMISSIONER GORTON: So I looked at this

3 analysis in a different way. Maybe you guys caught what I

4 missed, but it seemed to me that what -- and Chris, if I

5 missed something, please correct me. It seemed to me that

6 what the analysis looked at was: Is the current level of

7 funding, whether it's 13, what Chris looked at, or 16, as

8 has been proposed in the draft bill, does that fairly

9 allocate, and therefore, is it okay to lock that in and

10 make that the base for our allocation going forward?

11 And what I took away from this is on a whole

12 variety of material variables, it in fact does not fairly

13 allocate. And I don't see this as an exercise --

14 CHAIR ROSENBAUM: Right.

15 COMMISSIONER GORTON: -- in changing states'

16 behavior any more than I see managed care rate-setting as

17 being an exercise in changing managed care plans' behavior

18 except around the edges.

19 The real issue is if you're a managed care plan

20 and you sign up to manage a population, then is there

21 enough money in the rates to do that with some reasonable

22 likelihood?

1 And it seemed to me, and maybe it's just my mind
2 set, that the question before us is: If we were to lock in
3 the states' current base rates, will there be enough money
4 for them to manage the populations?
5 And what this says to me is, well, you know, the
6 current state doesn't allow for age-gender mix, states with
7 high birth rates, states with lots of kids, states with
8 lots of aging people. The current base rate, because it
9 got set back in the last century and it's just been trended
10 forward since then, doesn't allow for the fact that there's
11 material differences in wages and what it costs to deliver
12 in a state. There are material differences in who has
13 duals and who has limited benefit eligibility.
14 So I just look at this as being a -- the question
15 being: Should we lock in the current state 2016-2013, or
16 should we think about making some sort of actuarial
17 adjustment to the current state with perhaps the idea of
18 compression? Although, I think that's a different
19 question. But simply, is the base adequate to use it as
20 the starting point for all the trending forward stuff? And
21 what Chris's analysis suggests to me is maybe the base
22 needs some looking at before we start trending forward.

1

2 EXECUTIVE DIRECTOR SCHWARTZ: I actually -- I

3 think I agree with the first part of your comment.

4 And then I want to raise another issue, which is

5 I think it is true that the bill that was leaked over the

6 weekend obviously locks in the current variation.

7 And what Chris's first analyses show are some

8 ways that if you consider that current distribution of

9 spending equitable on some, inequitable on some more or

10 less objective measures, but what it doesn't tell you is

11 that the current distribution of spending also reflects a

12 lot of different factors. For example, a low-spending

13 state can be low-spending because it is extremely efficient

14 or it can be low-spending because it has a very skimpy

15 benefit package or eligibility group. And you can't

16 distinguish.

17 CHAIR ROSENBAUM: Or level of care.

18 EXECUTIVE DIRECTOR SCHWARTZ: You can't

19 distinguish in the two of those. So I don't think that you

20 can really use these to talk about -- you would have to be

21 able to disentangle that --

22 CHAIR ROSENBAUM: Right. Exactly, exactly.

1 EXECUTIVE DIRECTOR SCHWARTZ: -- first before you
2 could say that this resulted in something that was truly
3 more equitable and truly more representative of sort of an
4 appropriate amount to spend –
5 COMMISSIONER GORTON: Yes.
6 EXECUTIVE DIRECTOR SCHWARTZ: -- because we don't
7 have measures of those things. So I would be careful about
8 sort of interpreting what the redistribution of money
9 really does.
10 And Chris and I had a conversation about to what
11 extent should we do the geographic cost variation piece
12 because to some extent the different ways that states pay
13 providers already captures some of that.
14 Now you could argue, not to pick on Toby and
15 Andy, but you know, New York famously considered high-
16 spending, California known for being low-spending, those
17 are choices that they made. So maybe they over-adjusted
18 from sort of the national perspective, but it's all sort of
19 baked into it.
20 CHAIR ROSENBAUM: I must say this is -- this, to
21 me, is the -- this whole discussion has been sort of
22 Exhibit A as to why one would move forward on this kind of

1 a policy on a demonstration basis and take selected states,
2 carefully chosen, test out the methods for establishing
3 base years, alterations. So it's quite striking, you know,
4 to think about doing this instead as a demonstration.
5 Yeah?
6 COMMISSIONER MILLIGAN: Yeah. I just -- I'm
7 jumping back in because I think I want to sort of jump on
8 the comment, Anne, and I agree with you, and I want to make
9 something I think very explicit. Kind of what's fair and
10 what's equitable is in the eye of the beholder, and I think
11 that that's -- that there's an argument that taking the
12 snapshot now based on spending now, and if California spent
13 less per capita than New York, they made their decisions.
14 You know, they made their bet. That reflects their
15 choices. That's fair.
16 And I'm not asserting that. I'm just saying that
17 that -- people could make that argument, or you could make
18 an argument that these various adjustments --
19 CHAIR ROSENBAUM: Right.
20 COMMISSIONER MILLIGAN: -- should be made or some
21 subset, and that that's fair.
22 And I think, Chris, the real value of your work

1 here, and Anne, the value of your staff's work here is it's
2 just illuminating that what this really opens up is the
3 question of what is fair, what is equitable, and sort of
4 forces people to think about those principles more so than
5 answering the question.
6 And the second comment I wanted to make -- and
7 it's piggybacking, Kit, something you said. I think that -
8 - you know, I talked about do you set per capita -- make
9 rate-setting with managed care. I'll keep it out of the
10 per capita cap discussion.
11 With rate-setting, do you try to drive change
12 because of how you allocate, you know, low birth weight
13 baby spending and so on. I think that where that is
14 analogous to per capita caps isn't so much how you set each
15 state's initial level but more how you deal with trend over
16 time because I do think that there is a premise that per
17 capita spending could and should be constrained more than
18 the historical way has constrained spending. I think that
19 that's a very debatable point.
20 But whether, you know, use of a whole variety of
21 tools would reduce the trend over time and that going to
22 per capita spending isn't simply federal cost containment

1 but that it's trying to drive change in the way that I
2 illustrated with LTSS mix issues or low birth weight baby
3 mix issues. So I do think that that question of whether
4 rate-setting in the per capita cap sense is meant to drive
5 behavior change is embedded in the very discussion of
6 trend.
7 CHAIR ROSENBAUM: Brian.
8 COMMISSIONER BURWELL: I just want to agree with
9 that. I think -- just in the real world, I think the whole
10 compression idea is going to go away very quickly. States
11 are not going to -- you're not going to get 60 votes with
12 states getting less money than they get now.
13 However, so like compression to me is like
14 putting states at risk for their past behavior. That's not
15 going to happen. But you could put them at risk for future
16 behavior. So there could be adjustments in the trend rate
17 or, you know, even a change in FMAP. I mean, there are all
18 kinds of ways that you can bring the lower -- allow greater
19 increase for the lower-spending states and slower increases
20 for the higher-spending states moving forward, but I don't
21 think it's going to happen retroactively.
22 CHAIR ROSENBAUM: Looking. Looking. Going once.

1 Going twice. Well, thank you very much. Lots to think
2 about.
3 And we now have time for public comment. Any
4 public comment? Going once. Going twice.
5 **### PUBLIC COMMENT**
6 * [No response.]
7 CHAIR ROSENBAUM: We're adjourned until tomorrow.
8 * [Whereupon, at 4:11 p.m., the meeting was
9 recessed, to reconvene at 10:00 a.m. on Friday, March 3,
10 2017.]
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PUBLIC MEETING

Reserve Officers Association
Top of the Hill Banquet and Conference Center
Minuteman Ballroom, 5th Floor
One Constitution Avenue NE
Washington, D.C. 20002

Friday, March 3, 2017
10:02 a.m.

COMMISSIONERS PRESENT:

SARA ROSENBAUM, JD, Chair
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Session 6: States’ Experiences Managing Spending and Use for High-Cost Drugs

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1 P R O C E E D I N G S

2 [10:02 a.m.]

3 CHAIR ROSENBAUM: All right. We are just letting
4 everybody reassemble quickly here and we'll plunge right
5 in.
6 All right. I'm going to get us back to order
7 here. We've lost a couple of people, I know, to travel,
8 that they had to fly early, but why don't we allow maybe
9 one more minute. I think Chuck is still here. Penny is
10 still here.
11 All right. So thank you very much for coming
12 this morning. This is a session on a subject of great
13 interest to the Commission, and that is States' Experiences
14 in Managing Spending and Use for High-Cost Drugs. The
15 Medicaid statute, of course, is very complex when it comes
16 to drug coverage, and so state experiences around the
17 available tools for managing drug costs under the
18 circumstances is extremely important, so thank you so much
19 for this work.
20 **### STATES' EXPERIENCES MANAGING SPENDING AND USE FOR**
21 **HIGH-COST DRUGS**
22 * MR. PARK: Today's session continues the

1 Commission's work on prescription drugs. Prescription drug
2 spending has been a key driver in the recent increase in
3 Medicaid spending. After many years of low to moderate
4 growth, the CMS Office of the Actuary found that Medicaid
5 prescription drug spending increased about 25 percent in
6 2014, and about 14 percent in 2015. The faster growth in
7 2014 was primarily due to increased spending for hepatitis
8 C drug.
9 This past October, the Commission began a
10 discussion on states' abilities to control spending for
11 prescription drugs in Medicaid. As part of that
12 discussion, you expressed interest in learning more about
13 state spending on high-cost drugs, and potential options
14 for states' to manage spending, such as value-based
15 purchasing.
16 Today we have brought together a panel to present
17 results from a recent MACPAC project, looking at state
18 experiences with the hepatitis C drugs, and state options
19 for alternative payment models or value-based purchasing
20 for prescription drugs in Medicaid.
21 Our first panelist is Brian Bruen, who is a lead
22 researcher scientist and lecturer in the Department of

1 Health Policy and Management at the George Washington
2 University. Mr. Bruen was a principal investigator on a
3 recently completed project for MACPAC, to review state
4 utilization and spending for the hepatitis C drugs, and
5 conduct interviews with states and managed care plan
6 representatives and their experiences as these drugs came
7 to market. He will present the findings from that project.
8 Our second panelist is Susan Stuard, who is from
9 the Center for Evidence-Based Policy at the Oregon Health &
10 Sciences University, and she is the project director for
11 the State Medicaid Alternative Reimbursement and Purchasing
12 Test for High-Cost Drugs, or SMART-D. SMART-D is a three-
13 year pilot program to help states develop and implement
14 alternative payment models and manage prescription drug
15 spending in Medicaid. Ms. Stuard will provide an overview
16 of the SMART-D project and discuss the challenges and
17 pathways states have to pursue alternative payment models
18 within the requirements of the Medicaid drug rebate
19 program.
20 Each panelist will give a brief presentation and
21 then there will be time for the Commissioners to ask
22 questions and have follow-up discussion.

1 With that I will turn it over to Brian to get
2 started.
3 * MR. BRUEN: Okay. Thank you, Chris, and thank
4 you to the Commission for funding this important work.
5 So this was a project that essentially was a rare
6 opportunity in research to work on one of your own ideas,
7 where MACPAC had approached and asked for ideas for
8 research and this had been a topic I had been thinking
9 about, just in terms of when you look at the hepatitis C
10 drugs, as sort of a case study, for lack of a better term,
11 for high-cost drugs generally, this was a class of drugs
12 that garnered significant attention, both at the state
13 level and nationally, because of the relatively high cost.
14 Chris alluded to the jump in spending on drugs in 2014. A
15 non-significant share of that, probably roughly 10 to 25
16 percent of it, depending on whose estimates you want to
17 listen to, was simply attributable to these new hepatitis C
18 drugs -- in fact, really just one of them, Sovaldi, when it
19 came to market in 2014.
20 And although these are not the first drugs to
21 cost thousands of dollars for a course of treatment, they
22 are the first to have such a large potential patient

1 population. And so when you have an estimated 3.5 million
2 people in the U.S. who have hepatitis C, and a
3 disproportionate number of those are in Medicaid, although
4 exact numbers are really unknown, these drugs obviously
5 raised a lot of concern, and therefore were really
6 interesting to look at from that perspective.
7 So one of the motivations for doing this study
8 was that we had looked at basically all of these events
9 happening in the hepatitis C drug treatment market, in a
10 relatively short period of time. So in 2011, you had a
11 couple of new drugs come on that were called direct acting
12 antivirals. They were more effective than the treatments
13 that preceded them, but still required use of interferon,
14 which came with a lot of very unpleasant side effects and a
15 very long course of treatment.
16 And during that phase, when Incivek and Victrelis
17 were on the market, there was this push by many drug
18 manufacturers to come up with sort of better alternatives
19 that would get rid of the need for interferon, and those
20 really hit the markets, all still-required interferon that
21 came out in late 2013, and really started to hit the market
22 in early '14, and then Harvoni and Viekira Pak were the

1 first two drugs that came to market that no longer required
2 an interferon regimen along with the drug.
3 And what ended up happening with these drugs is
4 you had this rapid change, so drugs coming to market in
5 relatively short sequence, which is relatively unusual, and
6 then, at the same time, you had a lot of evidence sort of
7 mounting about, in clinical trials they have been highly
8 successful, over 90 percent cure rate, curing being defined
9 as a sustained virologic response, and evidence was
10 mounting, sort of early on in their use, that these really
11 outstanding trial results were being maintained in public
12 use.
13 And so there was that, but then, of course, as
14 more and more people used the drugs -- these were drugs
15 that were approved on relatively short timelines -- as more
16 people used the drugs, more evidence comes out. So we've
17 noted here on the slide that there was an FDA warning on
18 Viekira Pak, and Technivie, at one point, about potential
19 liver interactions, which raised at least some concerns in
20 a very short period of time. And then there was also a lot
21 of press attention, advocates' attention to the limitations
22 that were being placed by states on the drugs, which I will

1 talk about in a bit more detail later.

2 And so CMS sent out a letter in November of 2015,
3 basically saying to states, you know, you need to cover
4 medically necessary drugs, and also you need to make sure
5 that your managed care plans are following close to, if not
6 the same rules that you are setting in fee-for-service.
7 And so there were obviously going to be some reactions to
8 that from states. So we wanted to look and see what was
9 happening with all of this stuff. There were also
10 lawsuits, and so one of the most significant during the
11 time period that we were looking at was an initial
12 decision, in federal court in Washington State, basically
13 putting an injunction on the state having a relatively high
14 fibrosis score standard, and saying you need to remove that
15 fibrosis score standard entirely, and I'll talk a little
16 bit more about what that means as we go on.

17 So how we did the study is that we started out
18 first by just doing a profile of all of the states across
19 the country, in terms of their trends in hepatitis C drug
20 utilization and spending, using publicly available Medicaid
21 state drug utilization data. We also relied on some
22 materials from the Oregon Health & Sciences University,

1 that had been compiled on policies for Sovaldi, Harvoni,
2 and Viekira Pak at different points in time. And what we
3 wanted to do was find states that had a diverse set of
4 policies, different patterns of use, and different patterns
5 of spending.
6 And so the next slide -- I'm going to skip ahead
7 very quickly -- just illustrates some of that diversity.
8 These are not necessarily states that we interviewed. What
9 we ended up doing is we just pulled four states, pretty
10 much at random, from different blocks that we had
11 organized. And what you can see, from looking at these
12 lines, red is Sovaldi, blue is Harvoni, green is Viekira
13 Pak. This is just utilization, not spending. But you see
14 that there were a lot of different patterns. Some states
15 had very slow rates of take-ups, some states had very fast
16 rates of take-up. Some states had sort of prospective
17 substitution of Harvoni for Sovaldi. Others, the
18 substitution really didn't happen until Harvoni came to
19 market.
20 So we were just curious as to why all of these
21 sort of different patterns were out there, how states were
22 reacting to all the changes in the marketplace.

1 Let me skip back here, just for a second, to
2 finish the methods. So what we ended up doing, we chose a
3 number of states and reached out, asked them to
4 participate, and we did semi-structured interviews with a
5 consistent set of questions for all the states. These were
6 conducted between September and December of last year. And
7 then we did separate interviews with representatives from
8 national Medicaid managed care plan associations and a
9 couple of local health plans as well.
10 So what we found was that when states were making
11 their policies around hepatitis C drugs, most of them
12 actually used the same standard processes that they used to
13 establish prior authorization criteria and other criteria
14 for access to any drug that comes to market. So they went
15 through their pharmacy and therapeutics committees, through
16 their drug utilization review boards. They reviewed
17 evidence. They reviewed guidelines from groups such as the
18 Association for Liver Diseases. They reviewed the
19 materials from manufacturers, in terms of recommendations
20 for prescribing.
21 But what was interesting about it is pretty much
22 all of the states said it was not business as usual. There

1 was a lot more scrutiny, things were happening a lot faster
2 than they were used to, and the stakes were much higher, in
3 terms of if they got the policies wrong -- I mean, there
4 were states that basically said, you know, if everybody who
5 we thought was eligible came in on day one and got these
6 drugs, our drug budget would have tripled -- our entire
7 drug budget would have tripled.

8 And so there was a lot of concern. They set
9 policies at various levels, trying to balance both access
10 and cost. And so initially a lot of the states came and
11 they set standards for fibrosis score, which is a liver --
12 basically fibrosis disease severity -- and they set
13 standards of F3 or F4, which is a fairly significant level
14 of damage to the liver, to put it mildly. It is not
15 reversible, so once you've started treatment it won't sort
16 of fix that problem with your liver. It will just sort of
17 hopefully stop future damage from the virus itself.

18 And so states put these policies in place, that
19 all states had prior authorization for the drugs, and a lot
20 of states had very active management of the drugs from day
21 one. And what was interesting in talking to the state
22 officials is a lot of times that patient management and

1 that close monitoring and that prior authorization is cast
2 in public materials as being barriers to access, threats to
3 care, and the state officials sort of strongly believed
4 that their patient management monitoring in many cases was
5 really beneficial, that what they were doing was that they
6 were trying to make sure that patients were seeing the most
7 appropriate providers, that those who were sickest got care
8 first, that, you know, they were being basically mindful
9 stewards of the public's money.

10 Now, they viewed the requirements. A lot of
11 states had requirements for specialist involvement, so you
12 either had to have the prescription written by a specialist
13 or you had to at least have a specialist involved in the
14 process, in consultation, and again, that's often cast as a
15 barrier, and a lot of the officials that we talked to in
16 states, and the managed care plans, viewed that specialist
17 involvement as being appropriate and no harmful for access
18 at the time. Part of this comes from the fact that, at the
19 time, they were, again, sort of triaging the most sick
20 patients first, and their belief was, okay, if we're
21 covering people who are at advanced stages of the disease,
22 they really should be seeing a specialist at that point in

1 time anyway.

2 In terms of substance use disorders, which is
3 another area where there's been a prohibitive concern about
4 states limiting access for people with alcohol or substance
5 use disorder, or a history of such, there the opinions were
6 much more mixed. There were some states who really
7 believed that requiring a period of abstinence or other
8 evidence of commitment to treatment was absolutely
9 necessary to ensure that people would not end up going
10 through treatment and then ending up contracting hepatitis
11 C again through illicit drug use, for example. And other
12 officials pointed to the guidelines and other evidence that
13 patients with current SUD can actually be effectively
14 treated and were successfully completing treatment in many
15 states.

16 But, of course, the elephant in the room, as
17 talked about in some of the panels yesterday, is this
18 budgetary challenge and the fact that states would look at
19 these drugs, and every state we talked to was very
20 optimistic about the potential of the hepatitis C drug
21 treatments to really be beneficial, to produced downstream
22 benefits, that they would result in cures, they would save

1 some money downstream on more expensive treatments,
2 potentially, keep people out of hospitals. But they were
3 really, really concerned that they just didn't have an
4 effective way to deal with the up-front costs.
5 So they really had to figure out ways to balance
6 access. And states came up with all sorts of ways of doing
7 this. One of the things that's evident in the report,
8 which you all have a copy of, I think, in your briefing
9 books, is that states really took a variety of approaches.
10 You had a small number of states that had almost no
11 limitations on access, and their theory was we're avoiding
12 later costs. We've figured out that we think we can afford
13 it. We have our fingers crossed. We're going to see what
14 happens. Most states looked at their estimated numbers of
15 people who had hepatitis C and sort of had that scenario
16 of, geez, if they all come at once this is really going to
17 be expensive. A lot of them then put limitations on again.
18 Initially, most states had fibrosis score requirements of
19 F3 or F4, very significant.
20 Over time, what's happened is that states are now
21 gradually expanding coverage. They're rolling back some of
22 the restrictions, and a lot of this has to do with cost. So

1 when the drugs first came to market, we're talking about
2 $70,000 to $80,000, with rebates, for a course of
3 treatment. Now, with competition, with more drugs on the
4 market, net cost to the states -- net costs total -- are
5 around $40,000 to $60,000, according to most estimates.
6 Again because of the secrecy of rebate information, it's
7 impossible to know the exactly amounts for any individual
8 states. And we did hear some thoughts that it may even be
9 lower than that in a few places. In the states contracting
10 in supplemental rebate strategies, also vary widely. So it
11 was really hard to look at that and say that there was any
12 consensus on sort of what was the best approach.
13 But one thing that was very clear is that
14 affordability is absolutely paramount in their decision-
15 making. Even the states with no restrictions were very,
16 very concerned about affordability and really were careful
17 in their modeling to try and make sure that they could
18 afford it before they set those relatively low standards.
19 And all of the states that we talked to talked
20 about wanting to treat more people if it became financially
21 possible, and they all basically said lowering the net cost
22 through rebates helps, but they really would have preferred

1 if the prices for the drugs were lower in the first place.
2 For managed care, states used three main
3 approaches to help the managed care plans pay for their
4 hepatitis C drug treatments. Here again there was really
5 no favored, so some states used supplemental payment, a
6 sort of additional payment, and then some of those states
7 would then incorporate that payment into base rates for
8 later years. Other states have actually continued just to
9 have an add-on for hepatitis C or other high-cost drugs on
10 top of their budget. Some states have come up with risk-
11 sharing. Some of these are actually quite elaborate. So
12 you have some states that are agreeing to cover 100 percent
13 of the cost of access of actuarial estimates, other states
14 following different types of risk-sharing agreements with
15 shared risk between the state and managed care entity, for
16 example.
17 And then a few states have excluded hepatitis C
18 drug coverage from the services covered by managed care
19 entirely, and this is not just states that already have a
20 carve-out. There are some states that are basically doing
21 it just for HCV or just for a couple of other products.
22 Now what was interesting here is that the one

1 thing that came out in our discussions was that the CMS
2 letter to the states had a much bigger impact on managed
3 care than fee-for-service policy. A lot of the states
4 looked at the letter from CMS and said, "We think we're
5 already there." But on the managed care side, they
6 realized that they needed to sit down with their plans,
7 figure out what their plans were doing, in terms of
8 coverage, and try to make those things work consistent
9 between their fee-for-service rules and the managed care
10 rules. And there was a lot of discussion, some still
11 ongoing, a lot of changes in the way that states operated
12 around high-cost drugs, basically setting up groups with
13 managed care plans and the states sitting down on a regular
14 basis to talk through potential policies and ideas.
15 So to wrap it up, the lessons learned and needed
16 tools, we sort of asked the states at the end, you know,
17 what were some of the things that you learned, and, you
18 know, if you had a wish list, what would you really like.
19 You know, cheap drugs was sort of the obvious answer but
20 one that I'm not sure we necessarily know how to get to.
21 In terms of the sort of more, I guess, realistic tools,
22 some of the things they talked about -- again, the state

1 officials believe that their policies really encourage
2 appropriate utilization, they encourage appropriate
3 interactions with expert practitioners, that they encourage
4 better management of patients, both during and after
5 treatment. So yes, while many of their policies have been
6 characterized as barring people from treatment, they didn't
7 necessarily view that as being as disastrous as it's often
8 portrayed.

9 There was no consensus at all on best practices
10 for managing costs, either in the fee-for-service or
11 managed care program. Every state sort of felt like the
12 way they were doing it was the right way, which is not
13 atypical in the states. But the one thing that we heard
14 over and over again was that state officials want better
15 data and analytics. They really have a hard time deciding
16 what drug is best, what drug is the most cost-effective for
17 what populations. There are studies out there but they can
18 be hard to get a hold of.

19 And then the states also noted that with budget
20 cuts and other limitations, they often don't have the staff
21 or resources, so financial or personnel resources, to
22 really be able to comb through all of this stuff and make

1 decisions. And so there they kept saying if the federal
2 government did anything to help us, you know, having some
3 sort of entity, like most other industrialized countries
4 do, that does these reviews, and puts the information out,
5 and makes it available to insurers, including Medicaid
6 managed care plans and Medicaid fee-for-service would be
7 really beneficial.
8 With that I will turn it over to Susan, and take
9 questions later.
10 * MS. STUARD: Okay. Thanks, everyone.
11 It's a great pleasure to be able to present to
12 you today. What I'm going to try to do is give you a short
13 overview of a project that we're undertaking at the Center
14 for Evidence-Based Policy, trying to provide some support
15 to state Medicaid agencies as the think about alternative
16 or value-based purchasing models for high-cost drugs.
17 We've been doing a certain amount of discussion
18 in the field and making presentations on this topic, so
19 it's tremendous to talk to this group of people who are so
20 conversant in Medicaid policy and understand a little bit
21 about the drug benefit, because that always takes a lot of
22 time to explain, and I don't need to go into that here. So

1 I'll move quickly, knowing that we can take questions at
2 the end.
3 So let me tell you a little bit about what we've
4 been up to. The center has been undertaking a three-year,
5 three-phase pilot project, with funding from the Laura and
6 John Arnold Foundation, and the project has been really
7 focused on strengthening the ability of Medicaid programs
8 to manage prescription drugs with alternative payment
9 methodologies or maybe a shortcut would be sort of value-
10 based purchasing models, with a secondary goal of really
11 trying to enfranchise state Medicaid leaders in some of the
12 discussion about what's going on with high-cost drugs.
13 For an overview of the phases, we, for ourselves
14 and for the states, spent really the first six months of
15 the project in 2016 really trying to map the landscape of
16 Medicaid drug purchasing. I think you all have a sense
17 that this subject is pretty arcane. Even folks on the
18 medical side of the benefit usually feel not as
19 knowledgeable as they want about what's going on, on the
20 pharmacy side. You know, there are those two sides, and we
21 also found, even talking preliminarily with drug
22 manufacturers, that there were only a small cadre of folks

1 in each of these organizations that actually understood the
2 Medicaid drug purchasing side.
3 So I'll show you the website later, but we
4 produced 250 pages of research, separated out into five
5 papers in Phase 1. You might have gotten the summary paper
6 as part of your reading packet. It's all posted out there
7 on the public website.
8 We made the transition this summer into Phase 2,
9 working directly with states to talk to them about the
10 research and to start doing planning and technical
11 assistance to help them think about these alternate
12 purchasing models, and we're right in the middle of that
13 work right now, and I'll tell you a little bit more about
14 that. And then we're hoping to be able to make the
15 transition into a Phase 3 working on actual implementation
16 of these models sort of post contract and evaluation, and
17 we're working with the Arnold Foundation on the grant for
18 that last phase.
19 Here is the SMART-D website and a list of the
20 reports. It's a lot of research. I would definitely start
21 with the summary report and the executive summary and skim
22 it.

1 For those of you who want to delve deep, the
2 legal brief is worthwhile if you're so inclined to go
3 through that, but we also thought it was pretty important
4 to put the search out there because, in particular, we want
5 to be transparent with the drug manufacturers about the
6 work and what we thought the possibilities were, because
7 they were going to need to look at these documents in order
8 to get to the table as well.
9 Key takeaways. I think if there were things that
10 I want you to know about the work and what we're
11 experiencing in the field so far, I would say this is
12 probably the high-level summary.
13 I think you're probably all aware that the
14 Medicaid Drug Rebate Program, set forth in statute in 1927,
15 is -- you know, it set forth some constraints, and it's
16 certainly a little bit of a Faustian bargain. But we find
17 even when looking at that existing set of statute and
18 regulations that there absolutely are legal pathways that
19 states can use right now to enter into alternative
20 purchasing arrangements from drug manufacturers. They
21 don't actually need any new authority. They have to be
22 incredibly mindful of how to do it and to do it

1 appropriately within the constraints of the MDRP, but it
2 certainly can be done.
3 Secondarily, we find that states are really
4 interested in this, but they absolutely need technical
5 assistance to create the capacity and navigate these
6 complex issues. And I think Brian really sort of touched
7 on this in his remarks.
8 I think everyone is aware that Medicaid agencies
9 are constrained in terms of the number of staff, and this
10 is an arcane, complicated area to move forward, but it
11 absolutely is possible, and I think we're happy to have the
12 opportunity with this grant funding to be able to try to
13 support some of that process.
14 We've also taken great care to really try to
15 engage with drug manufacturers and get them to the table
16 because this is a voluntary process. This is an effort of
17 states to try to come up with some of their own small
18 solutions and see if over time they can be grossed up.
19 We've talked to a lot of drug manufacturers. We
20 want to sort of engage and do a lot of education. I would
21 say only a subset are interested in really thinking about
22 this and sitting down at the table and negotiating.

1 I think the good news for us is that so far there
2 does appear to be a subset, and I think that's heartening.
3 I wish it was more, but you start somewhere and build from
4 that base.
5 So let me tell you just a little bit about the
6 Phase 1 findings, and I'm going to move pretty darn quick.
7 I think we were concerned coming into this project that
8 there is a lot of sort of hyperbole about high-cost drugs
9 and what happens and wanted to sort of understand for
10 ourselves was this a real issue, was this the issue we
11 thought it was.
12 So here's what we did, and here is what we came
13 up with. It was a pretty rudimentary analysis. We picked
14 a high-cost level, $600 per prescription. If it was 30
15 days across a year, that would be about $7,200, certainly
16 not the highest cost, but we took that as a cutoff point
17 because that's a common federal Medicare and Medicaid
18 level.
19 When we looked at the 2015 prescribing for
20 Medicaid nationally, we found 455 unique drugs in that
21 cohort.
22 Then we tried to look for something that was

1 really high volume or high cost. So instances where
2 Medicaid nationally -- spent at least $72 million on that
3 drug, to bring some stuff out that was pretty low volume or
4 some combination of medium volume, medium cost, so fun
5 things that came out and dropped out as we went from 455
6 unique drugs to 152 are things like snake venom antidote.
7 That was administered to three people across the country.
8 So there was some interesting stuff like that.
9 So when we applied both of those thresholds, we
10 ended up with 64 unique drugs that we took a little bit of
11 a closer look at. So for fiscal year 2015, here is what we
12 found. These 64 high-cost drugs, as we define them,
13 accounted for 9.3 million prescriptions, or 1.5 percent of
14 the prescriptions that were reimbursed by Medicaid
15 nationally. We found that prior to rebates, so not
16 accounting for rebates, that there was about $17 billion in
17 spending on these 64 drugs or about 32 percent of the
18 Medicaid drug benefit spending in total.
19 I think what was quite interesting for us is when
20 you compare that to Medicaid's overall spend writ large.
21 These 64 drugs were accounting for about 3 percent, so it
22 seems to us that looking at high-cost drugs was more than

1 just the media attention around hep C, but a larger more
2 systemic issue and a further pipeline analysis of the
3 projected cost of stuff coming out of the pipeline
4 certainly underscored that.
5 So I'll talk a little bit about alternative
6 payment models. What the heck is this? Right? What are
7 we talking about? In a simplistic way, we define an APM as
8 a contract between a payer and a drug manufacturer that
9 ties a payment for a drug or multiple drugs to an agreed-
10 upon measure.
11 We were able to find some of the best sort of
12 benchmarking information about this from the European
13 models. Most of the U.S. commercial market activity for
14 value-based purchasing sits behind confidentiality
15 agreements. While I think it's there, it's harder to get
16 at.
17 So in the work that we're doing with states in
18 the field, we're talking about financial-based APMs, a
19 financial cap, a volume discount at a certain level, and I
20 think the financial-based APMs are appealing because
21 they're easier to administer. The states have the claims.
22 It's a financial-based model. It's probably easier to

1 measure the outcome and administer those, and I think
2 actually drug manufacturers in a certain way feel
3 similarly.
4 The health outcome-based APMs are more appealing
5 for patient access and outcomes and for the evidence base.
6 So this is tying a payment to a predetermined clinical
7 outcome or measurement, and there is a lot of state
8 interest in doing this. But we are proceeding tentatively
9 there because this requires real data collection and real
10 agreement with the drug manufacturer and clinical data
11 sources that both parties agree upon to measure the
12 clinical outcome, and you have to be very mindful of what's
13 on the drug's label that you can measure, and things that
14 are not on the label are probably precluded from doing this
15 type of work at this point in time because of legal and
16 risk concerns from the drug companies.
17 So the legal analysis, we did this 75-page legal
18 brief, which you can look at, with outside counsel, and
19 they were tremendous. And we really looked at the Medicaid
20 Drug Rebate Program, the constraints there, what was
21 possible. We also looked at other legal issues that are
22 important, the anti-kickback statute, off-label promotion,

1 as I referenced, and what would be a common body of state
2 law. Any willing provider issues along those lines.
3 I won't give it a lot of attention, but what we
4 found, as I stated in my introductory remarks, is that
5 there really are opportunities for states to do this work
6 and do it right now. The legal pathways to pursue it are
7 quite narrow, and they have a lot of constraints, but it's
8 possible.
9 And the supplemental rebate arrangement is the
10 one that appears the easiest at the start. CMS has said in
11 guidance last summer that they actively encourage that, and
12 we find that a number of financial outcome or health
13 outcome arrangements could fall in this first category. We
14 call it Pathway 1. But we have states that are looking at
15 all of these other pathways to see what might be possible,
16 and that's very much about your Medicaid program
17 configuration in your state.
18 And then this is my last slide, technical
19 assistance. We are out in the field with states. We took
20 a good group of quite diverse states through a readiness
21 assessment process, and in that process, four states self-
22 identified as being ready to undertake a pretty intensive

1 planning phase with us by virtue of having pretty solid
2 data, analytics capacity, either themselves or with an
3 established external partner, having senior leadership that
4 was quite engaged in general and with this issue of drug
5 costs, and having either a mature Medicaid reform
6 initiative or a Medicaid reform initiative going into place
7 that they felt was well aligned. And those all seem to be
8 sort of key factors in bubbling that first set of four
9 states to the top, and then we have another group of four
10 to six states that want to enter into the process that sort
11 of loosely meet the same criteria.
12 So that's my contact information. So, Chris, I
13 will hand it back to you.
14 MR. PARK: Yeah. I guess it goes back to the
15 Commissioners to ask questions and have follow-up
16 discussion.
17 CHAIR ROSENBAUM: So Stacey and then Andy and
18 Penny and Brian.
19 COMMISSIONER LAMPKIN: How much alignment is
20 there between the small subset of manufacturers who are
21 interested in the 64 drugs that you focused on?
22 MS. STUARD: Some. You know, I'm going to be a

1 little bit elusive here, but some, yes. The small subset
2 of manufacturers that appear to be earnestly at the table
3 have some real high-cost drugs that are on that list, but
4 it doesn't certainly represent anywhere near the majority.
5 CHAIR ROSENBAUM: Yes, Andy.
6 COMMISSIONER COHEN: Hi, Susan. It's so nice to
7 have you here.
8 So your project is focused on what can we do
9 under our current law and circumstances, and it's great
10 that you have done that analysis, that you have described
11 the opportunities as like tricky, states have to be really
12 careful, they need a lot of technical assistance. So if we
13 -- if MACPAC has an opportunity to make recommendations for
14 change in statute to make those pathways less tricky, less
15 careful, and needing less technical assistance -- and,
16 obviously, every change has, you know, something that might
17 make an APM, which we might see as a good -- you know,
18 easier, may have some other countervailing challenge,
19 political policy or otherwise, but can you just talk
20 through what would be some statutory changes that might
21 make the development of APMs less tricky and expensive?
22 MS. STUARD: Andy, that's a great question.

1 Let me in the first part of my remarks stay away
2 from statute. The guidance that came out from CMS last
3 summer, encouraging use of supplemental rebates construct
4 for this activity was useful.
5 Additional guidance in that vein that tries to
6 assure states and drug manufacturers that this work is
7 appropriate or what are the pathways to get sort of a fact-
8 specific analysis that they're complying with the law,
9 those kind of guidance and engagement opportunities, I
10 think, would help spur the work, so stopping short of
11 statutory regulation change, that could do a little bit to
12 spur activity in the field.
13 When we look at the Medicaid Drug Rebate Program,
14 it is a program built on a stool with three legs, so it's
15 hard to pull pieces out of it without having the whole
16 thing fall, and we feel cognizant of that.
17 I think any changes would need to look at
18 mechanisms to keep states whole and the federal government
19 whole on the rebates that are shared back between states
20 and the feds with the FMAP. If a statutory change could
21 allow a certain amount of activity to explore this and see
22 if they can do a better job, sort of carve out maybe in

1 some kind of safe harbor activity to do this work, to let
2 states explore if this works, and is a better alternative
3 than just the statutory rebate, I think that would be
4 useful because it's not clear to me that anyone is ready to
5 say get rid of the whole thing, so creating a safe
6 environment to pursue the work before everyone says, "Let's
7 just get rid of these rebates writ large."
8 CHAIR ROSENBAUM: Penny.
9 COMMISSIONER THOMPSON: Stacey and Andy took my
10 first two questions, and I'm going to throw one to Brian,
11 which is you mentioned states saying that they would like
12 to see more analytic support. It's my impression -- first
13 of all, I'd just like to have you expand a little bit on
14 that, what kinds of things were they looking for, talking
15 about. Is it data? Is it a certain skill set that they
16 may not have resident inside of the state that they need to
17 have access to, a pool of resources?
18 But the other point I wanted to ask you to expand
19 on too, as part of that, is it is my impression -- and
20 maybe this has totally changed now because of the hep C
21 experience -- that a lot of states felt like they were
22 caught off guard by the demand for the hep C drugs, the

1 cost of the hep C drugs, the need to cover these drugs in
2 the way that they needed to be covered initially. I mean,
3 I kind of feel like your story about what happened in terms
4 of what states did and what the federal government did and
5 kind of what advocates did was a pretty well-told story and
6 pretty predictable that it would kind of fall out exactly
7 as it did and the way that it did.
8 So I'm wondering just if states are paying a
9 little bit more attention to the FDA pipeline and if that's
10 part of the analytic support that they're also looking for.
11 MR. BRUEN: This is a good question, and
12 certainly, the report goes into more detail, and I was able
13 to go into it, even though I went over my time.
14 In terms of your first question having to do with
15 what are the sorts of things they were looking for, some of
16 the specific things they talked about were high-quality
17 cost-effectiveness reports, comparative studies, so much of
18 the research that's done when drugs are coming to market is
19 always compared to a placebo or some other sort of non-drug
20 form of treatment, and comparing drugs to each other is not
21 done nearly as often as the states, I think, would like to
22 see, so they have some sense of should we favor Drug A or

1 Drug B for this population. Evidence reviews were another
2 thing they noted in there.
3 In terms of being caught off guard, certainly we
4 found states at both ends of the spectrum. We found states
5 that were very actively engaged, knew this was coming, and
6 sort of planned for it as much as they could ahead of time.
7 They were still caught off guard by the price, but there
8 were other states that basically said, "Yeah, we were
9 blindsided. All of a sudden, the bills started coming in,
10 and we were like, 'What is this drug, and why is it so
11 expensive, and why do we have no policy for it?'" And so
12 some of the variation that we observed among states was
13 simply due to sort of standard delays, and once they
14 realized they had a new drug that they had to deal with,
15 that it usually takes six to nine months for them to get
16 through the whole process -- and so there were states that
17 were basically -- the drug was on the market, and they were
18 trying to figure out how to cover it. There were other
19 states that pretty much had their policies in place before
20 it came to market, and even those states struggled with --
21 it came to market, and they said, "Gee, this is more
22 expensive than we thought."

1 COMMISSIONER THOMPSON: Thank you.

2 I also think thinking about these questions in
3 light of some of the proposals around FDA reform -- because
4 some of the challenges that people felt like they were
5 facing with hep C, as an example, on some of the current
6 high-cost drugs may be affected by some of the FDA reforms
7 that are coming as well to even raise the level of
8 challenge for states in terms of reacting and having the
9 data that they're looking for, for some of these things
10 that we're talking about.

11 MR. BRUEN: And one of the things we mention in
12 the report is that there were some states that explicitly
13 said one of the things they've done in reaction to their
14 experience with hep C is they have essentially noted staff
15 or a contractor to basically keep an eye on pipelines and
16 to alert them of potential blockbusters coming down the
17 pike.

18 CHAIR ROSENBAUM: Sorry. I'm sneezing.

19 Brian.

20 COMMISSIONER BURWELL: So, Susan, you referred to
21 the engagement that you're currently involved with
22 providing TA to four states. Is it reasonable to assume

1 that the nature of that engagement is the development of
2 alternative payment models, so the development of a set of
3 metrics that might be used in the model and then financial
4 arrangements around those metrics?
5 And the second part of the question is: Over
6 what time period will this engagement occur, and will other
7 states be able to benefit from the results of this?
8 MS. STUARD: Yeah.
9 COMMISSIONER BURWELL: These engagements.
10 MS. STUARD: Yeah. Those are great questions.
11 So when we're out in the field doing TA, technical
12 assistance work with states, we are really focused with
13 trying to help them identify drugs or drug classes in which
14 they have a great interest, and where we sort of mutually
15 agree that there's an opportunity for the state to get the
16 drug manufacturers to the table and negotiate an
17 alternative arrangement. So there could be a drug or a
18 drug class where they have a great deal of interest but for
19 various reasons don't have any value proposition to offer
20 the drug manufacturer, and there's no incentive for the
21 drug manufacturer to come to the table and negotiate. And
22 we've definitely run into instances like that.

1 But as it turns out, you know, all four of the
2 first states that we're working with tend to -- there's a
3 Venn diagram that really overlaps of drugs and drug classes
4 that appear to be pretty interesting opportunities to
5 negotiate differently with a drug manufacturer because
6 there's a nice health outcome measurement that could
7 happen, there's competition in the class, there's a payment
8 or a care model that you can pair with it to make it more
9 compelling for the manufacturer, all the while achieving a
10 better goal of either increased patient access or more
11 stability in financial outcomes.
12 So that's the work that we're doing, really
13 trying to help states think through all of the levers, the
14 legal pathways, the tools they have, what it would look
15 like, and start to engage the drug manufacturer to
16 negotiate. So the outcome of this would be, ideally, a
17 series of contracts between states and drug manufacturers
18 for these alternative models.
19 To your second question about sharing this work
20 between and among states, we think a lot of the structural
21 pieces of the work, how you think about this, how you go
22 through the process, what you do is stuff that can really

1 be shared across states. We anticipate that the same thing
2 is going to happen to Medicaid that happens in the
3 commercial market around these value-based contracts is
4 that the drug manufacturers are going to insist on
5 confidentiality around the terms of the agreement. So we
6 are anticipating broad ability to speak generally about
7 this but maybe almost no ability to speak about the
8 specifics --
9 CHAIR ROSENBAUM: Right.
10 MS. STUARD: -- yeah, in order to get it done.
11 Yeah.
12 So it's a good news-bad news situation, but I
13 think there's a lot structurally that can and will be
14 shared, and we're actually finding a lot of that dialogue
15 already starting to happen between the [inaudible].
16 CHAIR ROSENBAUM: Good. I've got little time and
17 four questions here.
18 MS. STUARD: Okay.
19 CHAIR ROSENBAUM: I've got four people. Toby,
20 Kit, Chuck, Marsha. Toby, you're up.
21 COMMISSIONER DOUGLAS: Great. First a data
22 question on the 16.9 billion or 33 percent of drugs, really

1 a striking number. Question was: Have you looked at it
2 with rebates? Because the other two-thirds I would assume
3 have the supplementals, and so this number is -- actually,
4 the percent is probably even bigger with rebates included.
5 MS. STUARD: Yeah. Brian alluded to this as
6 well. While you can, you know, accurately predict the
7 federal or the statutory rebate because it's in statute,
8 you can't get to any reliable numbers on --
9 COMMISSIONER DOUGLAS: Supplemental.
10 MS. STUARD: -- the supplemental rebate, and we
11 felt that it was just going to be too hard to do. We find
12 in conversations with states that they for themselves can
13 sort of ballpark where they are without running afoul of
14 the confidentiality requirements around some of that. But
15 we couldn't get there with our general analysis.
16 COMMISSIONER DOUGLAS: Yeah. Well, I would say I
17 definitely -- I mean, from knowing one of the bigger
18 states, it's a way --
19 MS. STUARD: Yeah.
20 COMMISSIONER DOUGLAS: It shows that it's a way
21 bigger percent.
22 MS. STUARD: Yeah.

1 COMMISSIONER DOUGLAS: On the policy side -- so I
2 mean, you know, with these high-cost drugs, it still comes
3 down to just the leverage or the negotiation. So when you
4 have no other drugs on the market, there's no -- there's
5 really -- even in big states, it's hard to get them to the
6 table. So you know, this proposal that's floating around
7 of saying states don't have to cover FDA-approved drugs, I
8 just wanted to get your reaction to that as a way to then
9 bring them to the table to talk about these types of --
10 MS. STUARD: Yeah.
11 COMMISSIONER DOUGLAS: -- alternative payment
12 methodologies.
13 MS. STUARD: You know, I want to be careful in my
14 remarks about this. You know, you guys know this. In the
15 commercial market, they can close the formulary when
16 there's competition in the class, right? And negotiate
17 pretty significant discounts on a drug, right?
18 Medicaid absolutely cannot do that. You know,
19 they have to keep an open formulary. They can prefer the
20 drug. They have tools. And in mature pharmacy programs,
21 they do that, and they do it effectively, and they have
22 stuff to offer in terms of negotiating with the drug

1 manufacturers to get them to the table. It's not nearly as
2 compelling, but there are some tools.
3 We are talking with states about drugs that are
4 coming out of the pipeline. You know, orphan drugs for
5 small populations where, you know, they can identify the,
6 you know, 5 to 120 patients who are likely to get this
7 drug, and they can look at the bill, and they can see it
8 might cost them between 10 and 70 million dollars to
9 support this drug.
10 And those are very complicated situations for
11 states. There's no competition in the drug class for these
12 drugs. And it can be difficult because sometimes when
13 these drugs are approved by the FDA the label might say
14 there's no clear clinical benefit for the drug.
15 So this is a difficult situation for states, but
16 I think a handful of states are really looking at trying to
17 see if they can engage with drug manufacturers, you know,
18 right as stuff is coming out of the pipeline in sort of
19 collaborative, evidence development types of scenarios. I
20 wish we were getting more interest, but there is some.
21 So I would say states might appreciate having the
22 ability not to cover every drug that is FDA-approved, but

1 that comes with a lot of responsibility in terms of how
2 carefully you review that, through what process, are you
3 protecting patients and patient access. And I would say
4 it's not something we take lightly.

5 CHAIR ROSENBAUM: Kit.

6 COMMISSIONER GORTON: So, Brian, just three
7 observations about your managed care piece. This may be in
8 your report; I may have missed it. The other thing that
9 surprised people was what was in the label once it was
10 approved. You can do all the surveillance in the world,
11 but you don't know what it's in the label until FDA
12 approves it. And nobody expected that that label would be
13 that sweeping, nor did anybody expect that CDC would come
14 out and be the cheerleader for treating everybody and their
15 brother and their second cousin. So I do think that there
16 were other elements about this one which made it
17 particularly challenging.

18 In response to that, I think it's important to
19 note on your managed care slide that while states did at
20 some point get to many of these places there were states
21 that just sat tall in the saddle and said "no," and then
22 there were other states that said, "Oh, we have these

1 wonderful managed care plans, and they're at risk. So they
2 can take care of this for us," and they didn't do anything
3 to adjust their rates until the next rate-setting exercise,
4 and even then they may not have done it terribly well.
5 So important to understand that states exhibited
6 a range of different behaviors and sometimes they were able
7 to pass the risk off. My little health plan in my little
8 state spent $72 million in 2014 on Sovaldi and Harvoni. So
9 that's one way that states manage the problem.
10 I guess the other thing I wanted to observe
11 quickly is that many carriers, including us, are not only
12 Medicaid carriers. And we work very hard in ours to make
13 sure that the clinical standard of care that's afforded to
14 Medicaid patients is the same as the clinical standard of
15 care that's afforded to our commercial patients.
16 And so we're making decisions across our self-
17 insured book, across our employer-sponsored book. Those
18 had far-reaching ramifications. And trying to balance all
19 of that and keep the access equivalent as we all got ready
20 for what was this triple storm in terms of the finances of
21 the health plan was very, very tricky. So this is one of
22 the places where it wasn't necessarily a great thing to be

1 a multi-product carrier, and I think we saw this if you
2 look at the financial statements of the publically traded
3 company. Every company across the country was reporting
4 erosion to earnings or even sometimes moving into deficit
5 because of the expenditures on hepatitis C.
6 CHAIR ROSENBAUM: Chuck.
7 COMMISSIONER MILLIGAN: Thanks. I have one
8 question for each of you.
9 Brian -- and I'm sort of going to pick up on
10 Kit's comment. I think one of the challenges when the hep
11 C drugs hit the market especially was around -- and you
12 alluded to it. Was kind of defining medical necessity
13 because there was on the public health side the view that
14 everybody with a diagnosis, however asymptomatic, however
15 low the viral load, should get it.
16 So the question I want to put to you is: From
17 you, what are the lessons learned around how to go about
18 defining medical necessity from the Harvoni/Sovaldi
19 experience?
20 MR. BRUEN: Well, I'm not a doctor, so I'm not
21 going to set it myself. But one of the things that was
22 very interesting in that discussion around where they land

1 in terms of the disease severity in particular, a lot of
2 times the states pointed back to the AASLD guidelines. And
3 when they first came out for the newest range of drugs,
4 after Sovaldi, there were provisions in there that
5 basically said we recognize that there may be barriers to
6 care in terms of, you know, inadequate budgets and
7 inadequate, you know, provider networks, and in that case
8 you should, you know, think about prioritizing these
9 patients over those. And they clearly prioritized mostly
10 people who were sick but had good prognoses to continue on
11 and survive.
12 And over time they have dropped those
13 prioritizations, and they've basically said in the
14 guidelines today, cover everybody.
15 But there's an interesting caveat, where they've
16 taken away the prioritization. But they still have a
17 sentence or two that alludes to again sort of challenges of
18 lack of resources or lack of access, and they still make
19 points about making sure that patients are appropriately
20 diagnosed, that they're committed to care.
21 So there are still some caveats that I think
22 states can look at in terms of thinking about medical

1 necessity and thinking about prioritizing patients, for
2 lack of a better term, when faced with limited budgets
3 because I think what's interesting about those AASLD is
4 they sort of make the implicit assumption that now that the
5 price of the drugs is down to 40,000 or 50,000 dollars
6 that, you know, cost is no longer a barrier or budgets are
7 no longer a barrier.
8 And in Medicaid, that is clearly not true. And
9 so I think there remains this really tricky balance of how
10 do you open it up, how do you ensure that patients who
11 really need it can get it, but at the same time you don't
12 as a Medicaid program open yourself up to potentially
13 blowing your budget completely out of the water.
14 CHAIR ROSENBAUM: Can I just follow-up with one
15 question on that point? I was going to ask you, but then I
16 decided not to, but then I'll jump in. And that is: What
17 was the effect of the Washington State decision? Do you
18 know? I mean, did that cause a number of states to alter
19 their guidelines, anticipating that they would face the
20 same?
21 MR. BRUEN: Absolutely. It certainly raised
22 their attention. They haven't necessarily changed their

1 policies yet. Some states had already changed policies
2 before that happened. Other states are sort of looking at
3 it, waiting to see what happens. I mean, it's fairly clear
4 the direction the case is going to go, but you know, I
5 think for some of the states who are in the most precarious
6 budget positions they're going to hold their ground as --
7 CHAIR ROSENBAUM: They're going to wait until –
8 MR. BRUEN: -- long as possible.
9 CHAIR ROSENBAUM: Yeah, yeah.
10 COMMISSIONER MILLIGAN: Yeah. It has felt a
11 little circular between like what you can afford equals
12 medical necessity equals what you can afford.
13 CHAIR ROSENBAUM: Right.
14 COMMISSIONER MILLIGAN: So my question, Susan, to
15 you is about the value-based contracting and one of my
16 concerns in general about -- value-based contracting is a
17 great thing. My concern is that the proliferation of
18 approaches might lead to the same dollar of savings being
19 counted multiple times.
20 So if, for example, you've got a value-based
21 contracting model with a patient-centered medical home or a
22 clinical group or a delivery system, and they manage the

1 patients, they deal with adherence, they have social
2 workers, they help deal with the social determinants pieces
3 of things, and it results in a lower drug cost and
4 appropriate utilization of services, who gets credit for
5 that savings?
6 My question to you is: In the value-based models
7 that you're working on, is there a risk of that issue
8 arising in terms of who the treating provider is with how
9 the rest of that person's medical care is being counted in
10 terms of total spent and total savings?
11 And I'm just wondering how siloed your model
12 might be versus how integrated therefore double-counting
13 risk if it arises.
14 MS. STUARD: Yeah. Again, great questions from
15 this group.
16 To try to unpack that a little bit, Chuck, I
17 would say as we've been working with states on drugs and
18 drug classes the preliminary APM designs that have the most
19 legs are where that value-based contracting model would be
20 very well-paired with an existing state Medicaid initiative
21 around some kind of enhanced care model.
22 So taking a state's existing PCMH program that

1 they already have in place and a tier of payments that
2 might look at quality measures. And let's say, you know,
3 adding an appropriation medication adherence measure in
4 there and, you know, working with the patient-centered
5 medical homes to, you know, allow a given drug to be
6 administered in that primary care setting, maybe where it
7 isn't always administered, and supporting them in that.
8 Perhaps adding a supplemental medical care payment into
9 that group to make that possible, to really support the APM
10 and make it successful for the patient.

11 I think the thing that I'm so struck by is every
12 time we're doing planning with a state agency medical
13 director and pharmacy director they are always rolling all
14 the way down to, you know, the patient and the provider and
15 how does this play out in the field.

16 So the ones that are going to have the most legs
17 sit inside a full policy and care model because that
18 actually, weirdly, creates value for the drug manufacturer
19 around measurement, adherence, compliance, you know,
20 coverage with evidence development because when you can
21 articulate a really coherent model for that the drug
22 manufacturer starts to respond a little bit differently

1 about the value proposition to the APM.

2 By necessity, some of these might be a little

3 smaller in scope at start. To do that work, you pick

4 something a little more narrow and little more well-

5 defined. But a number of the states that we're working

6 with have as a primary goal just to get something in place

7 and flex this muscle because if it works maybe it's

8 possible to build on it.

9 Did I address your question?

10 CHAIR ROSENBAUM: Good. And Marsha has got the

11 last question.

12 VICE CHAIR GOLD: Yeah. This is a question for

13 Brian. I think -- well, it builds on something that I

14 think was in your report. These are such expensive drugs,

15 yet reading the paper back then and what you all said, you

16 know, the sense is, God, these could save people and they

17 could be life-savers. And those are based on studies that

18 are in ideal circumstances, sort of our clinical lab of

19 randomized trials.

20 I was interested when I think you were talking

21 about implementation and whether there is some money lost

22 because the states pay for drugs that the people don't end

1 up taking or they don't complete a cycle or they need other
2 ones. And I'm wondering if anyone is looking at the
3 reality of how the benefits work with the costs in a real-
4 life setting. I mean, it feeds in ultimately to the
5 managed -- you know, the clinical management side, but just
6 understanding -- I think if I was a state I'd be interested
7 in understanding what I actually am buying, not what I'm
8 theoretically buying.
9 MR. BRUEN: No. It's a very good point. And one
10 of the -- I talked a little bit about the state sort of
11 active management. And one of the points that the Medicaid
12 directors and pharmacy directors and the people we talked
13 to who were in states that were doing this -- one of the
14 reasons they were doing that is they really wanted to know
15 what happened. They wanted to be able to track. So some
16 states, some of the smaller states where it's easier to do
17 this, you know, have spreadsheets, and you know, somebody
18 from the Medicaid agency actually reaches out to the
19 patients to see how they're doing and have they finished
20 and did they take all their drugs. So certainly that's one
21 of the things they're trying to do with the active
22 management is to make sure people go through treatment.

1 A number of states are monitoring patients after
2 treatment for things like re-treatment to see -- you know,
3 they'd like to know down the line, if people are re-
4 treated, is it because they relapsed, basically it came
5 back without anything that they did, or you know, was there
6 some intervening drug use or other sort of risk behavior
7 that brought it back? So they certainly want to monitor
8 that.
9 In some other work that I'm doing on hep C, one
10 of the more interesting things that we've seen is states
11 even looking at issues of, say, incarceration, where
12 patients who were taking the drug who get incarcerated.
13 Typically, when you get incarcerated, everything you have
14 is taken away. You're not allowed to bring drugs in for
15 potential resale purposes and other reasons.
16 But with hep C, they've really pushed actually
17 for some changes and some exclusions in those states --
18 that if somebody is on that medication, they were already a
19 few weeks in or a few months in, and they've spent
20 thousands of dollars on this person already, if they get
21 incarcerated, they basically have provisions to allow the
22 drug to come with them so they can continue their treatment

1 and finish the course of treatment because they figure
2 they're paying for it. They want to make sure the person
3 succeeds.
4 VICE CHAIR GOLD: Right.
5 MR. BRUEN: So you know, I think there's this
6 real challenge between the desire to make sure that anybody
7 who needs the drug can get it and at the same time making
8 sure that when people are taking it that they are --
9 they're ready for treatment, they're committed to
10 treatment, they're going to get through the treatment, and
11 then they're going to, you know, hopefully -- states also
12 talked about one of the reasons for close monitoring is
13 making sure that patients then got tied into SUD clinics or
14 other sorts of treatment to make sure that whatever risk
15 behavior led to them contracting HCV in the first place
16 they could hopefully avoid going back to in the long run.
17 CHAIR ROSENBAUM: Sorry about that. All right.
18 Thank you so much. And we are going to move to our next
19 session. This was great, most helpful to us.
20 And I just wanted to take two minutes to see if
21 there's any public comment on this segment.
22 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. And also,

1 just for the audience, the report that Brian and his team
2 did for us will be up on our website later this afternoon.
3 ### PUBLIC COMMENT
4 * CHAIR ROSENBAUM: I see no public comments, so we
5 can plunge right into 1915(b).
6 ### THE ROLE OF SECTION 1915(b) WAIVERS IN MEDICAID
7 MANAGED CARE
8 * MR. FINDER: Thank you, Sara.
9 Today's session is about the role of 1915(b)
10 waivers in Medicaid managed care. 1915(b) waivers are one
11 of the authorities under which states implement managed
12 care, and as we look at all of them, it is interesting to
13 see how state authority has evolved over time in this area,
14 from early Section 1115 waivers to 1915(b) waivers to state
15 plan authority.
16 The evolution of managed care in Medicaid
17 demonstrates how states test approaches or program design
18 through waivers for which statutory authority is later
19 enacted by Congress. Other examples include expanding
20 access to low-income parents of children enrolled in
21 Medicaid, benchmark benefits or alternative benefit plans,
22 family planning services, home- and community-based

1 benefits, and expanding access to low-income childless
2 adults.
3 As Medicaid managed care has matured, CMS and
4 states have accumulated more experience implementing and
5 operating managed care programs. There are also new
6 managed care rules that change the standards and
7 requirements for operating a Medicaid managed care program.
8 So, today, we will focus on what this means for
9 the role of Section 1915(b) waivers in Medicaid. First, I
10 will review these authorities, then some of the
11 requirements of Medicaid managed care. After that, we'll
12 compare authorities, and I'll conclude by raising some key
13 policy considerations for you to discuss.
14 So let's start with 1915(b) waivers. There are
15 four types of 1915(b) waivers. (b)(1) waivers, which allow
16 states to mandate enrollment in primary care case
17 management, or PCCM programs; (b)(2)s which allow a county
18 or local government to serve as an enrollment broker;
19 1915(b)(3), which allow states to share cost savings with
20 enrollees by providing additional services; and (b)(4),
21 which allow states to limit enrollees' choice of providers.
22 States generally use these waivers to waive

1 enrollees’ freedom of choice, either to mandate enrollment
2 in a restricted network or to enroll traditionally exempt
3 individuals in managed care, or to limit choice to a single
4 managed care plan.
5 Some states implement 1915(b) waivers in
6 conjunction with a 1915(c) waiver, which are known as home-
7 and community-based service waivers, in order to enroll in
8 a managed care plan that provides home- and community-based
9 services. In other words, they use a 1915(b) waiver to
10 waive enrollee's freedom of choice in order to enroll them
11 in a managed care plan, and they used the 1915(c) waiver to
12 provide the home- and community-based services.
13 Many 1915(b) waivers implement comprehensive
14 managed care programs or specialized behavioral or mental
15 health programs, non-emergent medical transportation
16 programs, home and community services, managed long-term
17 services and supports, or case management.
18 States apply for these waivers by completing a
19 pre-printed application. In that application, states have
20 to describe the program that they wish to implement and
21 provide enrollment information and financial information to
22 demonstrate the proposed waiver will not increase federal

1 spending. In 1915(b) waivers, this test is known as the
2 cost-effectiveness test.
3 Once an application is submitted, the Secretary
4 has 90 days to make an approval decision, which is
5 generally called the "90-day clock." The Secretary can ask
6 for more additional information, which resets the clock,
7 but there's generally a limited time frame in which these
8 waivers have to be approved.
9 They're generally in effect for two years. They
10 can be approved for five years if they include individuals
11 who are dually eligible for Medicaid and Medicare.
12 And oversight and monitoring responsibilities and
13 assurances for beneficiary protections and other protocols
14 are generally -- historically have been outlined in the
15 approval documentation.
16 So I mentioned these authorities a little bit
17 earlier, and now I'll describe them in a little more
18 detail.
19 1915(b) waivers were added to the statute in the
20 Omnibus Budget Reconciliation Act of 1981. Prior to that,
21 the only authority under which a state could implement a
22 managed care program was a Section 1115 waiver. These

1 waivers provide broad authority to waiver requirements of
2 Section 1902 in order to implement a program that promotes
3 the objectives of Title 19.
4 Section 1115 waivers are generally research
5 oriented and designed to test new approaches on a limited
6 scale, and because of this authority, they vary in scope.
7 For example, some states use them to implement small
8 discrete programs -- let's say family planning services --
9 and then, on the other hand, there are some states that
10 operate their entire Medicaid program under an 1115 waiver.
11 This variability in scope and authority has
12 implications for the administrative burden associated with
13 Section 1115 waivers, including the application process and
14 oversight and monitoring, and I'll address that again in a
15 few slides.
16 States can also implement managed care programs
17 under Section 1932, state plan authority. This state plan
18 authority was enacted in the Balanced Budget Act of 1997.
19 It allows states to require certain beneficiaries to enroll
20 in managed care and, in fact, require certain beneficiaries
21 to enroll in managed care. It also exempts a couple of
22 populations of individuals, populations of beneficiaries,

1 including individuals dually eligible for Medicaid and
2 Medicare, Indians, and children with special health care
3 needs, including foster children, from enrollment.
4 As Medicaid was evolving, so too were the
5 standards and requirements. CMS has enforced these
6 standards through regulation, which regarding managed care
7 was last published in 2002, and through sub-regulatory
8 guidance.
9 CMS updated these managed care regulations in
10 2016. In that update, they made many changes to the
11 regulation, and some of the changes that are key to our
12 discussion today include CMS tied to managed care standards
13 and requirements to the managed care program rather than
14 the authority under which it was implemented. Now
15 standards and requirements apply to comprehensive managed
16 care plans consistently, regardless of whether they're
17 implemented through a Section 1115 waiver, a Section
18 1915(b) waiver, or --state plan authority.
19 Prior to the reg, many of these standards and
20 requirements were outlined in the waiver approval
21 documentation, such as special terms and conditions. So,
22 therefore, the new regulation provides an enforcement

1 mechanism.

2 The regulation made many other changes to managed
3 care requirements. Some of the other changes include
4 increasing the access-to-care standards and assurances,
5 beneficiary protections, quality of care standards
6 including implementing a quality rating system, changes to
7 the rate-setting process and approval process, and contract
8 approval requirements.

9 I know the type on this slide is a little small.
10 Hopefully, it comes across clear in the handouts, but this
11 slide is intended to demonstrate some of the differences
12 and similarities among Section 1915(b), 1115 waivers, and
13 state plan authority.

14 One of the key differences is who can be
15 enrolled. Under 1915(b) and 1115 waivers, a state can
16 mandate enrollment in managed care for any beneficiary.
17 Certain populations are exempt from mandatory enrollment
18 under state plan authority.

19 The managed care standards and requirements are
20 similar across managed care authorities.

21 States apply for a 1915(b) using a preprinted
22 application. State plan authority also relies on

1 preprinted forms. 1115 waivers use a template. These
2 applications are far less prescribed than other
3 authorities. This reflects the variation and scope of
4 programs that states operate under this authority.
5 I mentioned earlier that state provide enrollment
6 and financial documentation to meet the cost-effectiveness
7 test for 1915(b) waiver applications. For Section 1115,
8 it's a little different. These waivers require that states
9 demonstrate budget neutrality. In other words, the federal
10 spending cannot be greater under an 1115 waiver than it
11 would otherwise be.
12 It's worth noting that if a state can demonstrate
13 savings by implementing a managed care program under a
14 Section 1115 waiver, the budget neutrality calculation
15 allows them to use these savings to finance services or
16 programs that would not otherwise be allowed under the
17 Medicaid statute; for example, states that expanded
18 eligibility using such savings under budget neutrality.
19 I mentioned the 90-day time limit for 1915(b)
20 approvals earlier. State plan amendments have a similar
21 90-day clock. On the other hand, there's no time frame
22 required for Section 1115 approval, and again, this

1 reflects the variation in the scope and authority in the
2 program the states have implemented under Section 1115
3 waivers.
4 1915(b) waiver approvals and renewals are for two
5 years at a time or up to five if individuals dually
6 eligible for Medicaid and Medicare services are included.
7 1115 waivers can be approved for five-year time periods,
8 and state plan amendments generally don't have an end date
9 or require renewal.
10 So given the available authorities and the
11 evolution of Medicaid managed care, what role does Section
12 1915(b) waivers now play? To that end, we have raised
13 three policy questions to start your discussion today.
14 The first question is: Could authority available
15 under 1915(b) also be permitted under Section 1915(c) or
16 state plan authority? The state's ability to waive
17 beneficiary freedom of choice is limited under state plan
18 authority in 1915(c) waivers. So some states may have to
19 apply for a (b)/(c) waiver or apply for a state plan
20 amendment and a (b) waiver in order to operate a program.
21 If states were allowed to wave freedom of choice or
22 selectively contract under 1915(c) waivers or state plan

1 authority, it would simplify the application process and
2 program management for states. On the other hand,
3 consolidation of these authorities has implications for the
4 federal oversight of these arrangements.
5 Question 2: Could states be allowed to enroll
6 traditionally exempt populations in managed care under
7 state plan authority? Title 19 exempts certain
8 populations. We've discussed individuals dually eligible,
9 Indians, and children with special health care needs for
10 mandatory managed care enrollment. They generally have
11 complex health care needs that may require a coordination
12 of care or coordination of benefits. Individuals may have
13 needs beyond those that managed care companies have
14 traditionally covered. Arguably, the Medicaid managed care
15 rule puts requirements into place and standards to address
16 many of these issues, and at the same time, states and
17 plans have accumulated a lot more experience providing
18 coverage to these populations over the past several years.
19 On the other hand, waivers provide an additional level of
20 oversight that may be necessary for the complex needs of
21 these populations.
22 Could changes be made to 1915(b) authority to

1 reduce administrative burden and simplify the authority for
2 states? For example, could the initial and renewal periods
3 be extended from two to five years? This would align
4 Section 1915(b) waivers with Section 1115 waivers. On the
5 other hand, the two-year renewal provides states and the
6 federal government a regular opportunity to reassess
7 whether the waiver is achieving its goals.
8 So, today, we are here to get your feedback on
9 whether you would like to pursue these questions or others
10 and what information that you might find helpful as we
11 pursue these questions. So I'll stop here and thank you.
12 I look forward to your comments.
13 CHAIR ROSENBAUM: I wonder if I could kick us off
14 by taking your three questions, which I think are obviously
15 not questions, but reframing them just a little bit. One
16 is, Are we at a point now where managed care ought to be
17 the default expectation for all beneficiaries who get
18 Medicaid? Okay. In other words, when 1915 was created, we
19 were at a very different place in terms of the whole
20 structure of the statute. We are way beyond the way the
21 world looked when 1915 was written, at least in its
22 original form.

1 So, one, is it a default expectation, especially
2 since 1932 has many degrees of managed care inside it?
3 It's not all big prepaid health plans. It's a variety of
4 arrangements. So are we now at a point in the United
5 States as compared to 1981 where we expect people to be in
6 integrated delivery settings?
7 And then separate from that, are there certain
8 populations who, if they go into integrated delivery
9 settings, when they go into integrated delivery settings,
10 merit considerations that go beyond the standard integrated
11 delivery setting provisions of the statute?
12 And then my third question is, Does in fact the
13 managed care rule take care of that problem? So, in other
14 words, to the extent that 1932 by itself was not attuned to
15 higher-need people going into managed care arrangements,
16 has that problem been addressed by the statute, by the
17 rule?
18 Which sort of brings us back full circle to the
19 issues, Toby, that you've raised, which is how should we be
20 thinking about this rule now, and it seems to me our
21 thinking about the rule is very difference, depending on
22 how the Commission wants to think about the bigger question

1 of whether the statutory constructs from 1981 is really
2 where we ought to be anymore or even where we are. So I
3 don't follow 1915 wars. I mean, I don't follow all the ins
4 and outs. So I didn't even know at this point how many
5 states have used 1915 to get exempted populations into one
6 type or another of managed care arrangement.

7 If we're at a point where basically every state
8 is now using the model and having to go through these two-
9 year issues and renewal issues and if the managed care rule
10 is the same, I have one set of reactions. If in fact very
11 few states are still putting foster children in or certain
12 other kinds of special needs populations in, maybe it's a
13 different answer.

14 But 1915 in its earliest forms is sort of such an
15 antique at this point, and it may be an antique that we
16 want to keep for all kinds of reasons. Don't get me wrong,
17 but it's almost 40 years old.

18 Sorry. I didn't mean to do this, but I've been
19 saving up for like two days.

20 EXECUTIVE DIRECTOR SCHWARTZ: Can Ben make the
21 factual point?

22 CHAIR ROSENBAUM: So Penny --

1 EXECUTIVE DIRECTOR SCHWARTZ: But can Ben give
2 the factual --
3 CHAIR ROSENBAUM: Oh, sure, sure.
4 MR. FINDER: So states operate managed care under
5 a variety of authorities, in case I didn't make that clear
6 enough in my presentation.
7 There are only ten 1915(b) waivers to implement
8 comprehensive managed care, although 35 states have 1915(b)
9 waivers to implement some kind of a program. Some of them
10 are used to implement specialized programs for mental
11 health or behavioral health services, non-emergent medical
12 transportation. Some of them are done in conjunction with
13 1915(c) waivers to implement managed long-term services and
14 supports.
15 CHAIR ROSENBAUM: I have Penny, and anybody else?
16 Brian and Leanna.
17 COMMISSIONER THOMPSON: Starting with what are
18 states trying to do and integrated care delivery, I mean,
19 there was a CMS letter a couple of years ago about kind of
20 outlining -- "Here are all the difference ways that states
21 are trying to coordinate care and the ways in which we can
22 think about these and use different authorities." I think

1 starting with what people are trying to do rather than
2 starting with federal authorities, I think is always the
3 better way.
4 And then there are various places where you can
5 rely on different authorities, depending on what you're
6 trying to do, to receive the necessary federal approvals,
7 and then I think the question is, Is it such a common
8 approach? Are the issues so predictable that there is no
9 reason that there ought to be multiple pathways, that there
10 ought to be cleaner ways to do this?
11 The second point is I think that sometimes we
12 give a little too much attention to whether something is a
13 waiver authority or a state plan authority, when in fact
14 maybe sometimes it's easier to get the waiver than the
15 state plan. There are business processes that you have to
16 go through, and if you've always had a (b) waiver and
17 you've always had a (b)/(c) waiver, it might just be easier
18 to kind of update that and get that renewed than if you
19 have to go through converting that to a state plan
20 authority.
21 I don't want to get too caught up in that piece
22 more than the substantive question of what is the state

1 trying to do and how do we make things that are -- where
2 there's a defined pathway, easy for states to take
3 advantage of to exercise those discretions and those
4 decisions on their part.
5 EXECUTIVE DIRECTOR SCHWARTZ: Can I ask, Penny,
6 though, if you reframe the question that way, like what's
7 your view on it?
8 COMMISSIONER THOMPSON: I think there should be a
9 managed care authority. I mean, it's sort of where Sara
10 was going --
11 CHAIR ROSENBAUM: Yes.
12 COMMISSIONER THOMPSON: -- which is setting aside
13 1115, you make this point in the chapter, which his right.
14 A lot of states use 1115 to do managed care so they can use
15 the savings to do other things, not because they are really
16 looking for authorities to do managed care. But I think
17 that in terms of thinking about -- and I don't know whether
18 it's really managed or it is integrated care or coordinated
19 care.
20 CHAIR ROSENBAUM: Whatever we call it.
21 COMMISSIONER THOMPSON: Whatever it is. Choosing
22 a delivery system that we all understand is a very logical,

1 responsible delivery system to use, and taking advantage of
2 that should be as easy as possible for states to do.
3 CHAIR ROSENBAUM: All right. I have Brian,
4 Leanna, Toby, Chuck, Marsha.
5 COMMISSIONER BURWELL: So I just want to make an
6 observation about MLTSS and the use of waiver authorities.
7 Often when states want to move to MLTSS for their long-term
8 care populations there's a decision point about whether to
9 go for an 1115 or a (b)/(c) waiver combo, as they call it,
10 and it's -- you know, the decision point often does not
11 revolve around the nature of the authority or what can be
12 done under one or the other. A major factor is the review
13 process. So states are often advised to go the (b)/(c)
14 waiver combo route because the review process stays within
15 CMS and it's a designated 90-day review. An 1115 has no --
16 you know, could sit somewhere for years and also goes, you
17 know, outside of CMS. So it's a different review process.
18 COMMISSIONER THOMPSON: That is true. I will
19 also say there's been, traditionally in CMS, a philosophy
20 of using the lower of authorities. So if what you can do
21 can be done in a state plan authority, you should use state
22 plan authority. If what you want to do can be done under a

1 (b) or (b)/(c) waiver, that's where it should be done. An
2 1115 should be reserved for something that can't be done
3 under those. And there's a little bit of also -- I mean,
4 that's a true point, but there's also a little bit of a
5 hierarchical view of that.
6 COMMISSIONER BURWELL: Yeah. I mean, so
7 sometimes there's a tradeoff, as -- if you stick with a
8 (b)/(c) it's basically just putting your program into
9 managed care, whereas in an 1115 you have more flexibility.
10 My second question -- and I don't know if we're
11 going to get into this later -- is are we having the
12 discussion because what could potentially -- are waivers
13 going to go away under --
14 CHAIR ROSENBAUM: No. I think that we're trying
15 to do is take the pulse of the Commission about whether we
16 might want to do some work on what ultimately, I assume,
17 would become recommendations regarding some revisions to
18 the statute itself, and then, potentially, identifying some
19 of the regulatory implications of those recommendations. I
20 mean, so it's -- we're starting to lay the groundwork for a
21 bigger piece of work.
22 EXECUTIVE DIRECTOR SCHWARTZ: And --

1 COMMISSIONER BURWELL: I mean, because, to me, it
2 relates to the previous conversation we had about what's
3 the nature of the entitlement part of Medicaid under a
4 reform. And so are you still going to have (c) waivers --
5 CHAIR ROSENBAUM: Well, we may. I mean, this is
6 why we assume a stately pathway here, because we are
7 working not knowing everything about the way the statute
8 will look. But on the other hand, like there will always
9 be an England, there will probably always be a Medicaid.
10 And so we -- you know, we need to work --
11 [Laughter.]
12 COMMISSIONER BURWELL: But I'm also thinking this
13 is like -- this is a way we might be helpful or contribute
14 to the discussion --
15 CHAIR ROSENBAUM: Yes. Yes.
16 COMMISSIONER BURWELL: -- because --
17 CHAIR ROSENBAUM: Absolutely.
18 COMMISSIONER BURWELL: -- a lot of people don't
19 get this.
20 CHAIR ROSENBAUM: That's what we're trying to do,
21 is be helpful.
22 EXECUTIVE DIRECTOR SCHWARTZ: I think there are

1 really two threads to this. One is there's obviously a lot
2 that's not known about what the scope of the reform is, but
3 there has continued to be quite a lot of discussion about
4 waivers, and how much easier it would be for states to get
5 waivers to do all kinds of things. So, you know, take that
6 for what it's worth.

7 And the other is, I think that there has been
8 sort of a constant drumbeat around the hassle and the why,
9 why, why -- why do we do things during -- waivers? Can't
10 we make it easier for states? And I think there's a real
11 question there about, is actually -- you know, there's
12 process changes, business process changes, and there are
13 also things that waivers do allow states to do, that but
14 for the waiver they couldn't do. And so, you know, what's
15 the tradeoff there? Is it keeping it in a waiver
16 appropriate -- that's one question. The other is, is there
17 something administratively that can be done that would
18 address those concerns?

19 CHAIR ROSENBAUM: Yeah, I mean, and to
20 crystallize it, I've, for years, scratched my head about --
21 because I don't, you know, read the fine print the way
22 somebody like Penny did, because that was her work -- or

1 those of you who ran Medicaid programs. But why should I
2 have to show the cost-effectiveness of managed care for
3 certain populations when, in fact, I can do this because
4 it's a sensible thing to do, whether or not it may be
5 particular cost-effective, whatever that means, without
6 going through that. And, furthermore, you know, a
7 population today of a child who is poor will be a child in
8 foster care tomorrow, and, you know, why am I having to be
9 on these different pathways? People are not immutable.
10 And so just from the structure of the policy, it
11 doesn't make much sense. It did in 1981, when the world
12 was a very different place for Medicaid, and everybody was
13 dipping the toe in the water, and there were certain
14 populations who nobody was ready to dip the toes in for.
15 But we're in a, you know, somewhat different place now.
16 So, it's still long-range, you know, policy development for
17 us.
18 Leanna?
19 COMMISSIONER GEORGE: Well, Serenity, my
20 daughter, was actually on a 1915(b)/(c) waiver once upon a
21 time. So I don't remember what the rule was like in 1981,
22 but when she went on the waiver --

1 CHAIR ROSENBAUM: You know what it's like now.

2 COMMISSIONER GEORGE: I know what it's like now.
3 In North Carolina we have about a 17-year waiting list of
4 individuals trying to get on the waiver, because of all the
5 services it provides. There is countless evidence of where
6 the waiver empowers families to work, so that they may not
7 qualify for Medicaid but getting those services allows them
8 to work and continue to provide for themselves or their
9 families. You know, there are countless reasons why the
10 1915(b)(c) waiver continues.

11 I remember several years ago when North Carolina
12 went from a local-managed entity to a public MCO system,
13 there were a lot of questions and concerns, and I think
14 watching this unfold, the MCO system with it has gone very
15 well, for a lot of people -- maybe not for everybody. I'm
16 sure we all, you know, worked with MCOs. We know how it
17 goes. But I see where the public MCO versus a private MCO,
18 what North Carolina has is a public, they are reinvesting
19 those funds, providing additional services through to the
20 populations they serve, such as substance abuse and mental
21 health things, and I think it's very important that it, you
22 know, from the consumer side of things, that's brought out

1 what it impacts.

2 CHAIR ROSENBAUM: So, I mean, you're making the
3 point that, and it's Penny's point too, that no matter what
4 you call these things, you've got a bunch of structural,
5 functional, practical issues, and what would be nice is,
6 you know, ways to ease some of the complications that are
7 needless, while, at the same time, making sure that you
8 don't lose the safeguards, particularly for higher-need
9 people, and the question is how do you do that.

10 Toby.

11 COMMISSIONER DOUGLAS: So the (b) and (c) waivers
12 definitely, from a state perspective, is always this
13 feeling of micromanagement and federal -- you know, it just
14 creates that tension between the state and CMS. And I'd
15 say with the managed care reg it really just, to me, raises
16 the question, more than a question of authority but is
17 there even any, you know -- just, states should be able to
18 do managed care, and there shouldn't -- the protections,
19 the framework for ensuring the implementation, the
20 monitoring, is within the regulation, rather than having to
21 go through any process --

22 CHAIR ROSENBAUM: Any statutory authorities.

1 COMMISSIONER DOUGLAS: Yeah. That said, I mean,
2 check a box, and they go and -- and they need to follow
3 that.
4 CHAIR ROSENBAUM: Chuck.
5 COMMISSIONER MILLIGAN: I agree with what Toby
6 just said. I want to maybe just elaborate a little bit. I
7 don't think that the mega-rule, and I don't the regulatory
8 framework is adequate to allowing everything to kind of
9 fold into a state plan. In certain ways I don't think --
10 I'll just give one brief example. With Native Americans,
11 one of the underlying issues is, you know, there's federal
12 treaty agreements --
13 CHAIR ROSENBAUM: Uh-huh.
14 COMMISSIONER MILLIGAN: -- there's, you know, a
15 very strong relationship between the tribes and the federal
16 government about providing health care under treaties, that
17 has typically been manifested by having, you know, self-
18 referred access to health service or tribal 638 providers.
19 So I think that if Native Americans could mandatorily be
20 enrolled in managed care, there would need to be some
21 protections around the treaty obligations and access to IHS
22 and 638 providers, which aren't there right now.

1 CHAIR ROSENBAUM: Right.

2 COMMISSIONER MILLIGAN: But I think that you
3 could envision a future where you don't need a (b) or a
4 (b)/(c) because the regulatory framework could provide the
5 requirements, or as part of the state plan, and I'm
6 sensitive to Penny's comment about kind of how it works on
7 the inside, but, you know, it doesn't need to work that way
8 on the inside. So I'll leave it there.

9 CHAIR ROSENBAUM: Marsha.

10 VICE CHAIR GOLD: Yeah. I think I want to pick
11 up or align myself with some of the -- where I thought Sara
12 and Penny and some others seem to be going. I mean, as I
13 was listening, I was thinking, well, what problem are we
14 trying to solve here? And I think that if we go forward
15 with this it would be important to sort of put it in some
16 context and think a little bit about what we're trying to
17 achieve, and also to get evidence for certain areas.

18 And so from my perspective, there's sort of two
19 things. One, the first and foremost is beneficiary
20 protection. Historically, that's why we have these
21 waivers, and that's what they're there for, and there was
22 lots of history with problems. I think it's perfectly

1 reasonable, given how much managed care has become the
2 dominant delivery reform to ask under which circumstances
3 we don't need these waiver authorities to do beneficiary
4 protection because we can accomplish it in some other way,
5 but to me that's the main thing that is there.
6 Then the secondary question is state hassle and
7 burden, and given appropriate, you know, beneficiary
8 protection, the question is, you know, what really is a
9 burden to states? And one thing that I'm missing is which
10 of these things drives people crazy, what takes a long
11 time, would it be easier if they'd done things a certain
12 way for a certain period of time, just to keep doing them,
13 versus even if it's theoretically simpler to shift over.
14 And so we're missing some feedback from states, a little
15 bit, on what these are.
16 And so that's the framework I would kind of think
17 about some of these things, and I agree that, you know,
18 we're in a different era now, and there is a virtue in
19 having a managed care regulation that cuts across all these
20 things, but beneficiary protection and easy -- you know,
21 less burdensome implementation and state flexibility remain
22 important.

1 CHAIR ROSENBAUM: Okay. And did you have --
2 yeah, you had your hand up.
3 COMMISSIONER COHEN: Thanks. I just will say,
4 quickly, I completely agree. This is a great area for
5 further work for MACPAC. I think there is agreement around
6 the table. We have moved past the old framework of paper
7 services, the default in managed care is an experiment.
8 All of that does not say it's not a binary decision, like
9 either we accept all the regulatory stuff that's in place
10 now. I think part of our work should be identifying --
11 like doing a, you know, just the next level is to go to the
12 sort of deeper crosswalk of what additional protections
13 would we need --
14 CHAIR ROSENBAUM: Mm-hmm.
15 COMMISSIONER COHEN: -- or for issues you need to
16 address, regulatorily or statutorily, if you were going to
17 sort of mainstream or make into a state plan sort of
18 framework, the, you know, authorities for states.
19 So I think this is a great body of work for
20 MACPAC to help modernize the statute and to sort of flag,
21 in a very complex area, what are the issues that need
22 further attention, and not just assume you default to the

1 current, even if stronger managed care regulatory
2 frameworks.
3 CHAIR ROSENBAUM: Great. Great. I have Brian,
4 Alan, Kit, and then I'd like to make a suggestion about how
5 we sort of -- what next steps we take.
6 COMMISSIONER BURWELL: I just want to speak to
7 the exemption for duals requiring a (b) waiver to go into
8 managed care. My perception is that that's got nothing to
9 do with Medicaid. It has everything to do with Medicare.
10 So in Medicare -- I mean, this is part of the conflict --
11 fee-for-service is still the default. So, I mean, the (b)
12 waiver requirement for duals has to do, still, with, for
13 some reason, that population needs additional protections -
14 -
15 CHAIR ROSENBAUM: Exactly.
16 COMMISSIONER BURWELL: -- and not --
17 CHAIR ROSENBAUM: These are the things that we
18 need --
19 COMMISSIONER BURWELL: -- be mandated --
20 CHAIR ROSENBAUM: -- to think about more.
21 COMMISSIONER BURWELL: -- into managed care
22 without additional scrutiny. You know, just a conflict.

1 CHAIR ROSENBAUM: Yeah. I mean, you're
2 absolutely right. I mean, that's why it's a lot more --
3 this is an involved process, and I think what we need to do
4 is decide how to move it forward, because there are a lot
5 of questions we need to ask.
6 Alan.
7 COMMISSIONER WEIL: Yeah. Following up on Marsha
8 and Andy's points, I mean, the origins here are consumer
9 enrollee protection and that the norm was not managed care,
10 and concern about taking something away. I'm trying to
11 imagine this conversation at MedPAC. You know, managed
12 care is fully established in Medicare. A third of
13 enrollees are in it. Why don't we just, you know, take
14 away the fee-for-service option? Something tells me there
15 would be a few more people in the audience, and a little
16 bit more resistance.
17 [Laughter.]
18 VICE CHAIR GOLD: We're not taking away the
19 options.
20 CHAIR ROSENBAUM: Thank goodness we're not.
21 VICE CHAIR GOLD: We're not taking away the
22 options. We're just --

1 COMMISSIONER WEIL: Well, but, I mean --

2 VICE CHAIR GOLD: The issue is whether you need a

3 waiver to offer it.

4 COMMISSIONER WEIL: So that's exactly where I'm

5 going here, which is that there's a key federalism

6 component here that doesn't exist in the Medicare program -

7 -

8 CHAIR ROSENBAUM: Right.

9 COMMISSIONER WEIL: -- which is -- and it goes to

10 Toby's, you know, original comment, which is, you know,

11 whose decision is this? Is it the enrollees? Is it to the

12 states? Is it the federal government? And if the state

13 makes the decision without federal, you know, direct

14 federal input, then that decision is taken away from the

15 enrollee. That's what I mean by taking it away.

16 But I -- all joking aside, I mean, I think I'm

17 trying to put this -- in the abstract, I think it's fine to

18 say this is the norm and, therefore, we should have one reg

19 and one way to approach it. The practical reality that

20 Penny mentioned, in terms of different processes, and Brian

21 too, and, you know, what works for who, when, that's not

22 going to change overnight, and if we just sort of have some

1 abstract, well, there ought to be one system, that may or
2 may not work. I'm also mapping it onto our conversations
3 about how much we've struggled with measuring network
4 adequacy, and measuring, you know, the things that we would
5 say are important.
6 CHAIR ROSENBAUM: Right.
7 COMMISSIONER WEIL: So my concrete suggestion is
8 that we do think about not just what's currently in place
9 in 1915 and 1115 and the state plan amendments, but to also
10 think about what's in place in Medicare, and how structured
11 that program is, in terms of requirements, and structured
12 in terms of choice, and structured in terms of benefit and
13 appeal rights. And I agree on the challenge of the
14 interface for the duals, but I'm talking about this not as
15 an alignment issue but more as a, well, there is a place
16 where we decided you can have one way to get out from under
17 the freedom of choice approach, and there's been a lot of
18 evolution, by the way, from the precursors of Medicare
19 Advantage, the names which have faded in memory.
20 COMMISSIONER THOMPSON: Medicare Plus Choice.
21 COMMISSIONER WEIL: Medicare Plus Choice. Thank
22 you. So, I mean, there's been some evolution in thinking

1 about what needs to be in place to make that a --

2 CHAIR ROSENBAUM: Exactly.

3 COMMISSIONER WEIL: -- viable, structured option,

4 and I think we should learn from it.

5 CHAIR ROSENBAUM: Yeah. Yeah. No, I have -- in

6 fact, I had made a big circle to myself, saying, MA plans.

7 So, I mean, it opens up a lot of questions. Once you

8 broaden state authority, then, you know, if we were to go a

9 route that, at least on the surface, broadened state

10 authority, what would the tradeoffs?

11 Kit, you get to close us out.

12 COMMISSIONER GORTON: That's a little scary.

13 CHAIR ROSENBAUM: Not.

14 COMMISSIONER GORTON: So I agree with most of

15 what has been said here. I do think it's an important

16 question that we should pursue. I think it's an important

17 field of inquiry for MACPAC, potentially, in the future, to

18 sketch out some -- an evidence base and some

19 recommendations based on that.

20 With respect to the evidence base, what I would

21 like to hear more about in future conversations with staff

22 are, there's been a lot of discussion about the need for

1 beneficiary protections and the role of federal oversight
2 and the importance that plays, and it's -- I accept that
3 it's a reasonable abstract construct. I would like to
4 know, practically, over the course -- and we don't have to
5 go back to 1981, but maybe over the course of the last 5 or
6 the last 10 years, as the managed care approach has really
7 matured and settled in, just how often, and to what extent
8 has CMS had to exercise their oversight authority, and, you
9 know, what is the value-add of that?
10 My premise, going to what Toby said, is that it's
11 a huge administrative burden, particularly anything that
12 happens on a two-year cycle, and even if it's just check
13 the box and resubmit your waiver, it's still you've got to
14 pay a small army of people to check the box and resubmit
15 your waiver, and then -- so he also has to pay a small army
16 of people to read what you submitted.
17 So, you know, I do think that we should ask
18 ourselves whether the administrative burden of that is
19 creating value, and to the extent that we can prove that it
20 creates value, then, you know, okay, let's continue it.
21 But if it's no longer creating value, the value that it
22 created in 1981, then maybe it can be scaled back, maybe it

1 can be revised.

2 And then just to restate the question that I have
3 posed at other times at the Commission, in this federalist
4 construct, where does the level of accountability exist?
5 Right? Are states not grown up enough and capable of being
6 accountable for the care that they provide to people who
7 live in them, and how much federal oversight is necessary?
8 And I'm not suggesting that that number is zero, but I do
9 think that it has trended towards 100 percent,
10 significantly, over the last 20 years, and I wonder whether
11 there's an opportunity to dial that back a bit.

12 CHAIR ROSENBAUM: Good. Let me make a
13 suggestion. So I was conferring with Anne, given the fact
14 that we seem to have hit an issue here that we are all
15 reverberating to, with a lot of, you know, caution and
16 trepidation and care. This is a big piece to tackle, and
17 yet, at the same time, there's sort of a sense that we are
18 at a place where maybe we can really make a contribution.

19 So my thought, Anne, is that you and Ben and the
20 other staff come back to us, based on this discussion, with
21 maybe your thoughts on the research, the policy development
22 agenda, that's needed, given the questions we've raised,

1 and that we, then, react back with you and add to that list
2 of things we think we're going to need in the way of both
3 understanding the details of the current regime, some of
4 the more detailed ways in which the current system is, in
5 fact, used, and for whom, the kinds of issues that Chuck
6 flagged, you know, the special things that would miss the
7 naked eye, like the 638 problem for Native Americans. But
8 that way, maybe by -- I mean, I assume it will be an issue
9 going forward in the -- you know, for next fall, that this
10 will be a time of developing this set of issues.
11 So if that makes sense to you --
12 EXECUTIVE DIRECTOR SCHWARTZ: Yeah.
13 CHAIR ROSENBAUM: -- that you come back to us
14 with sort of a plan of action, and then we can react to
15 that and give you any additional --
16 EXECUTIVE DIRECTOR SCHWARTZ: Yeah, that sounds
17 great, and I'm really -- we -- it was a trial balloon, and
18 it --
19 CHAIR ROSENBAUM: It worked.
20 EXECUTIVE DIRECTOR SCHWARTZ: -- it didn't pop.
21 But I just would also say, if folks have thoughts on some
22 resources or people that we should talk to regarding this,

1 let us know so that we can pursue those.

2 CHAIR ROSENBAUM: Good. Any public comment?

3 ### **PUBLIC COMMENT**

4 * [No response.]

5 CHAIR ROSENBAUM: We are adjourned.

6 * [Whereupon, at 11:47 a.m., the meeting was

7 adjourned.]