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Medicaid in an Era of Change: Findings from the Annual Kaiser 50-State Medicaid Budget Survey
Kaiser Family Foundation
October 14, 2014

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Diane Rowland, Sc.D: Good morning and welcome to the Barbara Jordan Conference Center and to our briefing on Medicaid in an Era of Change: Findings from the Annual Kaiser 50-State Medicaid Budget Survey. I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation and also the Executive Director of our Commission on Medicaid and the Uninsured. Today is really a great day for us as we join NAMD in releasing the survey findings. This is the 14th year that we have been monitoring and tracking the policy changes and budget impacts of Medicaid at the state level.

This survey that we do annually is only possible because of the time and the commitment of the 50-State Medicaid directors plus the D.C. Medicaid Director, and yes, all 51 have participated each year in this survey, which I think is a commendable 100-percent response rate, rare for a survey, especially one of the depth and detail of this survey. We really are pleased today to be able to jointly release these findings with the Medicaid directors and the National Association of Medicaid Directors and hope that you will find the findings useful throughout the year. This is not a one-day release of a new poll finding that then goes away. This is really the tracking and the monitoring of what is going on in a very dynamic era for the Medicaid program.

I also, of course, what to thank our long-term associates in conducting this survey; Vern Smith, Kathleen Gifford, and Eileen Ellis of Health Management Associates, and of course, at Kaiser Family Foundation, we put our staff to work as well and without Robin Rudowitz and the tireless Laura Snyder we really couldn't put our pieces together for this survey. To everyone who participated at the state level and to all who helped to put together these three reports that were released today, my deepest thanks.

Today, we're going to really look at Medicaid and many of the factors that influence it, and sometimes we think about the ACA as the only activity going on in town, but actually for the Medicaid program there's a lot of forces at work. The Affordable Care Act is coming into implementation, not just the expansion features of the Medicaid program, but also many of the changes in the way enrollment and eligibility work, and especially some of the major changes going on at the state level and delivery system reform that are really detailed in this report. We know that as economic conditions improve in the states, it enables them to make changes in their Medicaid program that will really help to reshape the program going forward in the future and ongoing is use of program administration will continue.

Today, we plan to release three reports that come from the survey Medicaid directors conducted in July and August.

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The three studies really look at both the implementation of the Affordable Care Act and the Impact on Medicaid Spending and Enrollment Growth. We also have the detailed findings from the Survey in Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey that we're releasing jointly with the National Association of Medicaid Directors, and that will provide you with a detailed look at the policy and program changes in Medicaid across the 50 states. Then we've done some case studies of a few states to give you some insights into some of the specifics; Utah, Virginia, West Virginia, and Michigan are profiled in the case studies.

Today, we're going to start by releasing the key findings and have Robin Rudowitz and Vern Smith present those to you, and then we are going to follow up with what I know will be an incredibly insightful panel from the Medicaid Directors themselves moderated by Darin Gordon who is President of the National Association of Medicaid Directors Executive Board and also the Director of TennCare, the Tennessee Medicaid program; with Steve Groff, the Delaware Medicaid Director; Cindi Jones, the Virginia Medicaid Director; and Kate McEvoy, the Connecticut Medicaid Director. I think we have a lot of information to provide you with and a lot of discussion to go on and I'm going to start by asking Robin to kick off our discussion.

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Robin Rudowitz: That you so much, Diane, and thanks everyone for coming, and I want to echo my thanks to both NAMD for cohosting the event as well as the Medicaid directors on the panel as well as those who work to complete the survey with their staff. I also want to acknowledge Laura Snyder, my colleague at KCMU who has worked on the report as well as my colleagues at HMA.

As Diane said, I'm going to talk about trends in Medicaid spending and enrollment, which are affected by changes in economic conditions as well as policy changes. In this figure, you can see that over the last 15 years, we see substantial growth in the Medicaid program during recessions with peaks in enrollment in 2001 and 2009 when you look at the orange line in the graph. Medicaid is a counter-cyclical program, so during economic downturns individuals often lose their job, incomes fall, and more individuals become eligible and enroll in public assistance programs including Medicaid. This increase in enrollment drives increases in Medicaid spending. Following the last recession, we've seen slow but sustained improvements in the economy, and as a result in fiscal year 2012 and 2013 we have seen average spending and enrollment growth in the Medicaid program slow.

However, our focus today is really on what's happening in fiscal years 2014 and 2015, and we can see in the figure, again, that when you look at the right there are sharp

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increases in Medicaid spending and enrollment that are primarily being driven by the implementation of the ACA. The major coverage provisions of the ACA went into effect in January 2014, so that was really mid-way through most state fiscal years, which begin in July, so when we look at 2015 we see that that's really the first full year of implementation during state fiscal years.

Our findings from the survey show that spending and enrollment patterns and trends vary across states that are implementing the expansion as well as those states that are not implementing the expansion. As enacted, the ACA brought in Medicaid to service the foundation of coverage for low-income individuals with incomes up to 138-percent of the poverty level, which is about $16,000 annually for an individual, but because of the Supreme Court ruling, or the decision to implement the Medicaid expansion effectively, became a state option. Currently, according to the map, we see that 28 states are moving forward with the Medicaid expansion, including D.C. That's two more than in state fiscal year 2014 with the additions of New Hampshire that started implementation in July as well as Pennsylvania that is scheduled to begin implementation in January 2015.

This map also shows that there are two states currently in active debate about moving forward with the Medicaid expansion. Both Indiana and Utah have been actively in

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discussions with CMS about implementing the expansion in an alternative way, and there are many other states that are also considering their options to move forward including Tennessee, and I'm sure we will hear more about that in a few minutes. CMS has offered guidance to states that says that there is no deadline for states to implement the expansion. For states that do move forward with the expansion, the federal government will pay 100-percent of the costs of those who are newly eligible for years 2014 through 2016. That rate phases down to 90-percent by 2020 and beyond. This ACA-enhanced match rate is significantly higher than the traditional Medicaid match, which is determined by a formula that's in the law and currently ranges from a floor of 50-percent to a high of about 74-percent.

When we look at expansion states, or we see that there's much higher growth in both enrollment and total spending in expansion states, so across all the expansion states they experienced 12.2-percent enrollment growth in fiscal 2014, and that is expected to go up to 18-percent. These rates are much higher than the national average and much higher compared to states that are not expanding. In line with these higher enrollment growth, we see higher rates of total spending. However, due to the influx of the federal funds that serve and pay for those who are newly eligible, we see a wide differential in terms of total spending growth and state

spending growth with state spending growth growing much more slowly than total spending growth. When when we look at states that are currently not implementing the Medicaid expansion, we see much lower rates of enrollment growth compared to the national average in those expanding.

In fiscal 2014, in states not implementing the expansion experienced 2.8-percent enrollment growth. That's relatively low and it was due to improvements in the economy as well as some of these states experiencing enrollment system difficulties. As we look to 2015, these states are expecting to see higher enrollment growth as system issues are resolved and we see increased participation among individuals who are currently eligible for the program. Total spending, again, is largely in line with what is happening with enrollment, but because there is no additional increase in the match rate for non-expansion states, because they are not implementing the expansion, then the rates for total spending and state spending are relatively similar and this is reflective of historical trends. That was a lot of numbers, so I am going to wrap that up with that summary of spending enrollment and turn it to Vern to talk about changes in policy.

Vern K. Smith, Ph.D: Thank you, Robin, and thank you, Diane. I'm very pleased to be here today to talk about the changes in Medicaid policies last year and this year. I'm very pleased to be here with four of the leading Medicaid directors

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in the country also and I very much look forward to the discussion of what is happening in their states.

Medicaid is a big story in 2014, and it's a big story for a couple of big reasons. One is the implementation of the ACA, which has dramatically changed Medicaid eligibility and enrollment policies and systems leading to the significant enrollment growth that Robin just described. Payment and delivery system reforms are also being implemented across the country improving value, improving outcomes, and saving money. There are a lot of other things that are happening also, the kinds of policy changes that we have traditionally tracked over the last 14 years, payment rates, benefits, and so on, and we'll talk about those, but the big story is about the ACA implementation eligibility enrollment on the one hand and delivery system and payment system reform on the other.

Let us look first at eligibility. This is a time of historic change and expansion in Medicaid. Clearly, the most significant Medicaid eligibility change in 2014 was the ACA expansion for adults, but in addition the ACA expansion important changes are also occurring in the way income is counted, the adoption of the modified adjusted gross income, MAGI standard, when determining eligibility for children and low income adults. With the adoption of MAGI came the end of the asset test for these groups. That was a very important change. Secondly, eligibility and enrollment policies and

processes have been streamlined and simplified and that has had an important impact also across all 50 states.

Altogether, in 2014, 31 states made changes that expanded eligibility including the states that adopted the ACA expansion. In the current fiscal year, 2015, another eight states were making changes that expand coverage. About half the states made changes to Medicaid eligibility for adults who could also get coverage under the Marketplace, and so a lot has been made of the issue of the transfer of data and information between the marketplaces and Medicaid. Those issues continue to this day, although, they are being resolved, but one of the important things that has happened is that people are being referred to Medicaid from the marketplaces. A few states restricted eligibility last year, but only four and none this year. That's the first part. Historic changes in Medicaid eligibility and procedures in coordination with the Marketplace.

Turning now to a payment delivery system reform. In some ways, this is an even bigger story than the eligibility enrollment changes in part because it's happening all across the country. Big states, small states, expansion states, not-expansion states, red states, blue states, east coast, west coast, north, south, in the middle - - across the country, 40 states had some kind of a payment or delivery system reform occurring this year, 30 states last year, so this is a really

big thing which is happening as states are working very hard to align payment and accountability with outcomes and coordinate care for Medicaid beneficiaries who have the greatest needs, who can benefit the most from the integration of care, care coordination, and case management. As we had our discussions with directors for the survey, I was struck by the number of times we heard Medicaid officials talk about achieving better care, better outcomes, and lower costs, the triple aim, through their payment and delivery system reforms.

Every state has its own approach. Some are using one or a combination of patient-centered medical homes, health homes, under section 2703 of the ACA. Accountable Care Entities of some kind, they may be formal ACOs, but possibly something else, care coordination organization or accountable care entity, whatever the state may call it, but they all have in common structuring the reimbursement systems so that they can reward high quality and better outcomes. These initiatives have often focused on specific populations such as persons with chronic conditions needing long-term care or dual eligibles.

One thing, which is a continuation of trends that we saw previously, the integration of physical health and behavioral health, and in some states like Arizona, New Mexico, Kansas come to mind, are working towards full integration of their physical/behavioral health and long-term care. This is where states are focusing a good deal of their attention.

Turning now to managed care. Managed care is a primary vehicle for achieving delivery system and payment reforms and it's now the primary delivery system across the country with managed care in all but three states in the country, Alaska, Wyoming, and Connecticut, although Connecticut has some unique features and I'm sure Kate will have some things to say about that shortly.

Two, major trends are evident in managed care, one is increasing reliance on managed care through expanding geographic coverage, making enrollment mandatory, applying managed care to more eligibility groups. The second trend, and it's very significant, is the ongoing and increasing focus on quality and quality improvement. Medicaid agencies are building in rigorous requirements into their contracts with MCOs to meet quality metrics relating to access, preventative care, prenatal care, outcomes for specific disease states such as diabetes or behavioral health, and with performance-based reimbursement a meaningful part of health plan payment is tied to performance.

These delivery system and payment system reforms in managed care are now being applied to long-term care. Medicaid is a primary payer in this country for long-term care and about a third of Medicaid spending is for long-term care, so it's important to look at this area. States continue to increase care in the home and community and to diminish reliance on

institutional settings like nursing homes. All but a couple of states reported at least one action in this direction and none in the opposite direction. Expanding the capacity for home and community-based service waivers was the most common action, but an increasing number of states are doing other things as well in the long-term care arena this year, about 20 states, for example, are enhancing or adding PACE programs. About a third of states are implementing one of the three new options created by the ACA to encourage states to accelerate the use of home and community care, and a significant is greater use by states of risk-based managed care for long-term services and supports.

Let me turn now to payment rates. Robin described how the economy effects enrollment and spending in Medicaid, and clearly it also affects some of the traditional policy changes that states make such as payment rates and benefits. During the recession, cuts, restrictions, to provider payment rates were the most common approach to controlling Medicaid spending, and over the last three or four years states have been restoring those cuts or enhancing the rates. Compared to 2012, when there were more rate cuts than increases, this year 45 states were increasing provider payment rates in some way.

Now, one area of particular attention is the 100-percent federally funded primary care rate increase to Medicare levels mandated by the ACA for two years, calendar years 2013 and 2014. The 100-percent federal funding for this increase

expires in December of 2014, so one big question was what would happen in January of 2015 as states looked to whether or not they would continue this rate increase at their regular federal match rate. At the time of the survey, about a third of the states said they would be continuing that, about a third said they would not. About a third said they were going to wait and see what would happen and had not yet decided.

Turning to benefits, the story is similar here. Just two states restricted benefits for 2015, the fewest in over a decade, and these cuts were very narrowly targeted, and for the third year in a row, 20 states added or enhanced benefits. The most common benefit enhancements were in the area of behavioral health, long-term care, home and community-based services, and dental. One benefit to Medicaid program is watching very carefully is specialty drugs. Virtually every state in the survey went out of their way to note their serious concern about the high cost of specialty drugs Sovaldi and the other ones that are coming down the pipe and indicated they were developing clinical protocols for its coverage.

Finally, to summarize, 2014 is a historic year for Medicaid programs. Enrollment has increased to record levels, eligibility systems have been modernized and streamlined, coverage has been extended to low-income adults, major payment and delivery system reforms are improving care, improving outcomes, saving money. If I were to summarize the results of

the survey this is in three sentences, I would turn to three Medicaid directors and what they said in our discussions with them when we were talking about the survey, which very succinctly described where Medicaid programs are now and where they're going. One said, "we are pleased to have expanded coverage to ACA adults, to have managed the expansion as efficiently as possible, and to have achieved a high degree of coordination with the Marketplace." A second said, "we're driving plans and providers to more value-based arrangements as part of our payment modernization efforts." A third said, "Medicaid will focus on continuing to integrate acute care and long-term services and supports into Medicaid Managed Care and also to integrate behavioral health and physical health services." I think that says it very well and I look forward now to the discussion with Medicaid directors.

Diane Rowland, Sc.D: Thank you very much, Robin and Vern, for your overview of the survey, but now we want to turn to the state perspective and I'm going to turn the panel over to Darin Gordon to interact with his co-Medicaid directors.

Darin J. Gordon: Thank you, Diane. What I'm going to do is I'm going to ask two different questions. I'm going to ask one at a time and have each state react to that question. I would request we try to stay within the 2-3 minute timeframe. Having Medicaid directors up here with a mic, we can run away

with that, but we'll try to limit that so that we leave plenty of time for Q&A from the audience.

Diane Rowland, Sc.D: That's why I'm sitting here.

Darin J. Gordon: Diane's going to elbow me if we get out of control, so as a first question we'll start out, Kate, down at the end and work our way back this way. What are the two or three most interesting things going on in the Medicaid program in your state?

Kate McEvoy: Good morning, I want to start by saying how honored we are to participate. Thank you to Diane and to Vern and to Robin and to the Kaiser Foundation. With respect to Connecticut, we're very proud we're an expansion state and we have a fully constituted state-based exchange. Vern talked about some of the transactional challenges and integrated eligibility and I think those are our main challenges for us, but not withstanding we were able to enroll a very significant number of new participants in Connecticut Medicaid and are now serving over 21-percent of the state population. That's a source of, I think, important new coverage for single-childless adults in Connecticut.

Also, remarkable in Connecticut is that we are using no managed care arrangements. This stands in contrast to the trend that Vern described. Our historical experience with managed care was not positive. We saw many challenges associated with lack of consistency across plans causing

confusion for both our beneficiaries and also for providers. We also were challenged by a relative paucity of data, waiting for encounter data from the plans left us ill-equipped to use data for the purposes of planning policy making and also to support beneficiaries, and our hypothesis has been that centralizing management of Medicaid services for all of our coverage groups in four single statewide administrative services organizations for medical, behavioral health, dental, and non-emergency transportation would, in conjunction with using predictive modeling tools to stratify as well as to provide data to our person-centered medical homes and other providers, would enable better outcomes and experience and also enable us to control spending.

I am happy to report that we have had that experience. The health outcomes have improved substantially, especially with respect to using that vehicle of the person-centered medical home. Person-centered medical homes are now serving over one third of our beneficiary population and that's increasing rapidly. We are also seeing improved care experience through use of a goal-directed intensive care management feature that is available to any member of our Medicaid population, and we are also seeing PMPM expenditures hold remarkably constant. We had only a 1.8-percent increase in PMPM over the last year-over-year comparison. We, of course, are seeing dramatic increase in enrollment and

corresponding increases in expenditures, but I think the PMPM experience is something that we can point to as starting to prove out that hypothesis of the ASO arrangements. Thank you.

Darin J. Gordon: Cindi?

Cindi B. Jones: I'm Cindi Jones from Virginia. I, too, want to thank everybody for inviting us to participate. Virginia has 8 million citizens, 1 million of them are on Medicaid and we have about an 8 billion dollar budget for Medicaid. We are a non-expansion state, so we still have a million uninsured in Virginia and at least half of those might qualify for Medicaid if we do expand.

Our primary care delivery system is managed care and I think managed care is not the same today as it was yesterday. We've done lots of things within our managed care program to even improve the care, the quality, and the value we get from the system. We've done a lot of technical things, as Vern has said. We've collected almost 6 hundred million in pharmacy rebates since 2010 as a result of the ACA. We've worked with our managed care plans for program integrity and their error rate is less than 1-percent. We continue to move populations into managed care. We moved 10,000 foster care children this past year and we're moving our long-term care recipients and for at least their acute care at this time.

We've also done a lot of payment and delivery reform. We've allowed the plans to come up with two different models

each on payment or patient-centered medical homes to serve as pilots, and we've instituted a quality incentive program. We also have good quality outcomes, the HEDIS measures, and 90-percent of our children in managed care saw their primary care physician last year. Managed care is our primary delivery system. We're also part of the duals project, the Medicare/Medicaid financial alignment project. We now have 26,000 individuals and families in Virginia that have the peace of mind of knowing that Medicare and Medicaid is blended, they have one card, one place to call, and all their services are fully integrated, so we're very pleased about that.

The third thing that we're working on now is because we're a non-expansion state we have tremendous residents that have care needs, so we're focusing on the seriously mentally ill, not a 100-percent match but our normal 50-percent match are going to provide targeted benefit to our seriously mentally ill for up to 20,000 people. We are submitting a waiver, 1115 waiver today. I think we did it in four weeks, which might be record time.

Darin J. Gordon: Thanks, Cindi. Steve?

Steve Groff: Thank you, and I would like to thank you as well for inviting me today and for all of the products that Kaiser puts out because they are very useful for us and we appreciate them. Delaware is a small state. Many of you probably know that. We have less than a million residents but

over 225,000 of them are currently served in our Medicaid program. We are an expansion state, which was not a real big lift for us because prior to the ACA, since 1996, we were already serving childless adults up to 100-percent of the federal poverty level under a demonstration waiver, so we've seen about a little over 8,000 new enrollees under the expansion. We are an FFM partnership state. In fact, we were the first to submit our blueprint to choose that route. After analysis, we didn't feel that we could effectively create a state-based exchange, but we wanted to maintain control over plan management and consumer assistance and we found that to work fairly well, although, there were challenges this past year.

We are a heavily managed care state. Since 1996, most of our population has been served through managed care organizations. In April of 2012, we rolled in our long-term services and supports including our full duals for all of their care. Right now, our state completed their state health innovation plan in the past year. Medicaid has been heavily involved. The state just recently established the Delaware center for health innovation, which is a consortium comprised of the private sector, state agencies, our academic institutions, the medical community, payers, and stakeholders. Medicaid will play a large part in promoting the recommendations of that center. It is focused not only on

payment reform, but also in workforce development, population health, quality and metrics.

We recently went out to re-procure our managed care contracts, in so doing we went out to other states to look for best practices. We pulled in all of our sister agencies from within the state to help us in developing the RFP and what eventually became the new contract. Our new contracts begin January 1st. We believe this is going to give us an opportunity to better enforce program integrity requirements, to identify and enhance our quality measures, to promote payment reform. We do have requirements in there with the expectation that we will move to pay-for-value but also beyond to total-cost-of-care around a uniform score card that will be developed by the innovation center, so we really are looking at that as the vehicle for us to promote health transformation in the state of Delaware.

I'd just like to very quickly highlight two other things that we are doing. We are hoping to finalize an 1115 waiver demonstration amendment that will allow us to enhance community-based services and specialized services for individuals with severe and persistent mental illness and substance use disorder. That's a collaboration with our Division of Substance Abuse and Mental Health. We're very excited about a 1915-I program that we're hoping to receive approval on very shortly that will allow us to implement across

disabilities initiative to help promote employment for individuals with disabilities. Thank you.

Darin J. Gordon: Thanks, Steve. I'll be brief in Tennessee with regards to some of the things that we find to be the most interesting. Actually, we started out with a lot of things integrated in managed care and then over 10 years we then took everything out of the ownership of the managed care plans. Over the last 10 years we've learned from all the ways to do it wrong from the first 10 years and we've been reintegrating all of the services, behavior/physical health and long-term services and supports and we've seen great success there. We've seen our patient satisfaction over the last six years stay about 90-percent, reaching a high of 95-percent multiple years in a row—or over multiple years, they weren't in a row, it went down to 93-percent one year. We've seen the majority of our quality measures go up since 2006 when we started capturing those quality measures. We've seen our trends over the last 10 years stay under 3-percent, which is, I think, an important factor given the size of these programs and all the important services state government offers.

At the same time, we see that while we made a lot of progress there, we see that next area of opportunity being where else can we integrate. That's where dual eligibles come into the mix. It's obviously an area all across the country. It's an area I think we can all do better at, and I think

whether you're a dual demo state or whether you're not, I would tell you a vast majority of states are looking at better ways to integrate those services so that we can serve that population better and more cost effectively.

Then, at the same time, while you see vast improvement in the relationship between the state Medicaid agencies and the managed care plans, you do look at whether or not there's more that can be done between the managed care plans and the provider community and that really gets to payment/delivery system reform. While some of the plans have tried various forms of payment reform and even working with some of the providers on delivery system reform, it clearly requires the assistance of the state, and quite frankly, a multi-payer initiative in order to really get the type of effect that one would hope for.

We launched off, over a year ago, as part of a governor-leader initiative, to change the way we pay for services in our state and our goal is to, over the next five years, to get over 50-percent of our spend in some type of value-base payment arrangement. We work very closely with our health plans in doing that. That involves not just changing from fee-for-service to a value-based reimbursement perspective, but it also involves pretty significant changes in our delivery system in order to help support that initiative.

I'll say that many of the things that you hear the states talk about, it's the acute care side and the behavioral health side. I'd tell you there's plenty of opportunity in long-term services and supports for a value-based payment approaches as well as improvements in meaningful quality measures in that area, particularly with a growing population that we serve there.

Let's go to the second question. Again, two to three minutes each from the panel. What are the biggest challenges and opportunities facing Medicaid for 2015 and beyond? Kate?

Kate McEvoy: Thank you, Darin. I think both a challenge and an opportunity is synthesizing the multiple concurrent initiatives in which states are participating with CMS. I think you heard the directors allude to many of these. Connecticut, for example, has had the opportunity to have a planning grant, is seeking a model test grant, and SIM, state innovation model, is I think synthesized efforts in many states across payers to address payment reform, improvements to care experience, but really down to brass tacks how do we standardize and improve the experience both at the beneficiary level with care experience and also for providers across these multiple initiatives.

States are also participating in many long-term services and supports, reform initiatives. Connecticut has elected to participate in the state balancing incentive

program, the TEFT grant, and obviously continuing where the money follows the person efforts. Drawing all these strands together making this comprehensible and also reducing it at the practice level to something that keeps the beneficiary front and center so that we're making that comprehensible to the beneficiary, it's person-centered, and also improving the experience for the provider by harmonizing the use of quality measures so that that is not a burdensome process. We're interpolating the use of health information technology in a useful way. The strategies are direct, the strategies with use of predictive modeling tools, and that remains a challenge. I think we have many strands and bringing those together, knitting them into something that really makes sense to all of us, I think, is the next frontier.

I will also say I'm tremendously excited, as I know are all my colleagues, about the opportunity to partner, and in a much more vigorous way, with our counterparts in public health addressing social determinants, so transcending a purely health-focused approach in Medicaid, and looking at ways in which the Medicaid authorities can support that in a forward-thinking way, I think, is also an interesting and important challenge for us as we look to see how we want to improve people's experience with their engagement with communities and really improve outcomes in a way that is, as I said, not unique to health status.

Darin J. Gordon: Thanks, Kate. Cindi?

Cindi B. Jones: In Virginia, I think the biggest challenges as well as an opportunity is whether or not to do Medicaid expansion. There are three things that it turns on, political, moral, and fiscal, and if you just focus on the fiscal it makes no sense not to expand in Virginia. Governor Terry McAuliffe ran on it, but we're a 50-percent federal match state, which means for us and about 14 other states, it's the biggest bang for our buck. Plus, our governor has said he would find a way that the 10-percent could be paid for by other sources rather than the general assembly's budget, so I think on a fiscal standpoint, in fact, in the savings that we would get to our community, mental health, and our corrections, it's a good deal for Virginia and it's a good deal for Virginians.

The second challenge and opportunity is how to move all our long-term care people into coordinated care. Long-term care is not just one type of a person, it's a variety, and in Virginia, we're working on reforming our ID and DD waivers and we have to get that straight before we talk about how to coordinate it. It's just difficult because we historically have always had home income-based care since the '80s, moving something that's been a system into managed care is a little bit more difficult, but we are doing that.

I think our third challenge and opportunity is we're doing so much, the multiple reforms. We were doing 19 small

things that the general assembly gave us in 2013 and now the governor has given us a bunch of other things to do since we haven't expanded, and we also have multiple technical assistants. It's an alphabet soup of everybody that wants to help us reform our Medicaid program, so that's been challenging, but I do want to thank you all for the report because I think the report is a great dictionary of everything that everybody is doing and it's very helpful when I explain some of the differences.

Darin J. Gordon: Thanks, Cindi. Steve?

Steve Groff: Well, I could just say ditto, but I'll try to expand a little bit. Obviously, we've had challenges over the last several years and primarily in the last 12 months just implementing the Affordable Care Act. It's been a lift and I want to say that I'm extremely proud of not only the staff but all of the people in Delaware that contributed to making that happen, but let's be honest, we've really only addressed the first step, which is coverage. That's a great thing, but the real promise of healthcare reform and the Affordable Care Act is so much more and that's where the opportunity lies.

I think the challenge of realizing that opportunity is going to be that people need to rethink the way we do business. We see that those expectations are changing, people see the writing on the wall, the future is about better healthcare,

better outcomes. That's going to generate what we want to see as far as fiscal sustainability, but we have to get there. We have strengthened existing partnerships over the last 12 to 24 months. We have developed new partnerships and I think the promise is how we're going to leverage those resources to bring to bear a new way of doing business, and I want to reinforce the idea about social determinates, about collaborating with our public health partners about focusing on communities. It's not just about medical treatment, it's not just about coverage or paying for services, it's about bringing all those things together to make healthier neighborhoods, healthier states, and healthier people.

Darin J. Gordon: Thank you. Well, the great thing about Medicaid, there's always opportunities. I've been in this role for over nine years, and even before that working in the agency, there's always been opportunities for improvement. I think the comment that Kate made is very true, and I think we all keep it in front of mind is how do we design these delivery systems in a way that works best for the member and doesn't put the oness on the member to try to figure out if they have a physical illness or a behavioral health issue or if they need long-term services and support, then try to figure out which part of the maze we've created do they go to get the help they need. I think it's in the front of all Medicaid directors to figure out how to design a system that is more consumer-centric

and really meets the needs of the consumer in a more effective way.

I'd say that as far as some additional challenges, and we've heard a little bit about eligibility and trying to get to where everybody wants to be, I think every Medicaid director I've talked to around the country isn't at that steady state that they hope to get to, and I would say the federal government's there as well, but I'd say there's been tremendous progress as some of the data showed significant growth all across the country with regards to enrollment whether expansion or non-expansion.

I'd say another challenge for Tennessee is finding an expansion proposal that can satisfy the federal administration as well as meet the expectations of our general assembly as well, which given the history of TennCare and the early expansion efforts of TennCare, there's a history there and so trying to design a program that helps people understand why this time's different and how we can do it in a more effective way than our earlier experience.

I'd also say, and Vern hit on it, it cannot be downplayed, and it sounds like we're a broken record on this issue but specialty pharmacy is a very significant concern for Medicaid directors. The sheer size of the cost of these really effective, innovative drugs do put significant pressures on the states. In Tennessee, we're asked to produce a 7-percent

reduction plan this year and at the same time I have one drug that did not exist, end up costing me 100 million dollars last year, my total pharmacy budget's 700 hundred million dollars. That puts pressure on the rest of the program as we look at how we navigate this new area, which I think no one would argue about bringing on innovative drugs that really have some dramatic effect on people's health. No one's going to argue that's a bad thing. The question is how we do it in a sustainable way without having other impacts on other vital services that we provide our citizens. With that, Diane.

Diane Rowland, Sc.D: Thank you. I think we've clearly shown you there's a lot of innovation and change going on and a lot of challenges remain. We're going to open it up now to your questions. If you could please first identify yourself and raise your hand so a mic can get to you since this is being web cast, and then, second, if you want to direct your question to this full panel, that's one thing, but also you can identify if there's a specific person on the panel you'd like to have answer your question. The first mic is right there.

John Iglehart: Excuse me. John Iglehart, the *New England Journal of Medicine*. I would direct it to the four state directors, but certainly Robin and Vern and even Diane would probably have a comment on this, but the question is, in your states with the plans that you contract with, do they operate multiple networks or do they operate just one network?

If it's one network, do you have estimates of how many physicians in your state will treat Medicaid patients?

Darin J. Gordon: Yes, so with regards to Medicaid, all three of the health plans we have, each have their own network, and that's been the case for 20 years. We do have significant amounts of analysis that we do to look at access for members. I know there was a recent study released looking at the variability for different states and the types of tools that they use to monitor network adequacy, but not only do we use some outside help from our quality control contractor that goes out and actually verifies and validates information, we have a lot of sophisticated access tools that we do in mapping ourselves. I will tell you the last number I heard of the licensed docs in our state, it's just over 90-percent are participating in Medicaid.

Kate McEvoy: We, as I mentioned, do not use managed care arrangements, but I do think it's important to make a couple comments on network adequacy in general. For us, the Affordable Care Act, primary care rate increase, was a tremendous precipitator of increased participation. We saw a huge uptick in primary care, also some corresponding increase, obviously, in the related specialties that were eligible for that rate increase. We're planning to continue that at a slightly reduced level in Connecticut. I think that's an example of a policy level that's been enormously effective

corresponding to the eligibility increase to maintain the adequacy of the network. We, as Darin mentioned, use various tools, geomapping, and we regularly report, and the figures are very good in Connecticut, but I think it is the combination of levers that we're able to use. The enhanced reimbursement, which is instrumental in primary care and also for us with dental providers, we have now among the best access in the country primarily because of rate increases and also engagement with our ASO, so I think there's important reminders to us as we focus so much on eligibility that there are these other facets that we need to be deeply aware of with respect to adequacy in the network.

Cindi B. Jones: I was going to say, in Virginia, I think our Medicaid clients have better access than I do, and part of that is because it's managed care. I have six health plans that deal with the general Medicaid and three that deal with our duals, but they can pick up the phone and get connected, and the plans can't say we don't have anybody and that's when they reach out to their commercial counterparts. We also have very rigid adequacy and access requirements, but every plan does have their own network.

Steve Groff: In Delaware, each plan has its own network and I would concur with Cindi. One of the primary advantages for managed care that we found in Delaware was we have greater access for our members than we were able to

achieve through fee-for-service. We do monitor network adequacy and also we've tried to coordinate with the qualified health plans to have network adequacy standards that are in alignment since we recognize that there's probably going to be churn between the two populations.

Linda Bennett: Hi, thank you so much. Linda Bennett, ASFE. I wanted to ask the Medicaid directors, and thank you for coming and sharing your views, how you are foreseeing with SCHIP reauthorization issues for you. I know you mentioned that wonderful policy level that we did advocate for very strongly in the Affordable Care Act of boosting primary care payments and that is going to be ending unless Congress acts, and how you've been engaging in that effort to either extend those dealing with SCHIP reauthorization.

Darin J. Gordon: Let's do the reimbursement rate going away. In that regard, I'm sorry, that's what I thought you were saying, but in that regard I think the survey really touched on that some states are going to approach that differently. In our state, we're not in a situation where we can sustain that without the continuation of that funding and I think there's a mix across the country with regards to different states in how they're going to approach that.

With regards to the SCHIP reauthorization, we've had a lot of discussion amongst Medicaid directors in this regard. I think, and I've seen it all across the board, from our

perspective I think there needs to be discussion about how does SCHIP look in the new world. Now, with the qualified health plans and Medicaid how it's currently structured, does SCHIP dovetail well with the expansion of government programs. Now, that doesn't mean you don't cover, it's how does that fit, how does it interact? We have multiple government programs, and as we talked about like in the case of the duals, they don't always integrate very well or communicate very well, and people's families don't divide up very well or they do divide up.

In that case, they don't stay together when you look at all these programs, so I think there needs to a continuation of that funding, but I do think during that time there needs to be discussion about how do all these fit together and see where that policy discussion takes us. I've heard states also talk about, with regards to maintenance of effort, and that expires in 2019, so there's a lot of different things that people have to look at if they want to do something differently with SCHIP, but I think the discussion's worth having.

Vern K. Smith, Ph.D: On the primary care rate increase, maintaining it, again, I mentioned this. About roughly a third of the states said that they would continue it in full or in part. About a third said they definitely had made a decision with their legislature not to, and the other third really were saying let's wait and see because we'd love

to continue it if the federal government would maintain the 100-percent matching for the increase.

Diane Rowland, Sc.D: Question back here.

Debra Lipson: Good morning, my name is Debra Lipson with Mathematical Policy Research. Thank you all for your comments. It was very instructive and insightful. I want to pick up on the long-term services and supports reforms comments that were made. I know, obviously, Tennessee and Delaware are moving more in the direction of MLTSS, Cindi and Virginia, you're focusing more on the duals, and Connecticut you've got some marvelous initiatives there.

I remain frustrated and I know, I was just on the phone yesterday with another state Medicaid official, a veteran. We've been trying to resolve the issue of quality measures for this population in HCBS. As we move into more accountable systems for long-term care delivery, what kinds of domain strategies, measures, are you using to hold those plans accountable for quality and the degree to which they're meeting your person-centered goals?

Cindi B. Jones: Obviously, quality measures are paramount to checking the outcomes, but I think over 100 quality measures that we have in the dual program is overkill, and it seems like we've been dealing with this long enough that we should know and be able to agree to a definite set of quality measures that make sense and that recognizes the

person-centered focus of long-terms supports. Keep working and we'll get there.

Darin J. Gordon: I would just add I think the reason why we've been working at it for a long time is it's challenging, and trying to figure out what the right quality measures are, I agree with Cindi. It's funny. Every time we have a conversation with the folks about what kind of quality things should we report on, there's some people who are like everything, and then when you think about that and the ability for providers to sustain it, you got to balance that out. I don't think anything's bubbled to the top beyond survey data, which is not necessarily, I think, the place that we should strive for. I think we need to go beyond that, but there are areas we've seen, for example, some of our payment delivery system reform that we're looking at. When you think of folks that are on respirators and trying to think about is there a way to look at providers that are weaning folks off of those as opposed to just having people warehoused on that, and we've seen that historically. We're trying to sit there and incentivize and measure your ability to actually effectively wean people off of that. You can look at very specific areas and see where you can measure the quality and performance of that provider, but it gets hard when you look over the broader system. I'd tell you there's a lot of interest there, including by law the national quality agencies, and I think

their focus will help in the rigor for which they've constructed other quality measures, I think, will bring a lot to the table.

Diane Rowland, Sc.D: We'll go to the back of the room. Next question.

Brenda McLaughlin: Hi, my name's Brenda McLaughlin. I'm with inVentiv Health. One of the items that we haven't discussed today is pharmacy benefits. Could you please describe some of your state's innovations, and given the fact that you're now faced with some of the specialty drug costs, and I hear the goals of improved delivery and improved quality and outcomes and cost containment, what are your cost containment strategies in pharmacy?

Cindi B. Jones: I hate to use the word cost containment when I'm dealing with pharmacy. Obviously, the focus is on quality and making sure that our clients get what they need, but then again, after you look at the quality and you answer that question you have to answer the question about how much it costs. In Virginia, especially for Sovaldi, which is the drug of the day to talk about, we have through our preferred drug list for our fee-for-service clients, we have developed a prior authorization system just to try to make sure, and in some ways some people might say it's a step system just to try to make sure that we're utilizing the best drugs for the clients. In managed care, I have six managed care

plans that are doing something a little bit different, but we have developed a reinsurance program for our managed care for sometimes a client or some drugs that may be too expensive.

Darin J. Gordon: I agree with Cindi's comment. We used to have a run-away pharmacy program. It was growing at 25 to 30-percent a year every year, but that was over 10 years ago and since then we average closer to 1-percent trend in that particular area. It's constant vigilance in that area in regards to working with your pharmacy and therapeutics committee and make sure you're staying on top of what drugs are in the pipeline, making sure you're looking at evidence and having the discussion about effectiveness of various drugs. I think, again, the evolution of the specialty drug market is really creating a different challenge and I don't think anybody has figured out the right answer for that, but, by and large, I think the states have done a pretty effective just at managing pharmacy. Specialty is the one we're all trying to figure out, but that's not unique to Medicaid. That's been an issue in the commercial world as well. There's limited levers that you have in that regard, so more to come there.

Kate McEvoy: In addition, I think all of us are using utilization tools of the type that have been described, but I think the other piece that's very important for all of us is medication therapy management protocols, using those in conjunction with our health home efforts, especially for

behavioral health drugs, critically examining use of behavioral health medications for children. Many states have initiatives to track and limit the use of those drugs. Also through the dual demonstration we'll be using MTM as a dual demonstration strategy, and I think they are definitely untapped opportunities to support individuals who have a broad range of prescription drugs that have not been fully utilized yet.

Frank Rider: Frank Rider, from the American Institutes for Research, and I'll ask this question of maybe Vern and one or two of the state directors. Steve, you mentioned social determinants of health and leveraging new partnerships, and thinking about the people that Medicaid serves are often multi-stressed individuals or families. I'm interested in what additional federal leadership, guidance, incentives, or assistance for coordination among federal programs like HUD, Department of Labor programs, education, and even within Health and Human Services thinking about child welfare populations do you think are possible and at the state level would you find helpful to support those partnership efforts?

Steve Groff: Wow, that was a question. Yes, let me talk to the state level first, because I think there are many things that we can do and I'm very fortunate to be in a state where, first of all, many of the service agencies are under a single umbrella agency, so we have an opportunity to collaborate a little closer but also where we can bring the key

stakeholders from across the state very easily, which we do now, quite frankly. We can all get in a room and we can talk and what we're finding is that these are very multi-variant, multidisciplinary issues. We have to work together to find commonsense types of solutions that just don't fit into the structure of federal agencies or federal funding streams or federal regulations, so yes, could we use more flexibility at the federal level? Absolutely. Housing, critical issue. Nutrition, food benefits, food deserts; issue. We're looking at focusing on areas where we're seeing particular health problems, neighborhoods at risk, so what are the issues associated with that neighborhood and what are the resources available in that neighbor or close to that neighborhood that we can bring together. It's going to take some time and as far as what my recommendations are would be from federal agencies or whatever, I think we just need to continue to look for areas where we can be more flexible and we can be more innovative because the solutions are probably easier than we think they are and in the long run less expensive.

Vern K. Smith, Ph.D: I might just jump in a little bit. I don't know how to respond about the federal level, but from the mountain top from which I sit I see the states and what I see is a kind of thing that Steve described. You don't have to be a small state like Delaware even to have this kind of focus. One of the things that we have observed over the

years, I was thinking about this when Kate was talking about medication therapy management, states are so much more sophisticated now in the way they are managing their Medicaid programs. A decade ago, eight or 10 years ago, in the pharmacy area it was all about developing a preferred drug list and prior authorization. Now, it's a much more targeted, sophisticated approach to pharmacy management than it was then. The same now in terms of looking at the role of Medicaid, and Steve had mentioned the social determinates of health. Population health is a focus among Medicaid programs and it's not just narrowly looking at what Medicaid can do but across the whole spectrum, across behavioral health and long-term care. The full integration looking even at the non-medical aspects that affect healthcare, the focus is on outcomes and health. That's a big change from a decade ago.

Gary Jacobs: Hi, Gary Jacobs, Pricewaterhouse. Question has almost been asked by other people, but three items that just come to top of mind when we talk about this in our clients' states as well as individuals trying to implement this at the state level, but behavioral health, specialty drugs, and long-term care, that seems to be the focus of the problems and the challenges and what we're trying to solve for as well. What I'm thinking about is if you're a managed care state and you're saying now we're going to provide a capitation for long-term care, let's say, the role of the providers in that is a

challenge for many of the health plans who've never done this before. What are some of the tools and what are some of the levels that you all can start utilizing from the state level to motivate behavioral change in the system to get towards the realization of what I think we can all envision, but to me vision without execution in hallucination, and the objective here is to figure out how to execute both from the state perspective and from a plan and provider perspective. What do you think?

Darin J. Gordon: I'll say something, start us off on that particular point. I've had a lot of discussions over the years since we integrated behavioral health, as a good example, but the same holds true with managed long-term services and supports. First of all, you need to know what you expect and what you're looking to happen, but if you are, when we talked about trying to make our systems that we design, these very complex, large systems, easier for the consumer you also have to think about your other customers which are your providers and have I made the system, have I structured it in a way that can help them to be as successful as they want to be. When you have, let's say, a PCP with an individual who has behavioral health issues and you have a separate behavioral health organization or a separate entity that deals with behavioral health and they don't know who that is, that's a problem. From our perspective, if you think about it, if we can structure the

macro system in a way that enables the micro system to move in the direction you wish it to go, you have to deal with that first. When you do that what we've seen, and it came up in the question about looking at all the situation of the populations that we serve, it's very different in different locales.

If I came up with a solution on behavioral health and I told all of my behavioral health providers, so it should be done; it's going to be integrated at the clinical level and you shall do it, if they haven't bought in and structured that in a way that's right for them, we're not going to see the optimal outcome. It's going to be done begrudgingly, it's not going to be done well. Instead, set up a system that allows that variability to play out. Johnson City in northeast Tennessee is closer to Canada than it is to Memphis. Very different challenges in each of those communities, so set up a structure that allows that creativity, and what we've seen in that, and I think this is where we always have to have this balance, what we seen is we see community and mental health centers bring in an RN into their practice and build a whole system around that. We've seen PCPs bringing a behaviorist into their clinics, but they're doing that as we have our plans out there helping them see that you don't have to figure out this maze up top. There's one entity that you work for, for this person and we're here to help you, whatever the needs for that person is. We have to keep that in front of mind, but you can't sit there and

start on the provider side if you don't make the system easier for which the provider to operate in and to be successful in.

Kate McEvoy: I think the question raised is hugely important, when we look at serving individuals with a range of disabilities, I think it's very important for us to look at history to show what were the barriers, what were the failure points that largely resulted in those individuals being institutionalized without meaningful opportunities. We have a lot of tools now. Not just one example, but the money-follows-the-person demonstration has afforded significant flexibility to explore through use of new demonstration serves, partnerships with entities that are able to support us with housing subsidies, the need for accessible, affordable housing as a companion piece and a new examination of Medicaid of how we marry our coverage up with supportive housing and really tailoring the services to prevent those intercept points. Those points at which those people became disenfranchised from formal supports and had only really the institutions for informal supports in which to rely, and I think that's where you see the federal demonstrations giving us a very significant opportunity. Really the next stage is how do we build that into the structure of Medicaid coverage ongoing.

Phil Galewitz: Hi, Phil Galewitz, Kaiser Health News. Most of you, except for Kate, talk about the wonders of managed care and becoming more sophisticated and how you're trying to

push managed care to do better, basically, better quality, improve cost. Can you talk about the access issues? The Inspector General's report, which Darin referred to, talked about how most states including everybody up here did not have any violations against managed care for access. Does that say there are no access issue? Does that say you're not enforcing access standards? Also, the corollary to that is for new Medicaid patients today, what's their access like, particularly to specialists?

Darin J. Gordon: I think it's going to vary state by state, but when you look at what are the ways that you look at and measure access, and that particular study actually looked quite myopically. As you hear, as we talk all day today, whether it's program design or how we look at the services for individuals, this breaking away of these silos, so if I were to look at just my provider network group and so that's the only indicator to me about access then I would miss some significant areas for which I can look to, to say are my members getting the services they need. One of those significant areas that they miss is looking at appeals and whether or not people are appealing their inability to get the services that we need neurodegeneration we look at that quite regularly. Our networks, I don't know if our plans would say this is a good thing for us, but we have many provisions in our contract that are tied to penalties or liquidated damages and that's, again,

learning over the years, and so we have for if they've had an access issue. Most of our access issues are typically, contrary to the general perception, have been certain specialists where there's no other specialist in that entire area. That has been a phenomenon not just in the Medicaid side, and our plans have experienced both on the commercial and the medical side and they tell you in that same community that's an issue and a challenge for them on the commercial side. I think what I took from that study is there's a wide array of things that states do to look at networks and network adequacy and whether or not people do have access and whether or not we're all leveraging the best in class. There's probably more effort that can be done there, states are at different areas there, but I would tell you every state, I remember hearing this 10 years ago someone said I know when there's an access problem my phone rings, so it's not as if we're sitting there in the state and we have all these different ways to be able to look at the system that we can't be reached if people can't get services. Also, in the case of where we have managed care, our plans are held accountable for making sure that person gets the service for which they need and based on our data that has been effective.

Steve Groff: I would just like to add a thank you to Darin because I believe our new contracts borrow some of your sanctions, because our existing contracts actually do not have

very strong enforcement measures which doesn't mean that we aren't monitoring and that we're not confident that for the most part network adequacy is okay. Even though we are putting in these penalties and these provisions, it's really not my desire to have to use them. I don't think that that shows success. What I would rather do is continue to do what I'm doing now with my managed care plans, which is when we do identify these, primarily I would agree isolated events or areas, pockets, with specialty care, is to work with them and find solutions. What I would prefer is for the members to get the services they need, not for me to collect penalties.

Robert Pear: Robert Pear, *New York Times*. For the states that make extensive use of managed care, what is it like to have nursing homes in managed care and what has your experience been? How feasible is that, and those of you who are just moving to it what are the challenges in developing the specifications?

Darin J. Gordon: It goes back to what I had said earlier. If you know what you're expecting the health plans to do then they have a better chance of meeting your expectations. I can't say we've always done a good job of that. You sometimes leave too much to the imagination, but we had really good success in moving our long-term service and supports into managed care and we continue to build on that. I think, if you look at it from our context, we were a state that had some of

the lowest home and community-based services penetration out of any of the states. I think we were about 17-percent of our services were provided in the home and community-based setting. Through the structure that we put in place, the managed long-term services and supports and working with our health plans and setting forth our expectations ensuring that people have access and can make a choice to stay in the most cost-effective appropriate setting for them, in just one year that increased to 35-percent in the community, so it went from 17-percent to 35-percent in a single year. It's making sure the nursing homes are there for those who are most in need. I think there is a continuum and we didn't have a system that necessarily ensured that when people are transitioning out of a hospital setting. It was almost default to go into a nursing home and that isn't always the most appropriate setting. I think there are some opportunities there as you interact with the Medicare program to try and again address some of those issues the way the system's designed and whether or not it's handling it appropriates, but I think moving long-term service and supports into managed care was a logical step for us. One entity is responsible for the physical/behavioral health and long-term service and support needs of our populations and those needs, some would like to think they're bright lines, they're very gray and so don't make someone else try to figure that out as

they have a need for a loved one, but instead design a system that can react regardless of what the need is.

Cindi B. Jones: I just wanted to say, first of all, all managed care plans can't handle long-term care or long-term support, so you have to, when you're putting out your RFP, you have to be very careful when you're asking for it. Managed care for the regular Medicaid population's been there for a long time and this is a new entity. I would say that nursing homes are tough, especially in a dual project because you're not only managing their Medicaid, now you're going to start managing their Medicare, which is their bread and butter, and they've said that enough that the feds listened and said well if it's your bread and butter then we're going to take some of that away from you.

It hasn't been easy in Virginia. We do have some best practices for nursing homes. One of the recommendations is you've got to have your governor and your legislature agreeing with this including nursing homes or they'll be constantly be knocking at their doors trying to stop it, but we also have spent an inordinate amount of time with the nursing homes to make sure that their concerns and their needs have been addressed. The association's working with us, but they don't like how much we pay them but at least we pay them on time, so that was one of their main concerns in trying to make sure we don't interrupt or cause any problems with their licensure. It

has not been easy. We started this year. They're playing along with us because they know it's for the greater good, but it's definitely been tough.

Gary Radke: I'm Gary Radke with Anthem. Question is we talked a lot about quality and how important it is. We also had a question about coming to the right measures, but a big challenge is taking disparate data from a lot different groups whether it's home and community-based providers all the way up to health systems all the way up to MCOs and integrating that. Two questions. One is how are the states working to help make that process better and make that data better across your different stakeholders, and two, in this stage in the game how does ICD-10 play into your planning process for quality?

Kate McEvoy: Good question. We in Connecticut now have the benefit of a fully integrated claims set across all of our Medicaid coverage groups and all claims data. That's one of the legacies of converting from the use of mixed managed care and managed fee-for-service arrangement, so that has enabled much better use of that data for policy making and also for predicted modeling, but we've also been able to share data with our person-centered medical home practices. We're negotiating right now to do the same for our hospitals and correspondingly we're seeking real-time ED data sharing from them, so I think what you said is true. It's very important to try to synthesize that and through whatever means. We're

fortunate to been able to do it through our arrangement, but I know other states have other strategies.

Darin J. Gordon: From an encounter perspective in claims, that's, I think, the easier step and I think the way I interpret your question is really getting to some of the clinical data that's out there which I think through some of the health information exchanges that folks are trying to figure out, is there an easier delivery mechanism for that so that it can be pulled together and [inaudible 01:22:58] or added to the file. I think as you look at some of the payment delivery system reforms, because they're not just on the payment side, there's a quality component and trying to learn from the mistakes of the past, I know there are a lot of discussions about how can we incorporate other clinical measures in that.

I think most are starting out with the claims-based measures because it's easier, but I think as HIE advances and evolves and it has continued to evolve, I think you'll look at one key component will be how can providers provide some additional clinical quality measures that can be added to give us a full complement, a full perspective, of the quality of care that that individual receives and I don't think we're there yet. It goes back to what I said. Every call that I've sat in on people talk about adding different quality measures, and yes you have some folks just say add it all. You got to

think about whether or not you have a way to collect that. You got to think about the burden on the physician and is this something they can easily do or is that going to disrupt their workflows, so it's complicated but I think it's on the front of mind for everyone.

I will say ICD-10, I think, I was looking in the advancements and how you get that information and the benefits that are going to come from ICD-10, I think, more folks are looking at just making sure ICD-10 gets stood up at this point, then they are looking at what we'll do with it after we get it. We're trying to keep our eye on the ball at this point.

Patrick Willard: Hi. I'm Patrick Willard with Families USA and I guess my question is basically for Darin and for Cindi, and the question is what's it going to take for a state in the south to expand Medicaid? Darin mentioned the fact that you have to work with the feds as well as with the legislature, and it seems pretty clear that we're going to be looking at waivers for every state that is going to expand Medicaid going forward, the 24 states that are left. I guess the question is how much flexibility are states going to demand and what is the endgame there and then how long do you think it's going to take before we actually have all the states? Thanks.

Diane Rowland, Sc.D: Just an easy question.

Darin J. Gordon: I won't venture to guess how long it will take other states to expand, but I do think it is complicated and it's based on each state's dynamics. In our particular case, we do have the history of the expansion, which I know you're very well aware of, in which case that creates a different dynamic for our state. There was the most progressive expansion in Medicaid the country's every seen back in 1994 and, unfortunately, we were unable to sustain that. Unfortunately, that memory's very fresh; or maybe, fortunately, that memory's fresh in everyone's mind, and so trying to figure out how can we learn from that history and design an approach that will put us in a better position and give other folks comfort that we won't be repeating that same experience.

How do you get there? As I've told folks, in designing a plan that CMS will definitely approve, I know I can do that. Designing a plan that has a chance at getting a sufficient amount of votes and passage in our general assembly, I could probably tell you what that is. They're just two very different things. The governor, as we had that conversation and said, you figure out how to go right in the middle of that, so it's the harder path to take is trying to figure out how to structure something that can address a multitude of issues and perspectives. It's not an easy process. We start on this March of 2013 and we also had a lot of other things going on with regards to January 1 implementation of some of the

enrollment changes. I would have to tell you that I do think there's other conversations that are ongoing. I do think if you look at the states that have done something, if you look at the most recent states, moving your way back, there's some common themes. I suspect some of those themes will continue for some other states, but it is a process and each state's history and their dynamics are going to play into that and so it's hard to guess when others will end up coming into the expansion.

Cindi B. Jones: My whole biz even with Medicaid, everybody didn't take it out of the gate, and even with SCHIP, everybody didn't take it out of the gate, so I'm hoping history will repeat itself at some point and Virginia will take it on. I think it's going to cause the fiscal pressures, especially as the DISH decreases with our public hospitals and coming up with that amount of money might be the final thing that pushes in a couple years.

The governor has given four different plans to the general assembly, including one that was promoted by the senate. Every time we talk about wonder if they'll accept it if it looks like this or accept it if it looks like this, then we hit our self on the head and go, okay, we keep forgetting it's just politics and that's what it is at this point. After whatever election it is that people are scared of is over, maybe they'll consider it. The governor spends every waking

hour trying to figure out how to make this happen and right now his hands have been tied.

Female Speaker: We have one more question back here.

Dick Merritt: My name's Dick Merritt and it's a followup to this question here about expansion. You said that other conversations are probably going on about this. I live just across the river in the city of Alexandria in a state that is a Medicaid non-expansion state, and we're working with the mayor of the city of Alexandria in terms of a plan that can bring attention at the local level, really, to the needs of the low income and uninsured in our city to help close the coverage gap for that population and increase access for those individuals. My question relates to that. Are you aware of any examples in the non-expansion states of local initiatives that bring public/private resources together in terms of attention to the needs of that low-income, uninsured population, and try to improve access for those populations? Are there any examples, any contemplation, any conversations going on at local levels about this that you're aware of?

Cindi B. Jones: I just want to say obviously across Virginia there's some communities that have done some wonderful things at the local level and the Virginia Center for Health Innovation is a group that's trying to highlight those, but I just want to put out a figure though. If we expanded with 50-percent match, not getting our full 100-percent match, which

the general assembly asked us how much that would cost, that would $600 million general funds over two years. We can't bring very much general funds into this project. The governor has committed to bringing in some money for seriously mentally ill, which will be a statewide process which will take some of your uninsured clients and allow them have a targeted benefit package, so that's the best we can do at the local level. There's a lot, since you're in Virginia, like the Williamsburg Foundation is a good example of localities that have come together. It's trying to do what they can for the uninsured, but there are a million uninsured and their needs are pretty complex, especially with behavioral health, so it is a difficult challenge without the state and federate dollars.

Darin J. Gordon: I'd tell you and it kind of relates to something Cindi said a little while ago. Actually, in every urban area in our state there has been different systems that have come together—folks in the community come together and have been serving this population for some time. I think that one of the things that is going to change with all of that, these systems, typically driven by these hospital systems and how they set up some of these programs for the uninsured, are going to continue to feel financial stress and some of the Medicare cuts are coming into play, but also some state budget pressures that come into play that also put some financial pressure on them. I think those dynamics are going to change

some of those supports that were there before, and I would assume that that's likely going to continue to shed some light on as things shift, some of the supports that were there aren't going to be there and it may just shine a brighter light on some of the needs of that low income, uninsured population.

Diane Rowland, Sc.D: Over the 14 years that we've been doing this survey, we've gone from a Medicaid program that barely could make it onto the front page except if it was a potential fraud or abuse or other kind of issue to a central part of our healthcare system to a program that is both leading in terms of health delivery system reform, providing much more concerned care for those with severe disabilities, and especially the behavioral and mental health challenges.

I think this report that we've put out together with the National Association of Medicaid Directors really gives you a wealth of information about all the opportunities. Cindi called it a dictionary of policy choices and policy directions, but clearly we are in a new era and an era of change and I want to thank all of you for coming, but especially to thank again the Medicaid directors for their work on putting together this dictionary of what's going on. Really to Vern and his team and to Robin and our team and to everyone that is participating today, thank you for keeping Medicaid on the front burner.

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[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.