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Medicaid in a Time of Growth and Change: Findings from the Annual Kaiser 50-State Medicaid Budget Survey at a Forum with the National Association of Medicaid Directors
Kaiser Family Foundation
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DIANE ROWLAND, Sc.D.: Good morning, everyone. I'm Diane Rowland, the Executive Vice-President of the Kaiser Family Foundation and the Executive Director of our Commission on Medicaid and the Uninsured. We're delighted to be having this discussion today, Medicaid in a Time of Growth and Change, and I think the reports you're going to hear about will really document the many changes underway.

This is our 15th annual survey tracking Medicaid policy, so we've been watching and monitoring this for a very long time. We do focus on the whole program. This is not just about whether a state has expanded or not expanded Medicaid. We think the Medicaid program plays a far larger role than just the expansion decisions that are going on. It's a very dynamic program, and obviously takes care of millions of the neediest and many of the sickest of our American population.

Today we really are pleased to be able to thank once again NAMD and all of the Medicaid directors and their staff for their tremendous help in putting together this comprehensive review of the Medicaid program, and we're going to be highlighting just a few of the findings. The reports in your package will give you far more detail on the many changes underway in the Medicaid program.

The way we're going to handle the session today is we're going to start by sharing some of the key findings from

the survey. In your packet, you should have three reports. The first is on Medicaid enrollment and spending growth and highlights the national trends in state Medicaid enrollment and spending, and does provide some description of the differences between the expansion and non-expansion states.

We also have included three case studies, have taken an in-depth look at Alaska, California and Tennessee, just to give you a broader fabric of some of the changes underway in a few of the states.

The main document, and one that we will be discussing, is the Medicaid Reforms to Expand Coverage, Control Costs and Improve Care, which we have done jointly, releasing today with NAMD. That provides the most detailed look at the policy and program changes in Medicaid programs in all 50 of the states, and we are delighted that it always has included all 50 states. I think it's, perhaps, the only real comprehensive review we have of total policies across the nation.

We're going to start the first panel with Robin Rudowitz, the Associate Director of the Kaiser Commission on Medicaid and the Uninsured, and Vern Smith, the Managing Principal at Health Management Associates, providing some of the key findings from the survey itself.

Then we're going to turn to Tom Betlach, the President of the NAMD Executive Board and the Director of the Arizona Health Care Cost Containment System to do some interviews and

questions and moderate a discussion with two of the Medicaid Directors we have with us today, Justin Senior, the Deputy Secretary from Medicaid for the State of Florida and the Agency for Health Care Administration, and Gretchen Hammer, the Medicaid Director for the State of Colorado and the Department of Health Care Policy and Financing, so that we can give you some even greater insights into what's going on in some of the three states that are represented here today.

Following that, we'll give you a chance to ask questions to all of us. Without further ado, I'm going to ask Robin to begin the discussion by highlighting some of our survey findings.

ROBIN RUDOWITZ: Good morning everyone, and thanks, Diane and everyone to coming to this briefing. I wanted to echo Diane's thank-yous to NAMD, as well as all the Medicaid Directors for participating in the survey.

I also want to acknowledge all the people that helped with these reports as well as the event, including many of my colleagues here at the Kaiser Family Foundation, and, of course, our co-authors at Health Management Associates. It is a really big team effort to pull all of these reports out, and I wanted to give a special shout-out to Laura Snyder and Libby Hinton here at Kaiser for their great attention to many details.

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As Diane mentioned, today we're releasing three reports from the findings – that draw from the findings from our 15th Annual Survey of the Medicaid Directors. We are in the field in July and August of 2015, and this is generally when most states are finishing one fiscal year, state fiscal year, and starting the next. The survey is really two parts. We have an online or written component of the survey, as well as an interview with all of the Medicaid directors. Each year we ask some of the same questions that enable us to do some trend data, but we also adjust the survey to add new questions so we can capture some of the emerging policy issues.

I will start with some of the findings from the enrollment and spending report and then turn it over to Vern. We know that Medicaid enrollment and spending growth are driven by changes both in the economy as well as policy. In this figure, we see clearly that Medicaid enrollment and spending has peaked during the last two economic downturns.

Medicaid, of course, is a counter-cyclical program, so during downturns when people lose income, more people qualify and enroll in the program, and this increased enrollment tends to drive increases in spending.

More recently, the economy has been improving, but starting in 2014, we're really seeing the effects of the Affordable Care Act. The major coverage provisions of the ACA went into effect in January 1, 2014. That was partway or

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halfway through most state fiscal years, so what we're seeing in 2015 is really the first full year effect of the ACA implementation for states. We see another peak in enrollment and spending at about 14-percent across all states.

Under the traditional Medicaid program, financing is shared across the states and the federal government. The formula is in the law, and it relies on states per capita income, so under the formula, poorer states get a higher federal match rate. This formula is updated annually.

In this figure, we see that state spending and total spending often grow in tandem over time, so when state spending increases, we see increases in federal dollars, and, therefore, increases in state spending. However, there've been a few times over the last ten to fifteen years where we've seen a divergence in these trends.

The biggest example is in 2009 and '10 as a result of the temporary fiscal relief under ARRA when there was additional federal support, we saw an increase in total spending, but a decline in state spending. When we look at 2014 and '15, we see again a divergence in these trend lines, and that's a result of the enhanced match of the ACA.

Under the ACA, the federal government will pay 100-percent of the costs for those who are made newly eligible for coverage. As a result of that increase in federal dollars,

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we're seeing increases in total spending that exceed increases in state spending.

The last two slides really looked at enrollment and spending across all states, but, of course, we know that there's wide variance in what's happening across expansion and non-expansion states. This map shows that as of today, 31 states have adopted the Medicaid expansion, including DC.

When we look at the data from 2015, there were 29 states that have expanded Medicaid, so it's the 31 minus Alaska and Montana that have adopted the expansion for 2016. What we see here is that enrollment and spending growth in the expansion states far exceeds what's happening in the non-expansion states. We also see clearly the effect of that federal match rate.

For expansion states, we see total spending that grew at 17.7-percent in 2015, but much, much lower growth in state spending at 3.4-percent. When we look at the non-expansion states, we see that enrollment and spending growth is much more aligned across – across the categories, and we don't see that big variance between total spending and state spending, because the non-expansion states don't have access to that enhanced federal match from the ACA.

For 2016 across all the states who are seeing slowing in enrollment and spending growth, and we're also seeing a narrowing in that variance between expansion and non-expansion

states as the major effects of the ACA were experienced by most states in 2015.

That was my short summary of the enrollment and spending trends, and I will turn it over to Vern to talk about the policy.

VERNON K. SMITH, Ph.D.: Well, thank you, Robin. This is an extraordinary time in Medicaid. Across all states, more people than ever now have Medicaid as their health coverage, and Medicaid programs are leading the way in delivery and payment system reforms that improve health and control costs.

My job now is to, as quickly as possible, describe the significant policy changes and initiatives occurring across the states in fiscal ’15 and ’16. First, I’m going to look at the traditional policy levers, eligibility, benefits, payment rates, and then the strategies and initiatives that states have – are implementing to improve care and control costs through payment and delivery system reforms. Finally, we’ll take a quick look at the priorities that Medicaid directors described for the next year and beyond.

We’ll start with eligibility. Beginning in 2014, as Robin said, the ACA brought the most significant eligibility change in the 50-year history of Medicaid, the Medicaid Expansion for Adults Without Children, and as Robin indicated, it’s now been adopted by 31 states.

The ACA expansions led to the single largest growth in the number of persons enrolled in the program, new health coverage for about 13 million Americans due partly to the expansions in the 31 states and also due to greater take-up among those who are already eligible across all 50 states.

Since 2014, almost all the changes in eligibility have been small but positive changes to streamline and simplify, such as, for example, ending the asset test for certain individuals with disabilities.

This year, for the second year in a row, no state restricted coverage for broad groups of individuals. Yes, there were a few states that curtailed coverage for certain limited benefit programs like family planning or breast and cervical cancer, but those individuals then gained access to more comprehensive coverage, or in the case of New York or Minnesota, transferred from Medicaid to a basic health plan.

Going on to benefits, last year just one state limited a benefit, actually, a utilization control that applied only to the expansion population. This year, just five states had very targeted benefit limitations actually reflecting the strength of the economies across the states.

On the other hand, over half of states, a total of 28, expanded benefits in some way in one of these two years, 24 states last year, 18 states this year. Interestingly, the most common benefit expansion occurring in half of the states that

had an expansion of benefits was for behavioral health service. The second most common was for long-term care service for waivers and home and community-based services, and other expansions were in dental services and telemedicine.

For provider payment rates, another indicator that state budgets are in better shapes these days, no states are now making across-the-board budget-driven cuts to Medicaid provider rates in fiscal ’16, something which we quite commonly saw only a few years ago during the economic downturn.

The rate adjustments for fiscal ‘15 and ’16, both increases and decreases tend to be those of a more routine and targeted nature. Something to be said on the hospital and nursing home bars on this chart. Historically, hospital rates and nursing home rates have typically included cost-of-living adjustments.

Our survey historically has classified rate freezes or no change in rates as a cut. That explains the large bars below the line there, but in actuality for hospitals, inpatient rates were reduced in only three states, last year five states, this year and for nursing homes, just one state reduced a rate last year, and four states doing so this year.

What’s noteworthy when you look at this is that the number of states actually increasing nursing home rates this year dropped from 37 last year to 29.

For health plans, managed care organizations, Medicaid programs increased the capitation rates for health plans three-fourths of the 39 states with risk-based managed care. Rates decreased in just one state this year, and five last year.

Now looking at some rates for ambulatory providers like doctors and dentists, very few states are cutting rates, and more than one in four states is increasing rates this year. States were required by the ACA to increase rates for primary care to Medicare levels for calendar years 2013 and 2014 and the ACA, the so-called primary care rate bump.

However, when the full federal funding for those services at that level ended at the end of 2014, only 19 states continued these rates into 2015 either fully or partially. For 2016, rate cuts for doctors and dentists are now a rarity. Only one state cut rates for doctors and no states cut rates for dentists this year.

Provider taxes. We've been tracking provider taxes now for over a decade. Going back all the way to 2003, for example, fewer than half the states, 21 states even had a provider tax in place at that time, and over the past decade virtually every state has added taxes or fees to help finance their Medicaid program.

Now only one state, Alaska, has no provider tax, and two-thirds of the states have three or more. This is a

significant change in the way the program is financed over the last decade.

Turning now to Medicaid payment and delivery system reforms, and first to managed care, which is clearly now the predominant delivery system across Medicaid, here's how things stand. All states except three have some form of comprehensive managed care now, and even those three states, Alaska, Wyoming and Connecticut, have policies in place to coordinate care.

The 39 states that contract with capitated risk-based managed care, well, there are 39 states that have kept a risk-based managed care. Nineteen states have a primary care case management system. It wasn't that long ago when there was many PCCMs as there were MCOs with those approaches across the country, but the trend has definitely been toward reliance on MCOs.

Five more states ended their PCCM programs in 2015 or '16, bringing the total of states with PCCMs down to 19. One of those states was Florida. Maybe Justin will say something about that later.

We had a question this year that looked at MCO penetration rates by eligibility category. What we have seen is that states continue to expand their reliance on MCOs through going from regional to statewide, from voluntary to mandatory, from families and children only to elderly and disabled, by ending carve-outs, by adding more benefits like

pharmacy, dental, behavioral health and long-term care into the MCO coverage.

The result is a significantly larger role for MCOs across all Medicaid eligibility groups. In 21 of the 39 states with capitated risk-based managed care now, over three-fourths of beneficiaries across all categories are enrolled in a managed care. Twenty-one states is up from 16 that we reported last year.

It also was quite common, not that long ago, for states to exclude from MCO enrollment beneficiaries who were elderly or disabled. Now, only six states exclude elderly and disabled from MCOs. In 21 states, over half of the elderly and disabled are in MCOs.

States continue to implement new and more sophisticated managed care quality strategies. Over just the past two years, 31 different states have implemented new pay-for-performance arrangements, performance bonuses or penalties, new or higher withhold amounts that have to be earned back based on performance, new report cards to help beneficiaries choose a high-quality plan.

One state is explicitly requiring MCOs to address social determinants of health in improvements in population health. These are major advances in quality among the state Medicaid programs.

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At the same time, states are engaging in significant delivery system reforms. Over half the states, 28 this year, 27 last year, total of 37 states over the two years, implemented new or expanded delivery system reform initiatives.

These initiatives range from patient-centered medical homes to the health homes under Section 2703 of the ACA, dual-eligible initiatives, ACOs, payment reforms like episode of care, payment arrangements, major initiatives under DSRIP, the Delivery System Reform Incentive Payment Program. These are major, complex initiatives difficult to implement, but significant for the way they coordinate, integrate and improve outcomes across physical health, behavioral health, and long-term care.

Finally, it's – it is sometimes easy to overlook what states are doing in long-term services and supports, and we find that just about every state, 46 states this year and the same last year, continue to enhance their efforts to serve beneficiaries in a home or community setting and to be sure institutional nursing home care is used only when it is needed.

Looking ahead, what are the major issues and priorities of state Medicaid programs for 2016 and beyond? As we listen to Medicaid directors, these are the themes that we heard. First, there's still work to be done to complete implementation of the ACA, especially the new eligibility and enrollment systems and coordination with health insurance marketplace.

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Several directors mentioned specifically that one of their top priorities now is to help ensure health insurance coverage for all people in their state. Second, controlling the growth in cost is a perineal issue for Medicaid. State tax dollars are always scarce, even in times when the economy isn't in recession.

The focus on insuring the greatest possible value for state taxpayers is always a top priority. Many directors in this area specifically singled out their priority on controlling the escalating costs of specialty drugs.

Looking ahead, one of the upcoming issues in this area for those states that are implementing the ACA expansion, states are focusing on the challenge of finding the funds for the 5-percent share which will be a factor in their 2017 budget discussions which will begin in January.

Third, delivery system and payment reform initiatives are difficult to stand up, but they are clearly priorities discussed before to help because of the potential to improve health outcomes and make the system work better.

Fourth, there are a number of administrative priorities. States are focused on making their systems just work better. Many states are getting new Medicaid management information systems. They have other systems or information technology projects that they need to improve the program administration and to implement their reform initiatives.

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Finally, the vocabulary of Medicaid is changing. It now includes terms like the social determinants of health and population health. Medicaid is partnering with public health agencies and others to improve the quality of care, health outcomes and overall health status of their communities.

This is an extraordinary time for Medicaid. The program has an expanded role in the health care system in every state, and state Medicaid programs are focus on performance, value and improving health in a way never seen before in the 50-year history of the program.

Now I look forward to hearing the perspective of three Medicaid directors who we have here today. Thank you.

THOMAS J. BETLACH: Thank you so much. My name is Tom Betlach. I'm the Medicaid Director for the State of Arizona. I'd like to begin by thanking Diane with Kaiser for putting together this wonderful survey annually and for all the states that participate in that.

I thought we'd start with enrollment. I have to start with a phrase here, state Medicaid directors were remarkably accurate in projecting enrollment and spending for 2015. Now I have been forecasting in state government for, like, 20 years, and I've never been called remarkably accurate in my forecasts. I thought that would be a great place to start.

In Arizona, in fact, enrollment with the expansion and restoration has come in very close to what our overall

estimates were that we did back in the spring of 2013 when the issue was being debated at the legislature.

What's interesting to note, besides the fact that the forecasts were remarkably accurate, is not only have expansion states seen significant growth, but I think also the non-expansion states, which is highlight at the growth rate of 5.1 versus expansion rates at 13.8-percent, have seen growth as also.

I thought I'd turn it over to Justin to talk a little bit about your experience in Florida, and then we'll go to Gretchen in Colorado.

JUSTIN SENIOR: Sure. I will – I'll brag on our forecasters within our agency, because we actually, back in 2012, I feel remarkably accurately projected what the eligible but not enrolled population would be and what type of woodwork effect we would get from the Affordable Care Act and from the other factors that were going on in our program.

The exchanges in our state have had a remarkable response from the population. We've had more than a million people sign up on the exchanges on the federal level. When they go to the exchange, so many people try to sign up for health care and learn during that process that they are likely to be Medicaid-eligible, and they're turned over to our eligibility agency.

As there started to be a lot of coverage and a lot of awareness of these coverage opportunities, we were expecting that those people would eventually find their way to the Medicaid program who are Medicaid-eligible, and we'd have a reduction in the number of people out there in Florida at any given time who are eligible for Medicaid but not enrolled. Those people would find their way to enrollment.

We have projected about a quarter of a million people would do that, and that is roughly what has come to pass. We figured in 2012 that by 2016, '17, our program would have about 4.1 million in it, and that is actually what it looks like now to the forecasters projecting much closer to the fact.

The consequence of that is interesting because, ordinarily, as one of the slides showed, Medicaid is a counter-cyclical program. You see these spikes in enrollment when the economy takes a downturn, but we actually, even though our economy is going very well and we're running surpluses and the unemployment rate is continuously going down – and I think that's happening around the country to various extents as well – we're seeing this big uptick in enrollment and an uptick in the total cost of our program.

Even though the per-member-per-year, the per-member-per-month that we're paying in the Medicaid program is actually declining, that's still putting pressure on other budgetary priorities in the state. That is something that you always

have to think about. The two biggest things that a state does are education and health care at this point.

When you are spending money on health care, it does put pressure on the education budget. It does put pressure on some of the other priorities out there.

THOMAS J. BETLACH: Gretchen.

GRETCHEN HAMMER: Colorado has had remarkable success at changing the coverage landscape in our state. The recently released Colorado Health Access Survey, which is our ability to look more closely at some of the experiences of coverage and care for Coloradans, recently projected our current uninsured rate to be about 6.7-percent, which is about 353,000 individuals in Colorado.

That's down from a number of 14.3-percent. Much of that change in enrollment was due to changes in our state-based marketplace and through expansion of Medicaid enrollment. We had been on a long-term trajectory of changing eligibility in Colorado, making some state-based-initiated changes to our eligibility levels, and the expansion through the Affordable Care Act really added to that momentum.

We have been also close in our projections, although, again, I think all of us have been surprised and very pleased at the enrollment changes that we've seen. In particular, for children, who we had historically known many were eligible but not enrolled, the number of uninsured children is down to

anticipated 2.5-percent right now in the State of Colorado, which is a significant shift. That change of the landscape has been something we've been working on, and we hope managing well.

Our enrollment now in the state Medicaid program is about 1.2 million, and it was about 750,000 prior to the first open-enrollment period back in 2013. That expansion has been, to some extent, on track, but also, I think, a little faster than anticipated.

THOMAS J. BETLACH: Another interesting point that was brought up in the survey around the ACA and enrollment goes to the eligibility system changes. A heavy lift in all of our programs, regardless of whether or not expansion or not, and so if you want to touch just a little bit on that, I think probably a little over a year ago, we all were dealing with the sub-optimal consumer experience that was in place. A lot of progress has been made on the eligibility systems for us that interface with the federal marketplace, for our own eligibility systems.

One of the simplifications within the ACA was around the redetermination process. In Arizona in any given month, 30- to 40-percent of the members do not have to go back through a formal determination process because we're able to electronically match up with the resources to determine individuals are, indeed, Medicaid eligible. Do you want to

talk about your experiences as it relates to eligibility systems.

JUSTIN SENIOR: We actually had a fairly smooth roll-out with respect to our eligibility system. I think that our Department of Children and Families did an excellent job there. We were one of the first states to stop needing the flat files during the very first open enrollment period for Healthcare.gov. We didn't need them after about a couple of months.

I think that probably is one of the things that led to some of the eligible-but-not-enrolled population very seamlessly being able to get into our program, as well as probably some of the better outcomes maybe we were seeing in Florida around Healthcare.gov and Exchange signup, because we actually saw the extraordinary response to that very early on. We were the state, I think, that had the most sign-ups in the first and second year of the program, even more than California, frankly, and states that are larger than us and the most per capita.

GRETCHEN HAMMER: Colorado has a state-based marketplace, Connect for Health Colorado, and I think a suboptimal consumer experience is a nice way of saying – we certainly have been working to improve the consumer experience of looking to purchase coverage through the marketplace and determine one's eligibility for Medicaid. We look forward to

Open Enrollment Three. We think that the systems will be better than they have been in the past, and we continue to have the right kind of assistance network and infrastructure to support individuals to make appropriate choices about their coverage.

We also have been pleased to be on the forefront of some pieces of the technology. We have an app for our Medicaid program that allows individuals to manage some of their basic eligibility requirements around changes in address and those kinds of things. Our PEAK mobile app has been something that we're looking at to build on and to continue to improve ways that we interact with those who are served by Medicaid.

THOMAS J. BETLACH: There's a lot in the report dealing with the delivery system managed care, 39 states now leveraging managed care organizations, other states that depend upon other types of structures to help structure the care delivery system within their state.

I know Justin in Florida, you all have been doing a lot as it relates to changing your delivery system and levering MCOs. Do you want to spend a couple of minutes talking about that?

JUSTIN SENIOR: Yes, sure. Actually, as I was thinking about it, looking at that slide, so much of delivery system reform is connected to some of the other priorities when it comes to trying to control the budget, when it comes to your

own organization and systemic efficiency, even when it comes to population health.

In our state, we were running, a couple of years ago, really very large delivery systems side by side with one another. We had a primary care case management system, as Vern mentioned. We had managed care that was done in two different ways, depending on where you were geographically in the state, and we had a traditional fee for service system, any one of which they would have been a very large Medicaid program in and of their own right, given the populations they were serving.

We were running all of them side by side, and that put a lot of stress on our organization. When we shifted to statewide Medicaid managed care, we went to one delivery system. It is the managed care delivery system. That is the one that has become the predominant delivery system in the Medicaid program.

It really was an opportunity for cost savings and to drive down the per-member-per-month and the per-member-per-year, which we've had some success in doing. It also was an opportunity to get organizational efficiency. We wouldn't have to run all of these systems side-by-side.

We tried to design the system so that it was comprehensive. It includes behavioral health. We try to treat the whole person. It includes behavioral health. It includes pharmacy. That's a covered service. It includes

transportation. It includes dentistry. It includes all the things that are normally carved out that puts your teeth and your eyes and your brain in three different HMOs. We tried to make sure that you get –

THOMAS J. BETLACH: [inaudible 00:32:29].

JUSTIN SENIOR: Yes, exactly. Get everything into one coverage package and try to get a little bit better integration and think about the person as a whole. We also tried to design it so it incentivized people to engage in healthy behaviors and that the health plans that we use, they're empowered to reward individuals for getting to their primary care visits, for getting to their preventive visits and making sure that their – that we treat conditions as early as possible and as inexpensively as possible and reward that.

It has been a big shift for us. We serve more than 3 million people now in this particular model, and most of the people that are outside the model are dual eligible that receive their medical services primary through the Medicare program. Even when you see in the report that 79-percent of our population is in managed care, for the people that are really relying on Medicaid for their hospital services and their physician services, that's a significantly higher percentage than that.

As you move to the systems, the next thing, and the key for us, is to make sure that they're accountable, and one of

the frustrations is it takes a long time for data to roll in about these programs. What we've been doing and focusing on the last couple of years is really trying to defend the program from tweaks and changes from a legislative perspective so that we can actually figure out from a data front what is working and what's not working, and the changes that will be made to the program going forward will not be based on anecdotes, they'll not be based on lobbying, but to the greatest extent possible, they'll be based on information that we have about what's working and what's not working.

GRETCHEN HAMMER: Terrific. The delivery system in Colorado is an accountable care collaborative structure which uses the primary care case management structure, and it really has three core components. The first is primary care medical home. Colorado has been a leader in creating primary care medical homes for children and now for most of the population in the Medicaid program.

We also have regional care coordinating organizations, which the state of Colorado is a big state on the western side of the United States, and we have seven regions that we've broken it up, because the natural systems of care vary so greatly across our state that we need and want to honor regional variation. We have seven regional care coordinating organizations.

Then I think based on what Justin was just speaking of, the importance of data. We have a state data analytics contractor that provides a series of data analytics and reports to providers and to these regional entities so that they can better understand the needs of those who are in their communities and what kinds of interventions are going to be best to help people maximize their health.

The accountable care collaborative structure is the major delivery system. We do have a behavioral health organization structure for our behavioral health services, and those are coordinated closely at the local level. As we look forward to future delivery system innovation and reform, we'll be bringing those into administrative alignment in our next re-procurement. For now, these structures are working side by side in community to try and maximize Medicaid enrollees' health.

THOMAS J. BETLACH: One of the big changes going on in Medicaid as it's evolving is the population served. When you look at Medicaid traditionally, it provided coverage for kids, moms, the elderly, and now when I look at Arizona – and we've expanded. Fifty-percent of our population is age 19 to 64. I think Medicaid's done a great job in developing systems of care for newborns, when you look at programs around low-birth weight babies, for moms for prenatal care, for the elderly, home and

community-based services. We'll talk more about that in a minute.

I think, clearly, one of the great opportunities – and it's highlighted in the report – is around how do we deal with some of these new populations, looking at the social, economic determinants of health, looking at population health.

In Arizona, we're doing a lot on the justice system side, so we pay for 50-percent of the births, which in any given month is about 4,000 births. At any point in time over the course of the month, we have 10,000 individuals in an incarcerated setting in the Medicaid program, just dealing with the transitions coming in and out of the justice system.

I know we had one of our plans come to us the other day, and they have equity requirements where they have to keep money, basically on reserve for us. They asked if they could take a significant portion of that equity and put it into a loan program to provide housing for homeless individuals.

I think you see a lot going on within this space of social economic determinants of health, population health. We're spending a lot of time on behavioral health, physical health integration as part of that, and looking at ways to integrate across the system. For us, there's really three levels of integration. There's the provider level and looking to create an integrated system there. There's the payer level,

looking to have and braid the funding streams across all the different areas, as well as the policy level at the state.

That's sort of a long-winded way of laying out this issue, but if you could each touch a little bit upon what you're doing in your states.

JUSTIN SENIOR: As a state that hasn't engaged in the expansion, we still primarily focus on the health care needs of children and of pregnant women and of frail elders in terms of home and community-based services and long-term services and supports.

We serve about 4 million people in any given month, over 2 million of those are children. We pay for between 50-usually and 60-percent of the births in the state of Florida in any given year. Then we just provide premium and cost-sharing assistance for a high number, several hundred thousand Medicare beneficiaries, and about 100,000 frail elders in any given month are served in home and community-based settings. Usually, they're Medicare eligible and we're providing long-term services and supports to them.

At the same time, we do have some innovations directed at the adults that are eligible for our program, and one of the key features of our program as we've designed it going forward is something called a specialty plan.

We pay risk-adjusted rates in our program, so it's not a one-size-fits-all capitation payment. That's not unusual,

but that does allow us to allow plans that really cater specifically to certain populations. When it comes to adults, we have a specialty plan that caters specifically to individuals with significant mental illness, schizophrenia, bipolar disorder, major depression, and serves that population with a risk-adjusted rate for the population that they serve.

They have an enhanced benefit package that is – that is catered – that caters towards that population, and they have enhanced network adequacy requirements around psychiatrists and therapists and psychologists that also cater to that population. The care coordinators and their care coordination model specifically goes toward it as well.

We also have two plans in our state that cater toward the HIV/AIDS population. They are available, one or the other, in every part of the state except for the Jacksonville area, which was a feature of the competitive procurement where no one won there. That also serves primarily an adult population and gives a care coordination model that is specifically aligned to dealing with that population.

We are very hopeful, going forward, to learn more about that model. It takes time for these HEDIS scores to come in. They come in on a calendar-year basis, and we just got the HEDIS scores for 2014 over the summer, as everyone else did. You certified HEDIS auditors, these are quality scores. They

look at whether people were connected with care in the way that you'd expect.

In order to be counted in a HEDIS score, you have to have been in your plan for a full 12 months, and what we realized is, particularly behavioral health, is that we had pulled everybody out of the denominator, because they'd joined a new plan in the middle of 2014, so everyone with schizophrenia, everyone with a significant severe depression, they had been pulled out.

They certainly can choose some of the other plans, so we did capture some of them. About 40,000 people joined the plan around the state for the SMI population. We have 10 to 15,000 people in the HIV/AIDS population. We also have some specialty plans that cater to children that have attracted nearly 100,000 people. Specialty plans are a big feature.

There's always a debate in the Medicaid program about whether you carve something out or carve something in, and this is a very different approach in Florida, I think unique to Florida, but potentially something that other states are going to be looking at to see whether it works or not and to decide whether they are going to adopt it as the idea of rather than carving behavioral health out and serving the behavioral health needs of a person separately or in a separate delivery system, still having holistic delivery system, but having plans that

really cater what they're doing to that population and exclusively look to attract that population.

In our program, you generally have a choice of four or five health plans in any region of the state, but if we've identified and flagged you as having something like schizophrenia, a sixth choice pops up. You can choose one of the regular plans. They cover behavioral health services, but you also could choose, potentially, from a specialty plan that caters to folks that have your condition. That's one of the things that we're really going to be following closely, and potentially tweaking, to try to maximize and optimize.

THOMAS J. BETLACH: Okay. Gretchen.

GRETCHEN HAMMER: Terrific. For those of you who may know, my boss is a public health nurse by training, and so our focus is significant in this area because of her deep commitment to that line of work. One of the things that we've been really trying to understand as the population that we serve has changed is what are the typical life stages and what's the appropriate amount of care and intervention based on one's life stage? Really bringing that lens to our work has been very important.

I think we've all intuitively known, and data over the last number of years has begun to codify as real, the impact of one's lived experiences, one's life circumstances on one's

health. We're trying to do a couple of different things in this area.

First is really focusing on what prevention can be done in a clinical setting, so tobacco cessation. We're partnering with the Colorado Department of Public Health and Environment to better align tobacco cessation efforts between the clinical experiences and the public health messages that they're working to send and interventions that they're providing.

Diabetes self-management, immunizations, preventive oral health services, those are all things that add to one's health significantly, but still operate mostly in a clinical setting.

On the social determinant side, we have a strong partnership with Nurse Family Partners, which is an intervention for first-time mothers who have the opportunity to have a nurse visit them and to support them through that final months of pregnancy and into the first years of a child's life.

We are working on issues related to housing, other kinds of interventions that really are about those life circumstances that individuals have and that impact their health. The Colorado Health Access Survey, which I mentioned earlier, estimated that one in four individuals who are served by Medicaid have fair or poor health, and that compares to a little less than 1 in 20 of those with employer-sponsored coverage.

That, to some extent, makes sense, given the role that Medicaid plays in the coverage scheme of our nation, but it's significant and something we have to be very mindful of, of what are the base health levers that we can – we can continue to work on to improve people's health and increase their potential to be as healthy as they can be and to reach their potential in their communities.

THOMAS J. BETLACH: Last question from me, and then we'll turn it over to the audience to see what types of questions they have. It's an exhilarating but exhausting time to be in Medicaid. As you look forward over the next year, sort of what is that one thing that you're excited about in your program? For us, it's the continued merging of behavioral health and physical health.

We had a separate state agency that oversaw carve-out. They've been merged into the Medicaid program, and we're really excited about that capacity and, really, the ability to focus on the whole person and eliminating sort of that whole separate system for just behavioral health services. We see a lot of opportunities in bringing, not only those organizations together, but also continuing to look at integrating the delivery system in the state of Arizona.

Each of you, what are you excited about over the next year?

JUSTIN SENIOR: For us, it's really a matter of accountability. As we designed our program, we tried to make sure that the accountability measures that we selected – and we work with the federal government very closely on our 1115 waiver – we tried to make sure that we had a shared definition of success and that we had defined what success was in the program.

We used a lot of the core measures that they had suggested as core measures of quality for adult and child Medicaid populations. For us, now, we are in a position where we're just starting to collect that data, and we want to drive it out.

We have health plan report cards that we're going to do that we are going to be updating in the next couple of months and driving out there, and these scores are at least the first, a partial year of our program. It is – these are the first scores that our health plans have achieved, and we want people, as they come into our system, to really be able to get engaged as a consumer and to shop.

We want them – right now we know that they're shopping based on the networks that the health plans offer. The health plans actually offer slightly different service packages than one another, so they shop based on the service package. We want them shopping on quality as well, and we want someone who is coming into the program who's gained eligibility as a

pregnant woman to be able to see what the prenatal and postpartum care scores are for the plans that are available in her region, and we want her to make a selection based on that. That's really what we're excited about right now.

GRETCHEN HAMMER: I think for Colorado, one of the things that we're focused on specifically, and is a very tremendous opportunity, is the chance to be part of broader delivery system reform across the entire state. We have a highly collaborative multi-payer approach to things, and now that Medicaid serves nearly 1.2 million, or over 1.2 million people – there's only 5.2 million people in the entire state of Colorado. We're a significant purchaser, if you will, and have great relationships with the plans, the other plans, in the market.

Through our CPCI work, our State Innovation Model, which is a multi-payer approach to integrated care, really our opportunity is to see how we can shift the entire delivery system to get better value than what we're getting today and to make Colorado a healthier place to be.

It's a – it makes it particularly challenging. We have federal partners that we navigate as a Medicaid program, and then we've got our state-based partners as well. It's exciting, but it is hard work to move the entire system forward. The focus on integration, the focus on the social determinants of health really is the place where we think we'll

be continuing to move and continuing to ensure that the program that we're providing is meeting the needs of those who are newly insured by Medicaid.

DIANE ROWLAND, Sc.D.: Well, great. Thank you all. You know, I'm glad that Tom's last question was what are you excited about, not what are you depressed about. I think, though, that that really does summarize what's in this report. This is a very exciting time with a lot of innovation and change going on.

It's almost like we're seeing a new era for Medicaid, both with regard to the eligibility changes, delivery system changes, the focus on social determinants of health - more of a public health approach. The old Medicaid program was often viewed as a bill payer. It's clearly a much different program today, and it's really helping to drive some of the changes in our overall health care delivery system.

I think this report, we've only touched the very top of it in this discussion. Please look inside, see all the various changes going on in the many states. Now we will open it up to your questions. If you would raise your hand, we will get a mic to you, and then please identify yourself. If you have a particular person you want to direct a question to, do that as well.

STEVE CAVANAUGH: My name is Steve Cavanaugh. I'm an independent consultant. On the way over here, I looked at

something I haven't seen for a little while, which is *Medicaid Watch*, a monthly publication. This month's was 14 pages long, single-spaced, of changes in every state. It's not easy to tell whether the change that they talk about are sweeping that state's Medicaid or managed care programs. That has been something that has been in there over time.

The thing that jumps out at me is how different it is in a state with a Democratic governor and Democratic legislature versus a split governance. I don't expect surveys to capture the political realities, but there might be a possibility of saying something about programs in states with exchanges versus programs in states without exchanges?

THOMAS J. BETLACH: Well, I'll just start in terms of Arizona. Obviously a Republican state, made the decision to go to the federal marketplace, but also made the decision to expand and restore coverage in our state. I don't know specifically what you want us to talk about in terms of the state-based decision, but, obviously, when you look at some of the challenges, not only of standing up the Medicaid eligibility, but also some of the challenges states went through in establishing a state-based exchange, you know, I think that when we look at Arizona specifically, for us it was a good decision to go to the federal marketplace as the source.

People are doing a good job of helping to educate consumers out there what it means to have two eligibility

systems. The eligibility systems are doing a much better job of communicating. I don't know if there was more you wanted us to elaborate on, but that's sort of our experience in Arizona.

DIANE ROWLAND, Sc.D.: Okay. Question back here.

ELIYON [misspelled? 00:50:46] BELL: Hi. Good morning. My name is Eliyon [misspelled? 00:50:46] Bell. I'm with the Pew Charitable Trusts. I heard each of you talk about making data-driven decisions, and I wondered if you could speak to a collection of outcomes and quality data, particularly from Medicaid managed care plans as they're serving an increasingly larger portion of the Medicaid enrollees. Could you speak to your experience and intersection with the implementation of T-MSIS?

THOMAS J. BETLACH: Okay. On your eight-part question, let's see. Data-driven quality, particularly on MCOs, so we have about 70 different deliverables for managed-care organizations that speak to a variety of different quality aspects that they're reporting on. Not only do we do a lot of the back-end, HEDIS-encounter driven-type calculations, and we post all that on our website, but there's a lot of things that you might not consider a standard report.

We look at gaps-in-care and attendant-care services for home and community-based services, as one example, of some of the measures that we're collecting. Out of the millions of hours authorized every month, what are the few hours that are

gaps in care in the system, and then what do the plans have in place as back-ups for those individuals that don't show where somebody's expecting somebody to come into the home and provide services to them. That's just a high-level example.

On T-MSIS, we're one of the states that have partnered with CMS. Obviously, trying to stand up a system where you're bringing in data from 50-plus organizations nationally, it becomes a challenging process, but I think CMS is continuing to make progress as it relates to receiving data from states.

JUSTIN SENIOR: With us, the real – the types of things that we look at for managed care, when it comes to managed care quality, number one, we'd look at consumer satisfaction. I guess there's really no order to this. We look at consumer satisfaction. We look at these health care effectiveness data and information set scores. That's where, if you have someone that has a diagnosis of diabetes, there's a certain type of care, optimal level of care tests that you'd expect them to receive, doctor's visits that you'd expect them to have during the course of the year.

Those scores, the question is, you send in a certified HEDIS auditor and they look and say, well, of the people in this plan that have that particular condition, what percentage of them actually received the care that you would expect them to receive? So many health plans now around the country participate in that scoring process that it allows you to

compare how your plans are doing versus other plans in your state versus other plans in other parts of the country on a near apples-to-apples basis.

Because of the eligibility differences, it's not quite apples-to-apples. If a state has Medicaid eligibility thresholds that are significantly higher and maybe are bringing in some middle-class families, that could change the numbers a little bit, but in general, you can compare and see how the plan is doing in connecting people with the care that you'd expect them to receive.

We also will look at encounter data. There are certain things and algorithms that you can run where you'd look at, well, someone just got admitted to the hospital and they had a primary diagnosis of this. You would not expect, if that condition was managed appropriately, that you would be admitted to the hospital, and you can look at what the preventable hospitalization rate is. Once again, you can compare plans to one another.

When you do risk adjustment, and most states do in the managed care setting, you actually can give a risk score to every single individual in your program, and we do. Then you can adjust for acuity levels to see how the plans are doing with respect to preventable hospitalizations and preventable emergency department utilization.

When it comes to long-term care, quality is a much harder thing to drive at. In large part, the medical services in long-term service and supports are delivered by the Medicare program. We are building ramps and making home modifications. We are sending in chore workers to help someone so that they can age in place.

A lot of determining quality there has to do with whether or not the actual caretaker showed up. Electronic visit verification becomes very important. I think a big part of consumer satisfaction is allowing the recipients themselves to choose the workers that come into their homes, something we call participant direction. We're trying to expand that in our state. Those are the types of things that we look at. As far as T-MSIS, we're one of the good kids. I think we're doing pretty well.

GRETCHEN HAMMER: I would just add, in Colorado, I think, and as I'm sure most of the health care system is, we're trying to differentiate a little about the importance of data and what kind of data we're looking to use. There's clearly data that should drive clinical decision-making, real-time feeds of individuals who've shown up in an emergency department the night before and real-time feedback to their primary care provider to let them know that has happened, those kinds of clinical decision-making tools and pieces of information.

Then there's data, I think, that we're looking to use at the state and at the regional level, in our case, that really help drive program management and program direction. That's slightly different than clinical decision-making data.

Then finally, this overall health improvement and impact data is also of importance, and that is where we're, again, trying to be as collaborative as we can so that our health care providers aren't crazy with 56 different data elements that they're trying to manage within their clinical delivery system.

We've really been very collaborative with, again, our CPCI and SIM partners to pick core measure sets that we could all be aligned toward throughout the delivery system.

Those are the three areas. I'm sure there are more. If my staff were here with me, they would give me additional ideas. I think it's just important when we talk about data to think clearly about which data is being used in which way.

THOMAS J. BETLACH: Can I just elaborate on one point on that for 30 seconds quickly? That is, you know, system design matters, and so what you can measure in terms of MCO deliverables depends upon what services they're responsible for. In Arizona, we're doing a lot to try and create comprehensive plans, like Justin described, for individuals with serious mental illness, where they're responsible for all

services, not just medical services, but housing and employment support services.

Then you can really have a comprehensive score card in looking at all the services an individual with serious mental illness may need delivered from that organization. Then you can really tie in value-based purchasing arrangements associated with a much broader array of outcomes as well.

I think this is something clearly a lot of states are looking at, is what is the system design, because you have Medicaid evolve, and many states have these silos of state-only systems for behavioral health services and other things like that. You're seeing a significant re-look now at what makes sense from a system-design perspective now that we have Medicaid covering 15-, 20-, 25-percent of the population in the state.

DIANE ROWLAND, Sc.D.: Perfect. Okay. Question here.

ROBERT McCARTNEY [misspelled? 00:57:44]: I'm Robert McCartney from the *Washington Post*, and I have a question for Mr. Betlach, and then possibly either Mr. Smith or Ms. Rudowitz, looking at the national perspective.

As you know, one of the main objections or concerns raised about expanding – whether or not to expand Medicaid in individual states was whether or not the states would be burdened too much in their budgets, especially when the federal match reduced.

THOMAS J. BETLACH: Mm-hmm.

ROBERT McCARTNEY: I'm wondering, looking forward in a state like Arizona, you know, how much of a concern is that? I mean, is there – is the burden going to increase enough so that there might be pressure, political pressure to actually reverse the decision and give up on that? Is it basically look like it's fully speed ahead for Arizona?

Then nationally, what's the outlook on that? I mean, the match is going to start going down in fiscal '17, it's going to go down even more by fiscal '20. How much of this – how's this going to change the individual state's attitudes about having expanded or whether to expand?

THOMAS J. BETLACH: Starting with Arizona, it gets complicated in a hurry, because we had previously expanded and so we don't get the full 100-percent match on all of the populations, and we actually see savings over the next several years as we continue to phase up in the federal matching rate for some of those populations. We, in fact, don't see additional costs as that 100-percent phases down.

I'm sure I made that completely convoluted and difficult to follow, but, you know, the bottom line is there's no net cost to Arizona as it relates to the decrease of the 100-percent because we do get the benefit of a previous expansion state rate.

DIANE ROWLAND, Sc.D.: And Colorado.

THOMAS J. BETLACH: Gretchen.

DIANE ROWLAND, Sc.D.: Gretchen.

GRETCHEN HAMMER: Again, I think there's a couple – there's a larger framework that I think is important that we all need to continue to keep in mind, which is how do we get better value for the health care dollars that we spend today as a broader, just, framework, that the total cost of care and other areas where we're spending health care dollars, can we continue to drive value and efficiency within that system as a critical component, in addition to making people healthier, so health care services are less needed.

We have a hospital provider fee mechanism that we mentioned which will be part of the way that we'll be able to finance the ongoing financing for the expansion of Medicaid.

DIANE ROWLAND, Sc.D.: And Robin for the national perspective.

ROBIN RUDOWITZ: We're also – we ask the question this year about some of the effects outside of the Medicaid program on other parts of the state budget, and we are seeing some evidence that states are seeing some savings in other areas of their budget as they implement the expansion, particularly related to behavioral health, as well as criminal justice, uncompensated care. Some states are seeing additional revenue as well, so many states are anticipating that some of those

savings in other areas of the budget will help compensate for the increase in the share for the newly eligible population.

I think additionally –

DIANE ROWLAND, Sc.D.: Robin, pull closer to your mic.

ROBIN RUDOWITZ: Additionally, the expansion population, even when it phases down, the match rate remains at 90-percent, which is much higher than a state's typical match rate, and overall, it is still a small piece of the population. In the context of the overall Medicaid program, that's important perspective as well.

VERNON K. SMITH, Ph.D.: Just to add one quick thing to this. Yes, 5-percent in 2017 is a significant lift for states in terms of their state general funds, but keep in mind this: There's never been, in the history of Medicaid, a match as high as 95-percent. This is an extraordinarily high match, and as Tom suggested in Arizona and in another eight or ten or twelve states over the years have expanded Medicaid at the regular match.

For states that are really focused on making sure that health coverage is available for the population in their state and have been inclined, as 31 states have, to expand their coverage up to this point in time, 95-percent is a very beneficial federal match rate, and I think would be a very strong incentive to continue.

ROBERT McCARTNEY: I understand that, but 20 states have not expanded. What I'm trying to understand, if you will, is as those 20 states look at the experience of the 31 states that have expanded and the match – when the match goes down, are they going to see, oh, yes, those savings that you described, Ms. Rudowitz, those savings are offsetting enough of the extra costs for us that it just makes sense for us, looking at our state budgets, to go forward? Or are they going to look at the experience of these 31 states and say, aw, this is costing too much, you know, we're going to stand pat and not expand?

I'm just trying to get a sense of – you know, we've had a couple of years of experience now. You know, what's the results in terms of the state budget that's going to shape the way this debate goes forward.

DIANE ROWLAND, Sc.D.: Tom.

THOMAS J. BETLACH: Can I just jump in for a second?

DIANE ROWLAND, Sc.D.: Yes.

THOMAS J. BETLACH: Because I think what's always fascinating about the Medicaid program is the debate on federalism that gets to carry out on a daily basis. We've been talking about it for 240 years in this country, and it plays out every day in Medicaid. It's great. You know, the Supreme Court – and I think rightly so – came back and said it's up to the state to make that decision and allow that debate to occur

within each of the state capitals in terms of what states want to do around expansion or not.

It becomes partly a financial question, partly other questions as it relates to the overall policy. Sustainability for Medicaid is a significant issue. Regardless of whether or not you expanded, states are dealing with the sustainability, and for those of us that were around during the great recession and had to put in place very significant budget cuts, it's what drives us on a daily basis to look for alternatives so that we don't have to go back during the next recession and cut rates and cut benefits and cut services to individuals, because I've been through that once and it was miserable. That's what drives us to look for alternatives within the delivery system to make it more effective in terms of driving outcomes.

DIANE ROWLAND, Sc.D.: Okay. I have one question here, and then we're going to go to John in the front.

ESHA JANE: [misspelled? 01:04:30] Hi, good morning. My name is Esha Jane [misspelled? 01:04:30], and I'm with Avalere Health. I know it was reported that many of the Medicaid directors said that cost is a priority for them in particular and that they're focusing on managing specialty drug spending in order to help control costs. Can you guys talk a little about what mechanisms are being implemented in order to control specialty drug spending costs?

DIANE ROWLAND, Sc.D.: Minor question here.

JUSTIN SENIOR: That is one of the very difficult challenges that any health care delivery system is facing right now. We do have, we've had, and I think there's a good news definitely to this, the number of drugs come down the pike for Hepatitis C that potentially are cures for Hepatitis C for most people, and then we've had some drugs come down the pike for diseases like Cystic Fibrosis that appear to be significantly more effective than drugs that have come down for that condition before.

Those costs are incredibly high. The costs associated with these drugs are incredibly high. With Hepatitis C in particular, all of us were caught for a brief period where this is a fairly common condition and one entity, one manufacturer got out in front and ended up with the only product on the market for a period of time. Really, when it comes to controlling drug costs, one of the ways you can do it is you can have a preferred drug list and you can negotiate rebates. If someone has a monopoly, it becomes very difficult to negotiate with that particular entity.

During the time period where you had one manufacturer and one pharmaceutical company with a cure for Hepatitis C, we really had to think very carefully about the number of people that would get it, how many people were going to show up. It's a big unknown. For HIV/AIDS specialty plans, this was a huge issue because the co-morbidity is really high, and just a

couple thousand people additionally showing up and choosing one plan over another was going to have enormous fiscal consequences.

We tried to control the spending by putting in some utilization management measures, some prior authorization measures, making sure that people didn't take the entire course of the drug if they were showing to be non-responsive to it early on, making sure that the people that were symptomatic were the first ones to get it, until we finally were able to negotiate with the manufacturers to get one product when there are competing products onto the preferred drug list.

We gave the plans what was called a kick payment, which controls really for volume. That took volume, the risk of volume, of people showing up in one plan over another, out of the equation, about $90,000 per course of treatment. Only a few thousand people showing up in one plan versus another, like I said, would have significant consequences to a plan's bottom line.

We took that volume risk out of the equation. We didn't know how fast people would show up. We were able to manage it in large part because we were running a surplus, in large part, because we had negotiated significant per-member-per-month savings in our program already in our statewide Medicaid Managed Care Program.

That’s going to be a challenge going forward. The Cystic Fibrosis drugs are chronic drugs. They’re not a cure. You would anticipate people taking them for the rest of their lives and enhance life expectancy. That is fantastic, but it does have about $100 to $200 million impact on a program the size of ours.

These types of challenges, I don’t – I certainly hope these blockbuster drugs don’t stop coming, but it does present challenges.

THOMAS J. BETLACH: Gretchen, di you want to add anything? Okay.

DIANE ROWLAND, Sc.D.: John. Here comes the mic.

JOHN IGLEHART [misspelled? 01:08:13]: John Iglehart, *The New England Journal of Medicine*. I have a several-part question around behavioral health. I think all three of you mentioned it, but I have the sense nationally that there’s a real groundswell of greater interest in this population.

My question is, if this is indeed right, what sparks a greater interest from Medicaid programs, and generally nationally? You all mentioned, I think, integration of behavioral health and primary care. What are the challenges that Medicaid programs face around integration? Thirdly, is the workforce that deals with folks with behavioral health challenges adequate in your states to accommodate greater demand?

THOMAS J. BETLACH: One of the drivers for us is just in looking at the data. GAO came out with a report not too long ago, identified 5-percent of the population equals 50-percent of the spend within the Medicaid system. This was pre-expansion. In that, it gave diagnosis-level detail.

For somebody with – I'm not remembering the numbers right off the top of my head – I think it was diabetes, you know, you had roughly 60-percent of the population also had mental health needs. When you just go down and you look at all the different chronic issues and diagnoses, there is a strong, high correlation of need for mental health, behavioral health, substance-use disorder services within the Medicaid population.

One of the big challenges for us, a state like Arizona is, we had a carve-out for three decades, and so you had this separate system spring up that responded to a separate payer stream and separate incentives and really didn't do a good job of integrating with the physical health system over here.

You talk about workforce, I think Arizona and other states have been creative in leveraging services like peer and family supports and other things like that, but it sat over here. It sat separate and aside from large hospital systems, large clinics, and so the effort now – I think you're right, it is a groundswell. It is something that the majority of our peers are talking about is what can we do as behavioral health services – 25-percent nationally are paid for by Medicaid –

what can we do as the creator of these systems to better integrate them.

I talked about it at the policy level, the payer level and the provider level, and I think you've got to look at what you're doing at all three levels to help integrate that system to better serve that population. Again, it goes back to the sustainability issue. If you can address that 5-percent of the population that equals 50-percent of the cost and improve outcomes, I think we're going to be able to do that by looking at a better integrated system around behavioral health and physical health services.

JUSTIN SENIOR: From a state perspective, you get to a really personal level trying to help a person that has a significant mental illness. The concern is, you've got to make an investment in that person on the front-end, because you don't want to serve that person in the prison, which actually has a huge impact, that you'll end up serving people in prisons and in jails. They'll be a victim or victims, and really, what you want to do, is you want to make sure that you make the investment at the appropriate time and really try to get at that person and get them the services that they need, reward them for adherence so that you're not dealing with issues on the back end, like that person's homelessness or that person committing crimes and ending up in the justice system.

I think there's a growing awareness that you really can't separate the two. I made the remark about having your brain and your eyes and your teeth in three different delivery systems. That is something that has been going on in the country in Medicaid programs for a long time.

There is an understanding now that you really can't disconnect the two. Mental health and physical health are very strongly connected, and it's very strongly connected to other issues in the state in terms of crime and in terms of the prison system.

You want to make sure that you invest in that person on an individual level at the right time, because mental health issues are – it's real. It's a health issue. It's not all in your head. It is a health – I guess it is, but it's all a health issue.

[Inaudible 01:12:44]

JUSTIN SENIOR: You know, I think that's something that we're going to see over time. Right now, some of the states that have done the expansion might have significantly larger mental health populations in their program than we have. I don't know that to be the case. We'll have to learn over time how that goes. Right now, I have not heard of shortages of behavioral health providers.

The mental health specialty plan that we have actually has twice the network adequacy levels of the other plans, so

they have twice as many psychiatrists per individual and things like that. Hopefully, we do have the ability. It's one area that really lends itself to telemedicine, and so there are opportunities to leverage your workforce in that particular instance. We have allowed the plans to engage in that sort of thing.

We haven't seen it yet, but it's something that you've got to watch. That's why you watch the network adequacy requirements that you have and enforce those in your contract. That's why you look at the HEDIS scores and make sure that people are getting in for the services that you'd expect them to receive and they're not showing up at the emergency rooms and they're not showing up with preventable hospitalizations. That's the type of stuff with respect to accountability that you need to watch to make sure you have an adequate delivery system.

DIANE ROWLAND, Sc.D.: Okay. Question over here.

JOHN IGLEHART: Let – can we let Gretchen jump in –

DIANE ROWLAND, Sc.D.: Okay.

JOHN IGLEHART: – because I know they're doing a lot.

GRETCHEN HAMMER: I'll be brief. Our State Innovation Model commits that 80-percent of all Coloradans will receive integrated care in a primary care setting by 2017, and so I think it's a shift that is important, both because of the individuals that Tom and Justin were speaking of in terms of

those with severe and persistent mental illness, but also the opportunity to provide additional behavioral and wellness supports for all members of our communities.

There's a clear tie between behavioral health management and things like obesity, things like smoking and other things. There is, I think, a prime opportunity for new kinds of workforce in that space, behavioral health coaches, for example. Others who have the opportunity, we have some block captains that exist in a community actually near where I live that are all part of about how do we engage those in our community to think about their health, to manage their health, et cetera.

I think there is workforce that is more community-oriented. The lay health worker workforce that has an important role to play, especially when we think of the notion of children and of pregnant women or postpartum women who have the opportunity to set a life trajectory that have the right behavioral health supports to make sure that happens.

Then how is the delivery system adequate to also continue to meet the needs of those with severe mental illness. It's a very – it's important that there's a continuum of care and support across the behavioral health spectrum.

DIANE ROWLAND, Sc.D.: Thank you.

LANCE KILPATRICK: [misspelled? 01:15:36] Lance Kilpatrick with Caring Across Generations. What impacts do you

see implementing the Department of Labor's homecare rule having on your state, and how are you going to ensure the maintenance of supports and services for the affected populations?

DIANE ROWLAND, Sc.D.: Gretchen, you want to start?

GRETCHEN HAMMER: I will start with a mildly vague answer, which I apologize for. I think that we're continuing to understand how that impact will – we have both consumer-directed and agency-based services, and so we're trying to understand and ensure that we get the right kinds of requirements in place.

The Office of Community Living, which is another office within our state Medicaid agency, oversees most of that work, as in addition to some of the program areas in my office. We're working on it at this point in time, and working as quickly as we can to make sure that we get the right kinds of structures in place.

DIANE ROWLAND, Sc.D.: Justin.

JUSTIN SENIOR: For us, we're still trying to understand the impact. It does look to us – we have two main delivery systems for long-term services and supports. One is the managed care model, and it's mainly frail elders delivered through HMOs and provider service networks, capitated. That does look to be okay when it comes to the Department of Labor Rule.

We also have an agency for persons with disabilities that runs a fee-for-service waiver for people with intellectual disabilities. There might be more challenges there, and we're trying to understand what the implications are and what the cost implications are as a Medicaid program.

DIANE ROWLAND, Sc.D.: Okay. I saw some hands over here.

[Phil Galewitz]: Phil Galewitz, *Kaiser Health News.* Before the expansion in 2013, there was a whole lot of concern about states wouldn't have enough providers to meet the surge in enrollment. Now you've had a lot of experience. Can you tell us what we've seen, both in Florida where enrollment's gone up, and in Arizona, and have you had to take any actions against health plans for not keeping up in terms of having enough providers.

THOMAS J. BETLACH: We have not in Arizona. We track and trend grievance and appeal data. We look to see what's going on with network sufficiency based on the requirements in our managed care contracts. We do secret shopper exercises. We make the plans do secret shopper exercises.

Again, we had covered part of this population before the recession, and we had to put a freeze in place. We have not seen any degradation in terms of access to care. Obviously, having coverage within the Medicaid system has helped those folks get access to care.

DIANE ROWLAND, Sc.D.: Gretchen as an expansion state.

GRETCHEN HAMMER: Similarly, we have the – again, I keep referencing the Colorado Health Access Survey, but it gave us some data to suggest that access has been adequate. We have a very robust Community Health Center Network across the state of Colorado, and they, in particular, as well as other providers, have created sufficient access.

JUSTIN SENIOR: In Florida, we've seen certainly a spike in the number of people enrolled in the program, even though we're not an expansion state. As we built our network adequacy requirements, we base them on the Medicare program, which not every state can do, but we have a very evenly dispersed population, several very large metropolitan areas, and a lot of Medicare Advantage organizations.

We actually require the same network adequacy requirements of our plans as they require in Medicare Advantage, which is significant because our population tends to be – there are a lot of healthy kids in our program, and so our population tends to be a little healthier than the Medicare population.

We also built in quite a bit of redundancy. We ask the plans to build networks for a population that is larger than the one that they actually have enrolled. We have not heard any issues from the plans in terms of building the networks, and we've had a very low level of complaints.

We also, however, do use secret shopper. We used it in the panhandle, and we have, kind of, surrogates that have helped us with some secret shopping down in Miami recently when it came to adult psychiatrists that have yielded very interesting information. We haven't had a lot of complaints out of that area, but we are intending to do our own secret shopping, and we are intending to act upon some of the findings of the people that are cooperating with us and our own findings if a plan or plans has come up short.

DIANE ROWLAND, Sc.D.: Great. Thank you.

SIVIN SONG: [misspelled? 01:19:54] Hi, I'm Sivin Song. I'm from University of North Carolina. I'm a grad student. I think you've touched on this a little bit before, but you've mentioned partnering with organizations to address social determinants of health. I was wondering if there are any programs in place at the partner level, and if there are, can you go into a little bit of detail, were they more effective or less effective than partnering with organizations?

GRETCHEN HAMMER: Sure. We have a variety of different levels of partnership. We have a strong commitment to working with our, what we call sister agencies, the Department of Human Services and the Department of Public Health and Environment. We have a particular area that we're working on which is called the Colorado Opportunity Project, and it's a program that's just getting launched that's really designed to think

holistically about the needs of individuals through each life stage and how a set of services and interventions can be put in place at the local level that address the complete need of a family member or someone in the later life stages for an individual.

That project is a collaborative project at the stage agency level, in addition to our normal, everyday collaboration, which is – which does occur on a daily basis. In addition, the regional entities that I mentioned, our RCCOs, Regional Care Coordinating Organizations, have built local partnerships within the local communities of care.

One of our RCCOs, just to be clear, is the entire western slope of Colorado. Within that, there are a variety of communities where they support local level infrastructure. We have a robust network of what we call health alliances in Colorado. They're local organizations who have come together to address public health priorities.

We have a state requirement for public health improvement plans for our local public health agencies, and through those, they often identify local priorities such as access to care, substance use disorder, those kinds of things.

Many communities also then partner with the local non-profit hospital who fulfills their community health needs assessment criteria under 990 requirements, so all of those pieces of infrastructure allow local community priorities to

come to bear and then local partnerships to be built. We hope that Medicaid and the Medicaid providers in that community and our regional accountable entities are well enmeshed in those, and that's, in fact, some of the things that we work with them on to ensure that they're connected to that local level.

DIANE ROWLAND, Sc.D.: Okay. We're going to have time for one last question.

RONALD WILLIAMS: [misspelled? 01:22:27] Good morning. My name is Ronald Williams. I'm a mental health case manager here in Washington, D.C., east of the Anacostia River, and my question to the panel is two parts: one, it's refreshing to hear you guys talk about integrated care, and do you think that this is the next step in getting that population to, you know, their somatic needs, their mental health needs, their social needs; and, two, do you think it will reduce fraud in this community?

THOMAS J. BETLACH: Do you want to elaborate in terms of what you mean by fraud a little bit?

RONALD WILLIAMS: Like I get news – news clippings from the Justice Department about ex-mental – or clinical outpatient mental health is being closed down due to, you know, some type of recruitment fraud. Do integrated care open that door to reduce that risk of fraud?

THOMAS J. BETLACH: I think clearly the answer to your first question in terms of integration, yes, it is – that is

the driver that we're all looking at. In terms of fraud, I think that this is an area in which you're starting to see a lot of maturity within the Medicaid systems of being able to more clearly define what are the services we can and cannot pay for, to put in more robust training and compliance programs around that.

I think any time you're spending $12 billion in a state – and Florida it's a lot more than that – you have bad players in a variety of different places. I think part of the fault has previously been with us not being able to clearly define what we can and cannot pay for. I think in states we're becoming a lot more mature about what that looks like, so I do think that's improving.

JUSTIN SENIOR: One of the unique things about Florida is that Miami is in Florida.

THOMAS J. BETLACH: I should have let you start.

JUSTIN SENIOR: Yes, right. Yes.

THOMAS J. BETLACH: [Inaudible 01:24:34].

JUSTIN SENIOR: What we try to do, you really have to try to set your system up so that the incentives are right, and so the managed care organizations are empowered to deal with fraud, that they have a plan to deal with fraud, that you are aware of their plan to deal with fraud and they are constantly communicating with you.

As you price the services that you're giving – and I said we pay risk-adjusted rates, what you're paying is, when it comes to someone with schizophrenia, you're paying what would be the expected cost of dealing with that individual.

At that point, the managed care plan is incentivized to deal with providers that it knows and trusts and that can deliver the care in the most efficient way possible, keeping the person out of the hospital, keeping them out of the emergency room, because those are the types of quality scores that you're enforcing against them. That's the type of thing, that's the type of delivery system that we're trying to set up.

You've got to set up a payment system that incentivizes efficiency as opposed to one that incentivizes more and more services being laid on.

DIANE ROWLAND, Sc.D.: I want to thank our last questioner for bringing the word "fraud" back into a Medicaid discussion, which we haven't had, but much of our discussion today has focused on moving forward in a very positive way and, I think, eliminating the fraud. Having new systems is really always a goal, as well as getting people better care and more integrated care. I hope you really have had a good exposure in this session to the many, many changes going on in the Medicaid program.

I'd like to thank the staff here as well as at HMA for pulling together all of this information in this report, to

NAMD and the Medicaid Directors and the staff at the Medicaid Directors' offices who had to pull together the much-needed information that's contained here for their contributions.

I think that this is a major contribution to understanding that this is a new and emerging and evolving Medicaid program. It is an exciting time. There's lots to be excited about. Thank you all for coming, and thank you to all of my panelists for being here with us today.

MALE SPEAKER 1: Thank you.

[END RECORDING]