DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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IAP Listening Sessions Summary

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The Centers for Medicare and Medicaid Services (CMS) launched the Medicaid Innovation Accelerator Program (IAP) in July 2014 to improve health and health care for Medicaid beneficiaries by supporting states' efforts to accelerate new payment and service delivery reforms. Through these improvements, CMS can reduce costs for the Medicaid program and, by extension, the health system more generally. CMS designed the IAP to provide support to states in accelerating their innovation efforts in selected program areas through a variety of technical assistance initiatives. While CMS identified the types of technical assistance IAP would provide (i.e., model development, quality measurement, data analytics, and rapid cycle learning/evaluation) and an initial program area of focus -- substance use disorders (SUD), CMS did not define other program areas. CMS held a series of Listening Sessions, as a first step to better understand states' interests and needs across a variety of program areas.

Why Listening Sessions?

CMS launched a structured pubic engagement process to better understand states' specific needs across functional areas and to support the identification of additional program focus areas. Between September and October 2014, the IAP team convened three in-person meetings in Baltimore, MD, Chicago, IL and Denver, CO and one virtual meeting. The purpose of these meetings was multifold:

- Explain the reason for developing the Medicaid Innovation Accelerator Program;
- Share examples of Medicaid innovation under across CMS;
- Assess interest from a diverse group of states and stakeholders about the types of technical assistance needed; and
- Create the starting point for identifying and prioritizing program areas and technical support needs to support driving innovation.

Each in-person session was divided into a state morning session and an afternoon stakeholder session where participants were asked to prioritize potential program areas and to identify areas of technical assistance need. Nine summary tables of the feedback received through these meetings are included in this document.

Nearly 200 people attended the in-person sessions and an additional 180 participated in the virtual session. Through this engagement process CMS met with 20 states as well as with diverse group of health plan representatives, providers, advocates, and professional associations representing a multitude of other Medicaid stakeholder perspectives.

Program Priority Areas

Under the IAP, CMS will work with states in up-to-five program priority areas. CMS selected the first program priority area; substance use disorders (SUD), and discussed with Listening Session participants initial plans to support states in accelerating their ongoing efforts in this area. In addition to providing an overview of its SUD work plan, the goal for holding Listening Sessions was to better understand states and stakeholders' interest in other program priority areas.

In tables 1-9, we summarized the feedback heard from the in-person and virtual sessions related to potential program areas. These themes should be seen as a snapshot of the participants who attended the sessions and who shared their thoughts with us. It should be noted that not all who attended submitted a feedback form. Table 1 shows ranking of potential program areas by Listening Session participants—there are many ways to consider these results (e.g., top areas ranked by states, top areas ranked by stakeholders, commonalties across states and stakeholder rankings, etc.). In general, prioritization of program areas tended to vary between state sessions and stakeholder sessions. When looking at the first five rankings there are a few consistencies: behavioral health and super-utilizers were ranked second and fourth respectively by both state and stakeholders. Both states and stakeholders agreed that substance use disorders (the initial IAP program area) is a priority, ranking it third and fifth respectively. Rankings could also be interpreted by looking at which priorities were identified by states only (e.g., payment approaches, behavioral health, substance use disorders, etc.) versus stakeholder priorities (e.g., population health, behavioral health, managed care, etc.)

Table. 1 Priorities Identified Through Written Feedback Forms (in-person meetings only). *Participants were asked to rank a list of potential program priority areas on a scale of 1-10 (1=not important, 10=very important). Total of 44 forms were submitted.*

Rank	State Session Written Feedback	Stakeholder Session Written Feedback
1	Payment approaches (incl. shared savings, bundled payments)	Population Health
2	*Behavioral Health (physical/mental health)+*	*Behavioral Health (physical/mental health)*
3	Substance Use Disorders	Managed Care
4	*Super-utilizers (of health services)+*	*Super-utilizers (of health services)*
5	Long-term services and supports +	Substance Use Disorders
6	Population Health+	Payment approaches (incl. shared savings, bundled payments)
7	Perinatal Health	Long-term services and supports
8	Managed Care	Perinatal Health

Note: + indicates that this topic was also identified as a priority during the virtual listening session.

Functional Areas

During the Listening Sessions, CMS also solicited feedback on the types of technical support and resources states need across the IAP's functional areas: data analytics; quality measurement; rapid cycle improvement/evaluation; and model development. The need for technical support in

the areas of data analytics and quality measurement came up repeatedly. For example, under data analytics Listening Sessions participant's noted assistance linking multiple data sources and sharing national benchmark data. For quality measurement, participants requested that CMS develop new measures in key gap areas (e.g., social supports and services) and to package existing measures in ways that can be used more effectively by states. This feedback helps to solidify the approach CMS is planning in these areas. Data analytics and quality measurement will play key roles across all of IAP's program areas, including substance use disorders.

Next Steps

CMS sees the Listening Sessions as the start of ongoing conversations with our state and stakeholder partners. With the first phase of engagement complete, our next step is to identify the next several program focus areas for the IAP. We will do this by conducting an internal review of prioritized potential program areas along with the feedback received from the Listening Sessions. Once these next several program focus areas have been finalized, CMS plans to hold a state panel to help further define the types of technical support states need in these areas. We encourage our states and stakeholder partners to continue to share their thoughts and feedback with us about IAP at: MediciadIAP@cms.hhs.gov

Tables 2-9: Summary of Feedback From Listening Sessions

Table 2. Substance Abuse Disorders

	Data Analytics	Quality Measurement	Model Development	Rapid-Cycle Learning/ Learning Diffusion
Focus on identifying super-prescribing providers ("pain specialists") via prescribing patterns and benchmark with peers across state(s)	x			
Consider changes to paying for residential treatment (how to consider it as a managed benefit)			x	
Provide guidance on oversight, credentialing, and regulations to successfully integrate SUD, mental health, and other areas of influence (homelessness, employment, training, etc.)			x	
Train and coordinate with workforce representatives, advocates, and providers for those not familiar with dealing with issues surrounding SUD and how best to identify, address (refer), and treat SUD.				x
Identify and promote models for telehealth to better support community-based SUD treatment and outcomes			x	x
Clarify and reduce obstacles to appropriate data sharing re: HIPAA and state-specific laws around substance use. This includes helping states navigate CFR 42 for data sharing.			x	x
Identify/share best practices around aligning primary health identification and referrals to treatment systems, case management/care management resources			x	x
Technical support needed around how to improve recidivism rates, placement opportunities, and best practice models for community transition			x	
Coordinate more actively to avoid duplication of efforts among other agencies (i.e., SAMHSA, CDC)				x
Focus on childhood exposure to tobacco as a topic under SUD			x	
Develop metrics and measuring health indicators for those who receive SUD services vs. others (as well as the analysis of these data)	x	x		

Substance User Disorders (continued)	**Data Analytics**	**Quality Measurement**	**Model Development**	**Rapid-Cycle Learning/ Learning Diffusion**
Technical assistance needed to educate consumers of SUD about managed care and other systems				x
Provide guidance on recovery and providers learning about their recovery process. States also need to support on credentialing and managing burdens of oversight.			x	x
Promote Screening, Brief Intervention, and Referral to Treatment (SBIRT) and depression/trauma screening to support early intervention		x		
Address reimbursement to support access to SUD services			x	
Support the application/use of American Society of Addiction Medicine (ASAM) levels of care				x

Table 3. Population Health

	Data Analytics	Quality Measurement	Model Development	Rapid-Cycle Learning/ Learning Diffusion
Assist states with linking Medicaid data to an all-payer database which also includes Medicare	x			
Further develop a combined care management system that integrates LTSS, public and social health services, behavioral health, and leverages HIE			x	
Identify which existing algorithms should be used to identify high-utilizers of health care services. Share best methods to use that algorithm to allow for benchmarking, understanding most appropriate interventions, and identifying which areas to impact.	x		x	
Use data integration and more real-time access to data to improve care management	x		x	
Identify/promote successful interventions and care models			x	x
Technical support to help with data integration (e.g., Department of Family Services and Medicaid data integration). Databases and care management are not always coordinated.	x			
Identify/promote techniques to engage super-utilizers (and other hard-to-reach populations)			x	x
Use/pay for Assertive Community Treatment (ACT) teams to address high-cost areas/populations			x	

Table 4. Payment Strategies/Bundled Payments/Shared Savings

	Data Analytics	**Quality Measurement**	**Model Development**	**Rapid-Cycle Learning/ Learning Diffusion**
Support states to build capacity and to collect data needed so that bundled payments can be more fully explored	x			
Support states to understand what services are included in a bundled payment to ensure that there are evidence-based purchases of health care services	x			
Consider paying for non-traditional Medicaid services in managed care organizations			x	
Create bundled pregnancy including pre-natal/post-natal services, looping in lactation, tobacco, etc.			x	
Create incentive pools for long-term services and supports combined with quality outcome and performance measures		x	x	
Disseminate information about states with approved shared savings programs. Share specific details on the methodologies used: are they very different, or did they build upon each other's design?				x
Focus on promoting multi-payer alignment			x	
Create life-stage bundles to study ROI – such as social-well-being bundles			x	
Create shared savings and incentive payments within traditional home and community-based waivers			x	
Explore bundled payments for behavioral health services, including how to support alternative delivery of services, telehealth, consultation models.			x	

Table 5. Behavioral Health

	Data Analytics	**Quality Measurement**	**Model Development**	**Rapid-Cycle Learning/ Learning Diffusion**
Identify best practices to integrate physical and mental health care and to align CFR Part 42-4			x	x
Integration of behavioral health and primary care (best practices, avoid duplicating SAMHSA efforts)			x	
Identify ways to overcome Olmstead challenges for high-need populations			x	
Explore ways to increase behavioral services in jails and during community transitions			x	
Share best practices for overcoming data transfer/data sharing challenges	x			
Work with providers/advocates to identify patients with behavioral issues and how to review relevant data (and compare to other states) to effectively use policy levers and engage provider community	x		x	
Share best practices for transitioning people from psychiatric, correctional, and residential care to the community				x
Promote a more effective workforce to meet necessary competences, including a focus on geriatric populations			x	
Identify/share best practices for treating children with conduct disorder needs			x	x
Identify/share best practices for treating adults with long-standing untreated psychiatric issues			x	x

Table 6. Long-Term Supports and Services as a Tool for Community Integration

	Data Analytics	Quality Measurement	Model Development	Rapid-Cycle Learning/ Learning Diffusion
Align financial incentives to help coordinate care			x	
Identify and share successes from Medicare-Medicaid (Duals) Demonstrations with shared savings			x	x
Community LTSS (better support) is very different from institutional LTSS (less balance and support) and the measures for quantifying outcomes are also very different		x		
Identify/share best practices related to behavioral health, workforce training and community integration, and transition planning				x
Update consumer direction rules/regulations			x	
Modernize health information technology (telehealth, telemedicine, teletherapy) relative to regulation and oversight			x	
Address lack of supportive housing (multiple types)			x	
Create shared savings and incentive payments within traditional home and community-based waivers			x	
Identify/share provider strategies for community integration and transition planning			x	x
States need support in assessing performance and quality on consumer-directed services, along with community integration and transitions. States are also interested in using supplemental enhanced payment guidelines to incent and use shared saving models for this purpose.		x	x	
Fee-for-Service financing strategies for LTSS and bundled payment approaches			x	
Support effective career ladders for LTSS and DD/ID provider workforce			x	

Table 7. Managed Care

	Data Analytics	Quality Measurement	Model Development	Rapid-Cycle Learning/ Learning Diffusion
Experiment with non-traditional managed care (patient-centered medical home as "managed care 2.0")			x	
Leverage health plan innovations/strategies in effective ways (how to do it, how to identify good strategies)			x	x
Traditional managed care models may not be best for people with developmental disabilities/intellectual disabilities. Identify and share the clinical and social-medical models that work best for these groups.			x	x
Applying a medical loss ratio to managed care contracts to match what NIAC developed on commercial side. Use the rebate as an incentive/bonus payment for providers who've demonstrated performance on quality metrics.			x	

Table 8. Super-Utilizers (of Health Care Services)

	Data Analytics	Quality Measurement	Model Development	Rapid-Cycle Learning/ Learning Diffusion
Super-utilizers are also related to "super prescribers" (typically pain management etc.). Look at connection between the needs of consumers and the care patterns of providers.	x		x	
Identify/share best practices related to patient engagement. It is important to keep people involved and active with their own care.			x	x
Identify/share best practices for coordinating and providing care for foster children. Identify ways to combine/coordinate data systems that touch foster children (e.g., Medicaid/CHIP, ACF, etc.)	x		x	x
Work with states to integrate SAMHSA, CDC and data that resides in other areas of HHS to identify interventions to help and prevent super-utilizers.	x		x	
Create/promote tools that allow states to compare individual provider patterns against state, regional, national averages.	x			x

Table 9. Perinatal Health

	Data Analytics	**Quality Measurement**	**Model Development**	**Rapid-Cycle Learning/ Learning Diffusion**
Tie perinatal health to behavioral health. Focus on issues around post-partum depression.			x	
Develop measures that can be used to assess perinatal care when services are part of a bundled payment.		x		
Develop measures that focus on dental care for pregnant women. These measures would be used to track health outcomes and transmission of dental caries to infants.		x		