PUBLIC MEETING

ONLINE MEETING
(VIA GO-TO-WEBINAR)

MODERATOR: CLARA ROBINSON

Thursday, April 2, 2020
10:01 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
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WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

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

2 [10:01 a.m.]

3 THE MODERATOR: Hello, everyone, and welcome to
4 today's MACPAC public meeting. Before we get started, I
5 would like to go over a few items so you know how to
6 participate in today's event.

7 You have joined the presentation using your
8 computer speaker system by default for audio. If you
9 prefer to join over the telephone, just select "phone" in
10 the audio pane in your attendee control panel to the right
11 of your screen, and the dial-in information will be
12 displayed.

13 Today we ask that you ask your questions
14 verbally, so please "raise your hand" by clicking on the
15 hand-raising icon on the left tab of your GoToWebinar
16 control panel. We will see your hand raised, and I will
17 unmute you when directed to do so by the Chair.

18 If you have chosen the phone as your audio
19 option, please enter your audio PIN number into your
20 telephone keypad. You can find your audio PIN number in
21 the audio pane of your GoToWebinar control panel. We are
22 unable to unmute you if you do not enter your PIN number

1 in, and that is for the people that have joined using their
2 phone.
3 For those of you who are using computer audio,
4 it's possible that you're also unmuted -- or have been
5 muted on your end, self-muted, so I will unmute you, and
6 then you'll need to unmute yourself as well. And if you
7 are having issues, I will direct you through that process.
8 And now I would like to introduce the Chair,
9 Melanie Bella. Go ahead, Melanie.
10 CHAIR BELLA: Thank you, Clara. Good morning,
11 everyone. Thank you for joining our meeting.
12 I appreciate everybody accommodating this virtual
13 meeting today. This is new for us, and all of this is new
14 for all of us. But it's important for us to finish the
15 work that we started over the past several months. We
16 certainly don't do this with blinders on and realize that
17 folks have attention other places. But this work will be
18 available for Congress and for others when people are able
19 to turn their attention back to it.
20 So we thank you again for joining us. We're
21 going to finish up what we started, again, recognizing this
22 is a tough time for states, for CMS, for Congress, for

1 everyone. It is a rapidly changing environment, and things
2 are changing daily, hourly, all the time, so we are doing
3 our best to adapt to that.
4 We've added a couple of relevant sessions to the
5 end of the meeting, but let me just kind of orient everyone
6 to the way today is going to work, and then I'll turn it
7 over to presenters for our first session.
8 So we are going to spend the morning, so the time
9 between now and lunch, going over three chapters, all of
10 which have recommendations. So the three areas that we're
11 going to be discussing have to do with integrated care for
12 duals, the Medicare Savings Programs, and coordination of
13 benefits with TRICARE. We will go through a presentation
14 for each of those subjects as well as a proposed
15 recommendation for the Commissioners to discuss and for us
16 to determine if there are any changes or any clarifications
17 to those recommendations.
18 At the end of that third session, we will take
19 public comments on the discussion to date. Then we will
20 take a break for lunch, coming back at 12:45.
21 After lunch we will talk about Medicaid's role in
22 maternal health. We will also then talk about

1 countercyclical financing, and we will end the day with a
2 briefing on COVID-19, things that have happened to date and
3 kind of looking back to how we've dealt with issues in the
4 past.

5 At the end of that time, we will also offer a
6 second opportunity for public comment. Following that, we
7 will take a formal vote on the recommendations that were
8 presented before lunch.

9 So that is the order of the meeting. Just to
10 reiterate, we'll start with those subjects that have formal
11 recommendations. We'll offer public comment. We'll take a
12 lunch break. We'll come back. We'll have additional
13 sessions, one more opportunity for public comments, and
14 then we will take a formal vote on those recommendations.

15 When we get into the last session, we can talk
16 more about how MACPAC views its ability to stay relevant
17 and impactful as COVID-19 continues to be an issue for all
18 of us.

19 With that, I am going to turn it over to our
20 first panel of presenters to talk about integrating care
21 for duals. Kirstin, Kristal, and Anna, welcome. Thank
22 you. And it's all yours.

1 **### REVIEW OF CHAPTERS FOR JUNE REPORT: INTEGRATING**
2 **CARE FOR DUALLY ELIGIBLE BENEFICIARIES**
3 * MS. WILLIAMS: Thank you, Melanie. Good morning,
4 everyone. This is Anna Williams starting us out, and today
5 Kirstin, Kristal, and I are going to provide an overview of
6 the first two chapters of the June 2020 report.
7 The first chapter provides descriptive
8 information about the dually eligible population. It then
9 provides a discussion on integrated care, various models of
10 integrated care available to states, and evaluations of
11 these models.
12 Next slide, please.
13 MR. BOISSONNAULT: Hold 1, please.
14 [Silence.]
15 CHAIR BELLA: While we are waiting, Clara, I know
16 that we've had some new people join. Would you go ahead
17 and just run over one more time how folks who would like to
18 make any comments will be able to do so at the appropriate
19 time with the hand-raising? Just for people that didn't
20 hear it earlier.
21 THE MODERATOR: Absolutely. No problem.
22 So today, if you have a question or comment, we

1 do ask that you "raise your hand," and you can do so by
2 clicking on the hand-raising icon on the left tab of your
3 GoToWebinar control panel. We will see your hand raised,
4 and Melanie will give me a verbal cue to unmute you. So
5 for those of you who have just joined, if you have joined
6 using your telephone, please be sure to enter your audio
7 PIN number into your telephone keypad so that I have the
8 ability to unmute you. And for those of you who have
9 joined using their company audio, when I unmute you, you
10 may also be self-muted, in which case I will walk you
11 through the process of unmuting yourself from your end,
12 which is simply just clicking on the icon of a microphone
13 that you'll see in your control panel. And it looks like
14 we have the presentation up again, so I'll turn it back
15 over to the presenters.
16 MS. WILLIAMS: Great. Thank you.
17 As I mentioned, this first chapter provides
18 descriptive information about the dually eligible
19 population. It then provides a discussion on integrated
20 care, various models of integrated care available to
21 states, and evaluations of these models.
22 This first chapter sets up the rationale and

1 support for the second chapter, which will make
2 recommendations that focus on key objectives, including
3 increasing enrollment in integrated care, making integrated
4 products available to more dually eligible beneficiaries,
5 and promoting greater integration in existing products.
6 Next slide, please.
7 To begin, I'll provide an overview of some key
8 characteristics of dually eligible beneficiaries.
9 Next slide, please.
10 When comparing dually eligible beneficiaries to
11 Medicaid-only and Medicare-only beneficiaries, we find that
12 dually eligible beneficiaries have more complex care needs
13 and more unaddressed social determinants of health, such as
14 homelessness and low health literacy. They also have
15 higher rates of service use across both programs and
16 account for a disproportionate share of Medicaid and
17 Medicare spending. To access the full range of services,
18 dually eligible beneficiaries must also navigate separate
19 delivery systems.
20 Next slide, please.
21 When dually eligible beneficiaries navigate two
22 separate health care systems, challenges can arise in

1 coordinating benefits. There are misaligned program roles
2 between Medicaid and Medicare, such as differences in
3 coverage of things like durable medical equipment. There
4 may also be insufficient care coordination across the two
5 programs where different providers are unable to
6 effectively communicate a beneficiary's care needs to one
7 another. In some circumstances, there may be cost shifting
8 between Medicaid and Medicare. For example, providers may
9 shift costs, avoiding certain actions that could reduce
10 spending in the other program to the detriment of the
11 beneficiary.
12 Many states also have policies that allow
13 Medicaid programs to pay less than the full cost-sharing
14 amount. When Medicaid does not cover the full cost-sharing
15 amount, the difference is absorbed by the provider. This
16 can impact dually eligible beneficiaries' access to care.
17 Next slide, please.
18 Integrated care is designed to address these
19 challenges by aligning the delivery, payment, and
20 administration of Medicaid and Medicare services with the
21 goal of improving care for dually eligible beneficiaries
22 and reducing spending that may arise. Enrolled

1 beneficiaries may be better able to access the full range
2 of covered services in both programs, and providers are
3 better able to share beneficiaries' unique care needs
4 across health care providers and other service providers.
5 Next slide, please.
6 As we've discussed in previous Commission
7 meetings, CMS and states have adopted several models to
8 achieve integration. First, there are Medicare-Medicaid
9 Plans which are part of the Financial Alignment Initiative.
10 Within Medicare Advantage, there are dual-eligible special
11 needs plans, or D-SNPs, which are often combined with
12 managed long-term services and supports, as well as highly
13 integrated dual-eligible special needs plans, or HIDE SNPs,
14 which will become a newly designated option for integration
15 beginning in 2021, and fully integrated dual-eligible
16 special needs plans, or FIDE SNPs, which are in place in 11
17 states today.
18 Aside from capitated arrangements, there is also
19 the managed fee-for-service model, another model under the
20 Financial Alignment Initiative. In this model, an
21 agreement is made between a state and CMS to set up a
22 coordinated program where the state makes an up-front

1 investment in care coordination and can share in savings
2 based on a retrospective payment from CMS.
3 Finally, PACE is an integrated program that has
4 been adopted by many states, though it remains relatively
5 small in terms of enrollment.
6 Next slide, please.
7 There is a limited but growing body of evidence
8 examining these models of integrated care. As a reminder,
9 MACPAC has assembled an inventory of these findings which
10 were discussed at the April 2019 Commission meeting. While
11 the results to date are mixed, some studies have found a
12 decrease in hospitalization and readmission among enrolled
13 dually eligible beneficiaries. Likewise, some studies have
14 found integrated care programs to be associated with
15 decreased per person Medicare spending, although effects on
16 Medicaid spending are currently largely unavailable.
17 Next slide, please.
18 Although considerable work has been done to
19 develop and implement integrated care models at both the
20 state and federal levels, only about one million, or less
21 than 10 percent, of dually eligible beneficiaries are
22 currently enrolled in integrated care programs. It is the

1 Commission's view that integrated care can lead to better
2 care for individuals and more effective and efficient
3 coordination between programs. Chapter 2 of the June
4 report will focus on related policy options and
5 recommendations.
6 With that, I'll turn it over to Kirstin to
7 discuss these policy recommendations.
8 * MS. BLOM: Thank you, Anna. This is Kirstin
9 Blom.
10 So in Chapter 2, we're going to spend time, like
11 Anna said, on policy options and draft recommendations.
12 Chapter 2 is organized by the four analytic themes you'll
13 see here that have been guiding our work over the past
14 year. These themes are increasing enrollment in integrated
15 products, making those products more widely available,
16 promoting greater integration in those products, and then,
17 finally, the future of integrated care, which may lie
18 outside of the existing Medicare and Medicaid structure.
19 So there are several points I wanted to highlight
20 first that you'll see in the start of the chapter, which is
21 that the Commission is noting that it considers existing
22 authorities such as those under the Medicare Improvements

1 for Patients and Providers Act of 2008 as well as the
2 Bipartisan Budget Act of 2018 to be important tools that
3 states can use to integrate care, and the Commission
4 encourages states to use those authorities to the greatest
5 extent possible to do things like tailor their contracts
6 with D-SNPs to the specific needs of dually eligible
7 beneficiaries in their states and to reflect their managed
8 care markets.

9 Also, the Commission is monitoring the emergence
10 and growth of D-SNP look-alike plans and has work underway
11 in that area.

12 The Commission's work in these areas is still
13 developing, but in the meantime, we are considering two
14 draft recommendations which we'll talk about today that are
15 modest but important steps towards increasing enrollment in
16 and availability of integrated models.

17 The two recommendations that we'll discuss later
18 on are both working to improve integration of care for
19 duals. They include creating an exception to the Medicare
20 Advantage special enrollment period for dually eligible
21 beneficiaries and increasing state capacity to integrate
22 care.

1 As Anna mentioned earlier, there are about a
2 million dually eligible beneficiaries, or less than 10
3 percent, that are actually enrolled in integrated care.
4 The Commission is focused on policies as a result of that
5 to increase enrollment and state participation in those
6 models.
7 These are the policy options that we're focusing
8 on related to increasing enrollments. There are several of
9 these we have talked about many times -- I won't go into
10 too much detail on them -- including default enrollment and
11 work on enrollment brokers. But the last one of these is
12 our first draft recommendation. This exception would keep
13 continuous enrollment for MMPs but would newly apply
14 narrower limits that exist under the special enrollment
15 period for both plan switching and disenrolling. Later on
16 in this presentation you'll see the specific language of
17 that draft recommendation.
18 Our second analytic theme is making integrated
19 products more widely available. The Commission is
20 exploring options to do this and to position states to take
21 advantage of existing opportunities.
22 The options we're working on include improving

1 state capacity on Medicare and assisting states with up-
2 front costs to establish integrated care models, both of
3 which combine to make our second draft recommendation,
4 which would provide additional resources to states. We're
5 also looking at ways to strengthen the MMPs since that
6 model is the most highly integrated option that is
7 available to the largest share of dually eligible
8 beneficiaries. And, finally, we're exploring potential
9 issues around differences in network adequacy standards
10 between the two programs.
11 And with that, I'll turn it over to Kristal to
12 discuss the other two analytic themes.
13 * DR. VARDAMAN: Thank you, Kirstin. This is
14 Kristal Vardaman.
15 The next theme of the draft chapter is promoting
16 greater integration in existing products. As Anna noted,
17 Chapter 1 described the continuum of integrated care
18 options. State adoption of integrated care products is
19 guided by many factors, including resource constraints from
20 competing demands. Also, as we note in the draft chapter,
21 states with highly integrated products did not simply get
22 there immediately; rather, their approaches often evolved

1 over time as they've gained experience with integrated care
2 such as through the gradual expansion of D-SNP contracting
3 requirements.
4 It might be difficult, for example, for a state
5 with no integrated care program to jump directly to a FIDE
6 SNP. Instead, they might build upon MIPPA requirements
7 over time to tailor contracts that best meet their needs.
8 Having plans manage long-term services and supports or
9 behavioral health may then become a logical next step after
10 those initial efforts.
11 Given your prior discussions on this topic, the
12 chapter states that it's the Commission's view that federal
13 policies should support state efforts to move along the
14 integrated care continuum.
15 Next slide, please.
16 After setting up that context for this section,
17 the chapter moves on to discuss four policy options.
18 The first is maximizing state use of D-SNP
19 contracting authority such as MIPPA which Kirstin discussed
20 a bit earlier.
21 Next is increasing selective contracting with D-
22 SNPs. That includes state decisions to limit the D-SNP

1 market to only those plans that have companion LTSS
2 products. This strategy involves a number of
3 considerations related to state procurement and the
4 potential disruption of the beneficiary-provider
5 relationship.
6 The chapter then moves on to discuss the
7 potential for D-SNP look-alike plans to affect integrated
8 care programs, which you all just had a discussion on last
9 month. These are traditional Medicare Advantage plans that
10 primarily enroll dually eligible beneficiaries and, thus,
11 compete with integrated care plans for enrollment of those
12 beneficiaries. Competition from D-SNP look-alike plans is
13 something to consider as a potential reaction to their
14 strengthening of D-SNP contracts and selective contracting.
15 The final policy option for this section is to
16 limit D-SNP enrollment to full-benefit dually eligible
17 beneficiaries. The Commission plans to explore the
18 potential effects of this option on both full and partial
19 benefit dually eligible beneficiaries as well as
20 alternatives.
21 Next slide, please.
22 That transitions well to the concluding looking-

1 ahead section of the draft, where we know that the
2 Commission's work on integrated care will be a multiyear
3 effort. Throughout the chapter, we note where the
4 Commission plans to pursue additional work to fill
5 knowledge gaps.
6 The challenges of integrating care in the current
7 environment have left some to begin exploring the creation
8 of a new program focused on this population. Thus, in
9 addition to exploring the previous theme, the Commission
10 will review proposals that would restructure coverage for
11 dually eligible beneficiaries in a more comprehensive way
12 than is possible under two separate programs.
13 Next slide, please.
14 Now I'll movie on to the draft recommendations.
15 The first draft recommendation reads: The Centers for
16 Medicare and Medicaid Services should issue sub-regulatory
17 guidance to create an exception to the special enrollment
18 period for dually eligible beneficiaries eligible for
19 Medicare-Medicaid Plans. This exception will allow such
20 individuals to enroll on a continuous monthly basis. For
21 purposes of switching plans or disenrolling under the
22 special enrollment period, Medicare-Medicaid Plan enrollees

1 should be treated the same as other dually eligible
2 beneficiaries in Medicare Advantage.
3 Next slide, please.
4 Continuous enrollment would be consistent with
5 current CMS policy for states participating in the
6 Financial Alignment Initiative. Those states have been
7 allowed to have continuous enrollment, but that also means
8 that beneficiaries can switch out of plans or disenroll
9 monthly. This is in comparison to a narrower special
10 enrollment period that applies to other dually eligible
11 beneficiaries enrolled in Medicare Advantage. This
12 recommendation would newly apply narrower limits on plan
13 changes and disenrollment and MMP enrollees but would
14 continue to allow beneficiaries to select an MMP at any
15 time. This could enable better continuity of care but also
16 maintain state preferences for continuous enrollment.
17 Next slide, please.
18 Now I'll move on to the second draft
19 recommendation, which reads, "Congress should provide
20 additional federal funds to enhance state capacity to
21 develop expertise in Medicare and to implement integrated
22 care models."

1 Next slide, please.

2 The reasoning for this recommendation is that
3 state development of Medicare expertise is essential to
4 integrating care. For example, designing D-SNP contracts
5 requires expertise in Medicare Advantage eligibility rules,
6 benefits, and processes. As the draft discusses, states
7 have competing demands on their resources, yet new models
8 require extensive planning and often dedicated staff. Up-
9 front costs to launch new products may be significant and
10 require state legislative approval, even when it ultimately
11 reduces state spending.

12 Next slide, please.

13 We look forward to hearing your feedback during
14 the discussion on these chapters and the draft
15 recommendations, and with that, we'll turn it back to the
16 Chair. Thank you.

17 CHAIR BELLA: Thank you very much, Anna, Kirstin,
18 and Kristal.

19 I'm going to open it up to the Commissioners now.
20 I'd like to ask that we start with any clarifying questions
21 about the presentation or any of the material that was
22 presented, and then we will turn to the recommendations.

1 But, first, I'd just like to clear out any questions or
2 general comments about Chapter 1 or Chapter 2 before we get
3 into the specific recommendations.
4 Any Commissioner that would like to make a
5 comment, please raise your virtual hand.
6 [No response.]
7 CHAIR BELLA: Okay. wonderful. Thank you for
8 those slides. You guys have done a great job of laying out
9 our themes and kind of explaining to folks the evolution of
10 our work.
11 I will mention that there is a rule in play right
12 now regarding look-alikes in particular, and MACPAC is
13 commenting on that rule as well. Those comments will be
14 available.
15 We are going to now turn to the recommendations.
16 I'd like to just make one overarching comment, particularly
17 for the audience, people in the audience who may not have
18 heard our opening remarks regarding COVID and the fact we
19 recognize that all of this work was done pre-COVID-19.
20 With regard to Recommendation 2, in particular,
21 that is a very strong theme we hear from all corners about
22 the need to support states, and the issue of state capacity

1 was one before COVID-19 and will most certainly be one
2 post-COVID-19. Arguably, it will be even more important to
3 support states, but we as a Commission recognize that we
4 need to be appropriate and nuanced in terms of making these
5 recommendations. And so we will do our best to make sure
6 that we're not tone deaf in light of everything else going
7 on, while still remaining true to the recognition that
8 these are important things. And the importance doesn't
9 diminish with what everyone is trying to grapple with right
10 now.

11 Okay. With that said, as preface for the
12 recommendations, I'd like to now turn to comments on
13 Recommendations 1 or 2, and we will start with Toby
14 Douglas.

15 THE MODERATOR: Go ahead, Toby.

16 COMMISSIONER DOUGLAS: All right. Thank you,
17 Melanie, and great job, everyone, on the chapters and the
18 presentation. It is going to be a really great addition to
19 our work.

20 I did want to follow up on Melanie's comments
21 just around the context of the timing, the COVID, and
22 clearly, we're in the midst of Congress authorizing huge

1 additional spending for states as well as just general
2 public.
3 That being said, it is our responsibility to be
4 looking to the future of how both federal government and
5 the states manage both payment and access for Medicaid, and
6 when we look at context of overall spending, clearly these
7 chapters show from delivery of care, the complexities that
8 dual eligibles face.
9 When you look at it from spending, these
10 individuals consume a third of overall Medicaid spending, a
11 third of Medicare spending, $600 billion to spend on
12 Medicaid, so a third of that, a third of $750 billion in
13 Medicare.
14 In the context of future post-COVID,
15 unfortunately, it's looking like we're going to be facing a
16 significant economic recession, and states, as we faced
17 back in 2008-2009, have very little ways to manage their
18 budgets given the intersection between the FMAP bump that
19 then puts constraints on changing eligibility. At the same
20 time, we know that states will see increases in enrollment.
21 So now more than ever, they're going to look to
22 ways that they can manage complex populations and really

1 try to bend the cost curve, and this is both from a state
2 and federal perspective. It's providing these tools and
3 infrastructure at a time where they'll be cutting budgets
4 and probably cutting staffing. It will be even more
5 important to then focus on a population, the most
6 vulnerable, that has the most opportunity for reducing cost
7 over the long term. So I really think this is an important
8 recommendation.
9 Thank you.
10 CHAIR BELLA: Thank you, Toby.
11 We're going to go to Kit and then Sheldon and
12 then Chuck.
13 THE MODERATOR: All right. Kit's hand is no
14 longer raised. So we'll go to Sheldon. Go ahead, Sheldon.
15 COMMISSIONER RETCHIN: Can you hear me?
16 THE MODERATOR: We can.
17 CHAIR BELLA: Yes.
18 COMMISSIONER RETCHIN: Okay. I have a different
19 concern. We've recognized this before, but I was looking
20 at the -- am I still there? Can everybody hear me? Hello?
21 CHAIR BELLA: I can hear you. Sheldon, it's
22 Melanie. I can hear you.

1 COMMISSIONER RETCHIN: Okay. My concern really
2 is both pre-COVID, during COVID, and then exacerbated by
3 COVID, and there will be a tail of it. And that is that
4 almost all the integrated -- actually, all of the
5 integrated care models rely on not just the availability of
6 providers but particularly primary care, and I think that's
7 just something we're going to have to be aware of.
8 With the swelling enrollment of Medicaid as it
9 is, I'm not so sure it's going to go back so quickly.
10 There are particular areas of the country, in the South,
11 where primary care availability is exacerbated. There are
12 scope of practice restrictions for nonphysician primary
13 care clinicians. So it's just something that we have to be
14 aware of that access to primary care may actually make it
15 very difficult to roll out some of these integrated care
16 models, unless there are incentives for primary care to
17 take these patients on.
18 I think we've recognized that in previous reports
19 that providers are an obstacle, but I think it's really
20 exacerbated. It's going to be exacerbated by COVID, and
21 the tail on that is going to last a lot longer than the
22 epidemic itself.

1 Thanks.

2 CHAIR BELLA: That is a great point, Sheldon.
3 Thank you. We will make sure that we reflect those
4 comments as we think about how our reports are shaped by
5 the events that have happened since we did the work.

6 It looks like Kit has his hand raised again. So
7 I'd like to try going back to Kit, then Chuck, and then
8 Bill. Kit, you have the floor.

9 COMMISSIONER GORTON: Technology challenges this
10 morning. I apologize for the stuttered start, and this is
11 Kit Gorton for everybody who is listening.

12 I would like to make two points. One, with
13 respect to COVID, it isn't going away. Phase 1, we will
14 survive in terms of the first wave. It isn't going to be
15 pretty, but it will be back in the fall. We're not going
16 to have vaccines anytime soon. We still have a huge
17 population of people who are susceptible to the virus, and
18 so this is going to become part of life. And we're just
19 going to have to incorporate it.

20 So I would just encourage us not to be thinking
21 narrowly about how we all hope that the first wave of
22 infections and deaths are going to end in the summer. They

1 will, I hope, but COVID is going to be around. The fallout
2 from this, as Sheldon said, is going to be fairly long-
3 lasting.
4 Which takes me to my second comment about making
5 a spending recommendation in this context. We've already
6 got three stimulus packages that have been pushed out by
7 Congress and signed by the President. There's likely to be
8 more, and I do think it would be reasonable rather than
9 states using that money to rebuild an old model to be able
10 to deploy some of that money to move to a new model. So I
11 think that in the context of the moment where Congress is
12 thinking about what else do states need, I think it's a
13 perfectly germane time to say these integrated models will
14 work better when we have outbreaks like this. People will
15 survive them better, and it will give us greater assurance
16 that mortality and morbidity will be managed effectively.
17 So now is absolutely the time. I agree with Toby
18 about that. Now is absolutely the time to sort of earmark
19 some of that stimulus money that's going out and have it be
20 applied to improving states' technical capabilities around
21 these issues.
22 Thanks.

1 CHAIR BELLA: Thank you, Kit.

2 Chuck?

3 [No response.]

4 CHAIR BELLA: Chuck, would you still like to

5 comment?

6 [No response.]

7 CHAIR BELLA: Okay. Clara, can we move to Bill?

8 Chuck, I think, is having some audio issues, so we'll move

9 to Bill Scanlon. Then we'll come back to Chuck.

10 COMMISSIONER SCANLON: Hi. Thank you. Am I on?

11 [No response.]

12 COMMISSIONER SCANLON: Hello?

13 CHAIR BELLA: Yeah. We can hear you, Bill.

14 COMMISSIONER SCANLON: Okay. Sorry.

15 I am very supportive of the objectives here. I

16 agree that these are incredibly unusual times, and I'm

17 worrying about the timing of some of this and some of the

18 expectations.

19 The Recommendation No. 2 was set up about

20 developing expertise in terms of Medicare and also some of

21 the foundational work for integrating care at a state

22 level.

1 I worry about both the economies of giving all
2 the states responsibility for developing expertise in
3 Medicare. To me, there should be a more active,
4 centralized engagement by CMS to ensure that this is done
5 efficiently and effectively and as quickly as possible as
6 opposed to saying we're going to give states money and that
7 they should go out and solve this problem.
8 Secondly, the concern in terms of timing and
9 saying that they should be initiating integrated models or
10 developing integrated models at this point in time, I worry
11 about the idea of giving states another assignment in this
12 time of crisis. I understand that sometimes crises are
13 opportunities for innovation, but I also appreciate that
14 when people are in crisis that that's hard to recognize and
15 hard to actually operate.
16 I would be much more supportive of this
17 recommendation being focused on CMS taking the lead in
18 making sure these happen as opposed to thinking that there
19 is going to be a specific amount of money that the Congress
20 can appropriate that will be that helpful.
21 When we talked about this in January, it seemed
22 like the dollar amounts were relatively small, and at this

1 point in time when we're overwhelmed by so many things, it
2 seems like small-dollar amounts are not likely to have much
3 of an impact.
4 Thank you.
5 CHAIR BELLA: Chuck, are you able to comment at
6 this point?
7 [No response.]
8 CHAIR BELLA: Okay. Thank you, everyone, while
9 we're trying to work out technical glitches.
10 Bill, I guess I would make one observation on
11 your last comment, and this is having sat at CMS in the
12 duals office. Granted, none of this obviously was during
13 COVID. But in terms of small dollars don't make a big
14 difference, for the states that got a million dollars
15 through the Financial Alignment Initiative, it actually did
16 make a pretty big difference for them, and they were either
17 able to hire dedicated staff, or they were able to contract
18 with external consultants to help them put programs in
19 place, or they did important stakeholder work. So I don't
20 think it takes a lot of money if your goal is to dedicate
21 resources like we had heard from Virginia and Arizona.
22 I hear you on the timing. I would also say,

1 again, from having been in that position, there's no way
2 CMS can do this. CMS is always needing to do this in
3 partnership with the states, and the states are the ones
4 that have to make the decision that they have the
5 initiative and the capacity and the willingness to do this.
6 So I don't think we've been saying that every
7 state would get extra money regardless if they do
8 something, but it feels like if we are endorsing the belief
9 that building state capacity is important, that those
10 states that are able to take this on, whenever they're able
11 to take this on, would be able to avail themselves with
12 some support for capacity building in this area.
13 Echoing an earlier comment, of course, this is
14 going to be long-lasting, but it would be a real shame if
15 we put all of this money into these efforts and we didn't
16 come out somehow better on the other side for a population
17 that is most likely going to be disproportionately affected
18 by COVID, much less all of the other challenges we've
19 already been able to solve with integrated care.
20 So I guess my overall point is I personally think
21 it has to be led by the states, with strong CMS support,
22 and I do think a little bit can go a long way if we're

1 talking about capacity building.

2 It looks like Chuck is back and raring to go. So
3 I'm going to turn it to you, Chuck.

4 VICE CHAIR MILLIGAN: Let's go with the raring to
5 go part. I want to, first of all, compliment the MACPAC
6 staff for the presentation. I think it was really good,
7 and the work that led up to all of the slides and votes
8 today was really stellar, so thank you for that work.

9 I had two comments I wanted to make, and first I
10 think I'm going to just follow on, Melanie, what you were
11 saying, and a couple of other earlier comments from Toby
12 and Kit, in particular.

13 As we have seen from the demographic information
14 for the duals, that's going to be part of Chapter 1, this
15 is a population that has a high degree of disability, a
16 high degree of chronic illness, and a high degree of
17 vulnerability and risk. And I think when all is said and
18 done with COVID, we are going to see that this particular
19 part of the Medicaid population was particularly
20 vulnerable.

21 And I do think that the integrated care models --
22 I want to talk about it from a health care perspective for

1 a second, because the integrated care models with home and
2 community-based long-term services and supports, with
3 especially behavioral health on the Medicaid side, and then
4 with the Medicare benefits like pharmacy and physician and
5 telehealth from both directions, the outcomes for this
6 population in a pandemic would be enhanced and improved and
7 their risk reduced in an integrated care model.
8 And so I don't think that this is competing with
9 other investments around COVID. To me this is squarely
10 within how to reduce the risk for these kinds of
11 populations that are home-bound, dependent on pharmacy,
12 dependent on personal care attendants going into their
13 homes, higher risk of behavioral health needs, anxiety,
14 depression, serious mental illness. And I do think that --
15 I guess the way I would frame it is I don't view this as
16 competitive for the federal funding. I view this as
17 aligned to the federal funding.
18 And I wanted to make that point very directly
19 because I do think the dual eligibles that are not in an
20 integrated model that are home-bound and have behavioral
21 health needs, rely on long-term services, rely on home
22 health care workers, personal care attendants, they are the

1 most vulnerable here.

2 The second comment I wanted to make is really to
3 reinforce, for the public, a comment that was made by the
4 staff during the presentation, that this is kind of the
5 first part of our kind of a work plan about this. We do
6 anticipate doing additional work as MACPAC over the coming
7 year and years. And so I would just want to let everybody
8 know that, don't assume that this is kind of the end of
9 where we want to weigh in on this topic.

10 That's what I wanted to contribute. Melanie,
11 thank you.

12 CHAIR BELLA: Thank you, Chuck. Darin Gordon,
13 please.

14 COMMISSIONER GORDON: So I wanted to align myself
15 with some of the comments made by Toby, Sheldon, and
16 Melanie and Chuck. I think this is a super important area
17 for states to focus on. It is an area that we have heard
18 from states that they know it is important but they need
19 the support and resources to think about how they are going
20 to approach solving these problems. And as a state that
21 ventured down this path, it is a very complicated path, but
22 it was one that, when we got to the other side of it, after

1 several years of investing time and energy and resources
2 into it, that we were able to see a tremendous benefit for
3 the population. And just echoing some of the comments said
4 before, if you look within the Medicaid population, pre-
5 COVID or post-COVID, this is a population that needs
6 additional support. And I think some of the things that
7 states could do, in response to some of the recommendations
8 we make here, and actions by the federal government, could
9 actually go a long way to not only improving the quality of
10 care for this population but also do a tremendous job in
11 using limited funds more efficiently.
12 CHAIR BELLA: Thank you, Darin. Any other
13 comments from Commissioners?
14 Okay. I don't see any additional hands. I just
15 was going to reiterate and sort of wrap up with where Chuck
16 went, which is to say that this is an area that will have
17 ongoing work for the Commission. This is an area of great
18 interest for the Commission. There is a range of options
19 that will be discussed in the chapters, starting with as
20 was described, a couple of more modest ones, in particular,
21 the recommendations we are making today, ranging to
22 something pretty bold, which explores looking at a brand-

1 new program that would be more appropriate for people that
2 have the multitude of needs that this population faces
3 today, and would look at how do we perhaps get out of
4 always trying to work around or put Band-Aids on the two
5 programs that really weren't ever meant to work together.
6 And in between the modest and the bold is a bunch
7 of other really exciting stuff that we will continue to
8 work on in future cycles.
9 So we are going to end this panel. Thank you all
10 and thank you to the presenters.
11 And we are going to move to our second
12 presentation, which has to do with improving participation
13 in the Medicare Savings Programs. And I am going to turn
14 it over to Kate and Kirstin. Thank you.
15 [Pause.]
16 CHAIR BELLA: Can we make sure Kate and Kirstin
17 are both --
18 MS. KIRCHGRABER: Sorry. I was muted.
19 CHAIR BELLA: Great. Thank you.
20 **### REVIEW OF CHAPTER FOR JUNE REPORT: IMPROVING**
21 **PARTICIPATION IN THE MEDICARE SAVINGS PROGRAMS**
22 * MS. KIRCHGRABER: Good morning, Commissioners.

1 This is Kate Kirchgraber. I hope everyone is
2 well. Before I get started, I just wanted to acknowledge I
3 am doing the presentation but Kirstin has contributed and
4 done a ton of work on both the presentation and the
5 chapter. So I just wanted to acknowledge and thank her for
6 that.
7 So today we're going to review the content of the
8 draft chapter on the Medicare Savings Programs, or the MSPs
9 as we call them. Sorry. I'm just trying to get the first
10 slide to come up, which it doesn't want to do. There we
11 go. Sorry. Now I'm getting ahead of myself. Okay. Sorry
12 about that.
13 So today we're going to discuss both the content
14 of the draft chapter on the Medicare Savings Programs and
15 the draft recommendations that we developed following the
16 discussion at the February meeting, and that's the
17 recommendation that you will vote on later this afternoon.
18 So as you may recall, under the MSPs, state
19 Medicaid programs pay for Medicare premiums and cost-
20 sharing for low-income, dually eligible beneficiaries. And
21 we know from prior MACPAC work that cost sharing assistance
22 can affect beneficiary use of services, and the

1 participation rates in the MSPs are relatively low, with
2 only about half of eligible beneficiaries enrolled.
3 So our work this year has been focused on
4 examining issues related to MSP enrollment, identifying
5 barriers faced by beneficiaries and states, and exploring
6 policy options aimed at increasing participation of
7 eligible beneficiaries and improving access to care.
8 We found that varying state approaches to program
9 administration, conflicting requirements between the MSPs
10 and other federal programs that serve similar low-income
11 populations, and a lack of awareness among eligible
12 beneficiaries all contribute to low enrollment. The
13 Commission considered a number of policy options to improve
14 enrollment in the MSPs and we will review those in a bit.
15 On this slide you can see the main sections of
16 the chapter, which begins with a brief review of the
17 benefits provided to dually eligible beneficiaries. As you
18 will recall, Medicaid and Medicare cover some of the same
19 services, but Medicare is the primary payer when benefits
20 overlap. Medicare generally pays for physician services,
21 inpatient and outpatient acute care, post-acute skilled
22 care, and prescription drugs. All Medicare beneficiaries

1 are eligible for the same benefits and are required to pay
2 premiums and cost-sharing, which can be challenging for
3 low-income beneficiaries to afford.
4 Medicaid wraps around Medicare's coverage by
5 paying Medicare premiums and cost-sharing and by covering
6 services not covered by Medicare, such as long-term
7 services and supports.
8 The majority of dually eligible beneficiaries,
9 about 71 percent, are eligible for full Medicaid benefits.
10 Partial benefit dually eligible beneficiaries make up about
11 29 percent of the dually eligible population, but they only
12 receive help paying for Medicare premiums and cost-sharing.
13 As you can see on this slide, MSPs are composed
14 of four separate programs that provide varying levels of
15 assistance and have different eligibility criteria. The
16 Qualified Medicare Beneficiary, or QMB program, is the most
17 expansive of the MSPs in terms of the number of
18 beneficiaries it covers and the benefits it provides. The
19 Specified Low-Income Medicare Beneficiary, or SLMB,
20 program, and the Qualifying Individuals, or QI, program
21 only pay for Medicare Part B premiums. The Qualified
22 Disabled and Working Individuals, or QDWI, program is the

1 smallest of the MSPs and it just pays for Medicare Part A
2 premiums for a specific subset of dually eligible
3 beneficiaries.
4 And just as a reminder, our discussions in the
5 chapter and the recommendation are limited to these first
6 three programs, so we are really just talking about QMBs,
7 SLMBs, and QIs.
8 Individuals have to apply for the MSPs through
9 their state Medicaid programs and must provide
10 documentation to verify their eligibility. States are
11 required to redetermine eligibility at least once every 12
12 months. In 2018, approximately 9.9 million dually eligible
13 beneficiaries received assistance through the MSPs. The
14 majority of those, about 79 percent, were enrolled in the
15 QMB program. But we know that participation rates are
16 generally low across the MSPs, with only about half of
17 eligible beneficiaries enrolled.
18 So a number of reasons have been cited for low
19 enrollment in the MSPs. For example, state policy choices
20 may be inconsistent with standards used both by other
21 states and the federal government for programs that serve
22 similar populations. Specifically, the one that we have

1 looked at, there are differences between state policies for
2 counting income, assets, and household size for the MSPs,
3 and federal policies for the Medicare Part D low-income
4 subsidy, or LIS program. And those differences make it
5 difficult to automate and streamline MSP enrollment. As
6 you saw in the draft chapter, our recommendation relates to
7 this issue.

8 But before we get to that, I am just going to
9 take a minute to review the other options that we
10 considered. As you might remember, we looked at a number
11 of options of varying levels of complexity. Starting with
12 the most simple, the Commission considered an increase in
13 outreach funding and administrative changes like requiring
14 the use of pre-populated forms for eligibility
15 redeterminations. We also discussed the possibility of
16 extending the timeline for eligibility redeterminations to
17 three years.

18 The most comprehensive option we examined was to
19 consolidate the MSPs into one program covering Medicare
20 premiums and cost-sharing for dually eligible beneficiaries
21 with incomes up to 135 percent of the federal poverty
22 level. But the bulk of the Commission's time was spent

1 discussing the interplay between the MSPs and the Part D
2 LIS program and finding ways to streamline the MSP
3 enrollment and eligibility redetermination process.
4 Which leads us to our draft recommendation. So
5 the draft recommendation reads:
6 Congress should amend Section 1902(r)(2)(A) of
7 the Social Security Act to require that when determining
8 eligibility for the Medicare Savings Programs, states use
9 the same definitions of income, household size, and assets
10 as the Social Security Administration uses when determining
11 eligibility for the Part D Low-Income Subsidy program. To
12 reduce administrative burden for states and beneficiaries
13 related to MSP redeterminations, Congress should amend
14 Section 1144 of the Social Security Act to require SSA to
15 transfer continuing LIS program eligibility data to states
16 on an annual basis.
17 So these are sort of two companion statutory
18 changes that are both aimed at increasing enrollment and
19 simplifying eligibility redeterminations.
20 The Medicare Improvements for Patients and
21 Providers Act of 2008, or MIPPA, amended the Social
22 Security Act to make the asset limits for the MSPs conform

1 to the asset limits for full LIS benefits, but despite this
2 change many states still count assets differently than SSA
3 does for the LIS program. This prevents those states from
4 using the SSA data to assess eligibility and may require
5 beneficiaries to submit additional documentation. At last
6 count, which was in 2012, 29 states required reverification
7 of asset data and 30 states reverified income data.
8 Requiring states to adopt the SSA definitions of
9 income, household size, and assets eliminates that need to
10 reverify the SSA data when beneficiaries are enrolling in
11 MSPs. So that gets at the first half of our
12 recommendation.
13 The second half of the recommendation would ease
14 the redetermination process. So even though SSA transfers
15 eligibility data from LIS applications to states, which
16 then the states use to start an MSP application, states
17 don't get the SSA data for eligibility redeterminations.
18 And SSA checks eligibility for LIS annually -- they do it
19 in August of every year -- but they don't pass that
20 information to the states. So the second part of this
21 recommendation would require SSA to share those data as
22 well.

1 With respect to the federal implications of the
2 recommendation, an increase in MSP enrollment would
3 increase federal costs. These costs would include matching
4 payments to state Medicaid programs both for the Medicare
5 premium and cost-sharing payments that states would be
6 making and for spending related to any increase in the
7 number of beneficiaries who qualify for full Medicaid
8 benefits.
9 But there would also be effects on Medicare and
10 the LIS program. If this policy results in any new MSP
11 enrollment sort of outside of the enrollment that results
12 directly from the application transfer, the enrollment in
13 LIS would increase. The policy could also have spillover
14 effects on Medicare Part B premiums because those include
15 an assumption about the number of full benefit dually
16 eligible beneficiaries.
17 So we were unable to get an estimate of the
18 budgetary effects from CBO. Development of an estimate
19 would require the creation of a new forecasting model and
20 collection of data that aren't currently available. For
21 example, we don't have complete information on the number
22 of people who are eligible for but not enrolled in each MSP

1 in each state. It is also difficult to know how the change
2 in policy would affect the relative distribution of
3 enrollment in each MSP, since we don't know which MSP the
4 new enrollees will qualify for.
5 This matters because, for instance, if the QI
6 program, which is fully federally funded, if there was a
7 large increase in enrollment in that program it would
8 increase federal costs more than a similar enrollment
9 increase in QMBs or SLMBs, since those programs are matched
10 at the regular FMAP, so it is hard to figure out the
11 distribution of those.
12 With respect to states, increased enrollment
13 would increase state Medicaid costs, but some of those
14 costs could be offset by the simpler eligibility
15 determination process. State costs could also be offset if
16 more Medicaid beneficiaries enroll in Medicare Parts A and
17 B, because Medicare would assume -- would become primary
18 payer for services that Medicaid was covering.
19 The recommendation would help beneficiaries by
20 enabling more of them to obtain assistance for paying for
21 Medicare premiums and cost-sharing, which would improve
22 their access to care. It would also reduce the burden of

1 submitting additional paperwork. And we found no direct
2 effects on plans and providers.
3 And with that I will leave the draft
4 recommendation up for your discussion, and I look forward
5 to hearing what you have to say. Thank you.
6 CHAIR BELLA: Great. Thank you very much, Kate
7 and Kirstin, for your work on this. Similar to the way we
8 did the last session I will first ask the Commissioners to
9 raise their hands if they have any questions about any of
10 the descriptive work or the analysis or any questions about
11 the overall themes that Kate presented this morning, and
12 then we will turn to the recommendation itself.
13 [Pause.]
14 CHAIR BELLA: Okay. I see no hands so we will
15 turn to the recommendation, and I would like to invite
16 Commissioners to please share any comments, feedback,
17 concerns, questions on the recommendation itself, which
18 should still be up on your screen.
19 [Pause.]
20 CHAIR BELLA: Kate, I just have sort of a
21 clarifying question. It feels to me like this is very
22 consistent with the legislative intent of MIPPA when

1 Congress was intending to try to align these two programs.
2 Can you speak a little bit about that? Like is this far
3 afield from where it looks like Congress was trying to take
4 the programs, in terms of aligning and simplifying and
5 doing all those things?

6 MS. KIRCHGRABER: Sure. I think -- so we
7 actually looked for a committee report going back to MIPPA,
8 from the committees of jurisdiction, and we couldn't find
9 one, but we could find both the CBO score and a later GAO
10 report that both -- you know, CBO definitely looked at it
11 as an expansion of MSP eligibility, to make the asset test
12 -- or make the asset counting the same. And GAO also sort
13 of made a similar reference in their 2012 report. So we
14 think, yes, that was the congressional intent, even though
15 we can't find the specific report language, but we do think
16 that was the intent.

17 CHAIR BELLA: Okay. Thank you. We will turn now
18 to Toby Douglas and then Chuck.

19 COMMISSIONER DOUGLAS: Melanie, thank you.

20 This is another one where when we looked at this
21 a couple months ago, definitely 100 percent supported, and
22 now given the budget challenges that both federal

1 government and states will inevitably be facing, it made me
2 pause and think is this the right direction.
3 But stepping back and thinking this through, both
4 in terms of the context of COVID and the population which
5 Sheldon and others articulated really well, and when you
6 bring it into the intent of what has gone on within
7 eligibility and enrollment across Medicaid in terms of
8 streamlining and the Affordable Care Act, these are
9 unnecessary barriers to enrollment. What we're proposing
10 here is to streamline and align with the vision of
11 eligibility and enrollment across multiple programs to
12 ensure that those who are eligible have an easier way of
13 getting on to these programs.
14 So while it does increase and will increase costs
15 to states, the benefits, both in terms of ensuring those
16 who are eligible and from a program integrity, still ensure
17 those safeguards are on the program as well as the health
18 benefits, and this time of COVID leads me to continue to
19 support this approach.
20 CHAIR BELLA: Thank you, Toby.
21 Chuck?
22 VICE CHAIR MILLIGAN: I want to align myself with

1 what Toby just said, and thank you, Kate and Kirstin, for
2 the work here.
3 First is I think this also aligns with the
4 process in a lot of other eligibility groups. So it's
5 similar to MAGI, and it's similar to how most states adjust
6 and use the Social Security Administration disability rules
7 for SSI. So I think this is part of a broader theme that I
8 think is a sensible way of eliminating barriers for
9 eligibility and streamlining the administration.
10 The second comment I wanted to make is that this
11 will have benefits also in how Medicaid aligns with
12 Medicare around Medicare Advantage rules. Medicare
13 Advantage program structures distinctions around LIS
14 status, and the more that MSP and LIS get aligned, the more
15 things like how special supplemental benefits for the
16 chronically ill, or SSBCI, can get organized around
17 characteristics of partial duals in a way that is sensible
18 to the Medicare program and Medicare Advantage.
19 So I do think, to me, it's not just an
20 eligibility pathway and take up and eliminating barriers
21 kind of benefit here. I think it also facilitates
22 alignment with MA for partial duals.

1 So I will leave it there. Thank you.

2 CHAIR BELLA: Thank you, Chuck.

3 Bill Scanlon.

4 COMMISSIONER SCANLON: Hi. Thank you.

5 Actually, I got knocked off the webinar, and I
6 hopefully heard most of what was being said and had to
7 redial in.

8 I am fully supportive of this, and I guess I
9 wanted to raise the question. In our materials, we have a
10 table that shows that there's a number of states that have
11 more generous income and assets standards out in the LIS
12 program, and so I'm wondering if the recommendation needs
13 to acknowledge that when we say the states are required to
14 use these definitions that they also have the latitude of
15 going beyond these definitions to increase eligibility.

16 I understand saying that requiring definitions
17 isn't establishing a threshold, but in some respects, the
18 way one defines something can be an implicit threshold.

19 CHAIR BELLA: Thank you, Bill.

20 I think, certainly, with the intent of the
21 recommendation being to -- it certainly is not to be more
22 restrictive, and so we can certainly clarify intent with

1 regard to states that have more generous approaches today.
2 I don't know, Kate or Anne, if you have anything
3 to add to that, but I think it's an important point to
4 raise so we can make sure we address it in the chapter.
5 MS. KIRCHGRABER: Yeah. We can definitely
6 address that in the chapter, and I think it was Bill who
7 pointed out that we meant to. So we will incorporate that
8 back in. We had had it in some earlier memos. Earlier in
9 either December or January, I think we talked about it. So
10 we will make sure that that gets into the chapter as well.
11 CHAIR BELLA: Okay. Thank you.
12 Other Commissioners who would like to comment on
13 this recommendation?
14 [No response.]
15 CHAIR BELLA: This is a very quiet crew today.
16 All right. I'll just wait a few more seconds to see if
17 anyone has any last thoughts.
18 [No response.]
19 CHAIR BELLA: Okay. It appears that we have no
20 additional comments.
21 I want to thank you as well. This is an
22 important issue. I think when Tim Engelhardt came and

1 visited, he said, "Don't forget about the MSP program
2 because there's always a lot of attention to integrated
3 programs and other things, and oftentimes maybe this gets
4 overlooked," so appreciate the work that we've done here,
5 looking at various options. And I think from the
6 Commission's viewpoint, we feel like the recommendation put
7 forward is the most impactful with the objectives that we
8 were trying to achieve. So thank you very much for that
9 work.
10 We will now turn to our next presentation, which
11 is on coordination of benefits with TRICARE, and Moira will
12 be presenting.
13 **### REVIEW OF CHAPTER FOR JUNE REPORT: COORDINATION**
14 **OF BENEFITS WITH TRICARE**
15 * MS. FORBES: Thanks, Melanie.
16 At our last meeting, I presented some additional
17 findings on the barriers to coordination between Medicaid
18 and the TRICARE program, which is the Department of Defense
19 program for civilian health benefits for military
20 personnel, military retirees, and their dependents.
21 At the end of that meeting, the Commission
22 expressed interest in potentially making a recommendation

1 to the Secretary or to the Congress based on our findings.

2 Today I will recap the material that has been
3 previously presented, and that could be included in a
4 chapter for the June report. This includes background on
5 Medicaid third-party liability or TPL policies, how
6 Medicaid and TRICARE coordinate benefits for the almost
7 900,000 people who are covered by both programs, and the
8 main operational and policy gaps that limit effective
9 coordination of benefits between the two programs along
10 with the consequences this has for Medicaid.

11 At the last meeting, the Commission talked about
12 some of the potential steps that CMS and other agencies
13 could take to mitigate these gaps. We have drafted two
14 potential recommendations for consideration based on your
15 discussion, along with a summary of the rationale and some
16 information on the potential effects of each
17 recommendation.

18 I will go through the next few slides quickly as
19 this is material we have covered before, but I can go back
20 and clarify or answer questions, if needed.

21 Medicaid, as a safety net program, is the payer
22 of last resort, meaning that generally all other sources of

1 coverage must pay claims under their policies before
2 Medicaid will pay.
3 Medicaid coordinates benefits with other insurers
4 as a secondary payer. This means if an insurer and
5 Medicaid both provide coverage of a given benefit, the
6 other payer is responsible for making payment, and Medicaid
7 is responsible only for any balance covered under Medicaid
8 payment rules.
9 Medicare and other public programs can be liable
10 third parties as well as private insurers.
11 States find out about other sources of coverage
12 from Medicaid beneficiaries themselves at enrollment and
13 renewal and through periodic data matches with other
14 insurers or data clearinghouses.
15 Studies by the GAO and others have shown that
16 it's better to know about other sources of coverage up
17 front in order to avoid paying claims that another insurer
18 is responsible for, than to pay and then seek reimbursement
19 from the other insurer, which is known as "pay and chase."
20 This is also why a lot of insurers and states
21 choose to work with data clearinghouses, which are vendors
22 with agreements with many insurance companies to share

1 data. They find that there is a positive return on
2 investment from being able to more effectively cost avoid
3 TPL claims.
4 To help reinforce Medicaid's status as the payer
5 of last resort and to help Medicaid be able to cost-avoid
6 instead of pay and chase, in the Deficit Reduction Act of
7 2005, Congress created a number of affirmative
8 responsibilities for states related to Medicaid TPL. For
9 example, they have to take reasonable measures to identify
10 and collect TPL. They have to require insurers in the
11 state to conduct data matches with Medicaid and to accept
12 TPL claims for up to three years, and insurers have to
13 provide plan eligibility and coverage information to
14 Medicaid.
15 The Office of the Inspector General found that
16 Medicaid TPL recoveries increased after these requirements
17 went into effect. A lot of states now use contractor
18 support to complete the required matches or work with TPL
19 clearinghouses. However, these requirements apply only to
20 private insurers. Congress did not apply these same
21 requirements to public programs, including Medicare and
22 TRICARE.

1 So now I'll recap some of the information about
2 coordination between Medicaid and TRICARE specifically. As
3 I said at the beginning, TRICARE is the DoD program for
4 civilian health benefits for active duty personnel and
5 their families. It's like the employee health insurance
6 for people whose job is the military.
7 Almost 900,000 Medicaid enrollees have primary
8 coverage through TRICARE. That's about 1.5 percent of
9 Medicaid enrollees, although that percentage varies by
10 state, depending on how many active duty military personnel
11 are stationed in each state.
12 For about 30 years, starting in the mid-'80s
13 until recently, states and the Defense Health Agency, or
14 DHA, which administers the civilian health program,
15 routinely shared enrollment files to support coordination
16 of benefits between the programs. TRICARE is the name of
17 the program. It's the primary payer. It processes claims
18 according to its policies. Medicaid is the secondary
19 payer. So it covers cost sharing for TRICARE services and
20 pays for Medicaid services that TRICARE doesn't cover, such
21 as adult dental and states that cover that.
22 So a little more about the data sharing between

1 the DHA and states. Between 1987 and 2017, the DoD and CMS
2 had a formal agreement that allowed state agencies to share
3 eligibility records with the DHA each year in order to
4 determine which Medicaid enrollees might also have coverage
5 through TRICARE.

6 In 2017, as part of the periodic review and
7 renewal of the data sharing agreement, CMS determined that
8 it was no longer able to certify the data security
9 provisions of the agreement. Without a signed agreement,
10 DHA stopped sharing files with state Medicaid agencies.
11 Without a mechanism for routinely getting eligibility and
12 coverage data, states cannot identify all of the Medicaid
13 enrollees who also have TRICARE coverage. Therefore,
14 states are very likely paying claims that should be paid
15 first by TRICARE.

16 To the extent that these payments can't be
17 recouped by Medicaid, the lack of a routine, complete
18 eligibility data match results in a cost shift from DoD to
19 state Medicaid agencies and HHS. Reinstating the data
20 match would help ensure that Medicaid remains the payer of
21 last resort as intended by Congress.

22 The Commission has heard that several aspects of

1 the process for coordinating benefits between Medicaid and
2 TRICARE limit states' abilities to collect TPL from TRICARE
3 carriers. So this mainly applies when there was the
4 process for actually sharing data.
5 When the DHA was conducting data matches with the
6 states, it was only doing so once per year with each state,
7 even though Medicaid eligibility is performed on an ongoing
8 basis and it can change from month to month.
9 In addition, TRICARE policy is to only accept TPL
10 claims from one year from date of service or from the date
11 of the last data match, again, when they were doing the
12 data matches.
13 The OIG surveyed states about this almost 10
14 years ago, and at the time, the vast majority of states
15 reported that the differences between Medicaid and TRICARE
16 filing timelines and the length of time it takes states to
17 file TPL claims after the data match made it very
18 challenging for their ability to recover liable third-party
19 payments, but in the 10 years since states were surveyed
20 about this and those findings were reported, there haven't
21 been any policy changes.
22 It may take states more than a year from the date

1 of service to receive and review a claim within the normal
2 course of business. That's a minority of claims, of
3 course, but it is possible under Medicaid rules, which is
4 one of the reasons that Congress created the DRA provision
5 requiring insurers to accept TPL requests from states for
6 up to three years after the date of service.
7 By limiting TRICARE TPL claims to one year, it is
8 likely that the timely filing policy results in states
9 improperly paying claims that are the responsibility of the
10 DoD.
11 Another TRICARE policy is to coordinate benefits
12 only with state Medicaid agencies. The carriers will not
13 accept claims for Medicaid managed care organizations.
14 CMS has stated in guidance on the Deficit
15 Reduction Act provisions that when TPL responsibilities are
16 delegated to a contracted MCO, third parties are required
17 to treat the MCO as if it were the state Medicaid agency,
18 including providing access to third-party eligibility and
19 claims data, to identify individuals with third-party
20 coverage, and adhering to the assignment of rights from the
21 state to the MCO. However, TRICARE, again, is not subject
22 to the DRA provisions.

1 So while two-thirds of Medicaid beneficiaries are
2 enrolled in comprehensive managed care plans and most of
3 those MCOs are delegated TPL responsibilities in their
4 contracts with the states, DHA won't share data with MCOs,
5 and the TRICARE carriers will only coordinate benefits with
6 and accept claims from state Medicaid agencies. This means
7 that states can only collect third-party liability for the
8 subset of Medicaid payments for fee-for-service. It also
9 complicates states' abilities to accurately set payment
10 rates for Medicaid MCOs.
11 When setting capitation rates, if states delegate
12 TPL responsibilities to Medicaid MCOs, they assume the MCO
13 can recoup a reasonable proportion of the claims that are
14 the responsibility of a reliable third party. As DHA will
15 not coordinate directly with MCOs, they are likely paying
16 claims that are the responsibility of the DoD, meaning that
17 the capitation rates are also inaccurate because they
18 overestimate the cost of providing services or
19 underestimate TPL recoveries.
20 Moving on to the draft recommendations, the goal
21 of both of these recommendations is to improve coordination
22 of benefits between Medicare and TRICARE and ensure that

1 claims costs are not inappropriately shifted to states and
2 the U.S. Department of Health and Human Services from the
3 Department of Defense.
4 The first recommendation would restart the
5 agreement needed for state Medicaid agencies and the
6 Defense Health Agency to routinely share eligibility and
7 coverage data. It reads, "The Centers for Medicare and
8 Medicaid Services should facilitate state Medicaid agency
9 coordination of benefits with the Department of Defense
10 TRICARE program by working with the Department of Defense
11 to develop a mechanism for routinely sharing eligibility
12 and coverage data between state Medicaid agencies and the
13 Defense Health Agency."
14 This recommendation would increase the integrity
15 of the Medicaid program and reduce cost shifting from
16 Medicaid to TRICARE. We anticipate this would increase
17 federal spending, as Medicaid is partially paid for by the
18 states and TRICARE is a wholly federal program, but it
19 doesn't represent new federal spending, as TRICARE is
20 already responsible for these payments.
21 The Congressional Budget Office, or CBO, was
22 unable to provide cost estimates for changes to federal

1 spending that could result from this recommendation, but
2 when they do provide estimates, it's from the perspective
3 of the unified federal budget, meaning that if they had
4 given us an estimate, they wouldn't have netted out the
5 estimate of Medicaid savings and TRICARE costs resulting
6 from this recommendation. They would have only given us
7 any net effects on federal spending.
8 We expect that this recommendation would change
9 the administrative demands on states. They would have some
10 additional administrative activities associated with the
11 data match, but improved coordination of benefits could
12 potentially streamline benefit administration and reduce
13 the need for repayment negotiations.
14 At the same time, some claims costs currently
15 borne by the states would be shifted back to the DoD. It's
16 possible the reduced claims cost would outweigh any
17 additional administrative burdens, but we don't have
18 details on how that might net out.
19 There could be some improvements for Medicaid
20 enrollees who have primary insurance coverage through
21 TRICARE as improved coordination of benefits should
22 simplify Medicaid payment of patient cost sharing.

1 Improved coordination of benefits should also
2 affect providers by helping to assure that claims will be
3 paid by the appropriate organization at first billing,
4 which would help improve their speed and accuracy of
5 provider payment.
6 We can't analyze the potential effects of
7 payments on detail. We don't have the data, but it's
8 possible that providers could receive higher payments if
9 TRICARE becomes a primary payer for services provided to
10 enrollees of both Medicaid and TRICARE coverage as TRICARE
11 physician rates are generally based on the Medicare fee
12 schedule, which is typically higher than the Medicaid fee
13 schedule.
14 We have identified four main points to include in
15 the rationale supporting this recommendation, but if you
16 vote to adopt this recommendation, I would appreciate your
17 feedback on whether there are other points we should
18 emphasize or changes you would suggest to these. The four
19 points are: Medicaid is the payer of last resort and
20 coordinates with other insurers as a secondary payer;
21 effective coordination of benefits requires information on
22 other health insurance prior to claims payment; almost

1 900,000 individuals have both TRICARE and Medicaid, but
2 there is no automatic mechanism for states to identify
3 whether individuals have TRICARE or changes, resulting in
4 missed opportunities for COB; and, TRICARE is a federal
5 program, and federal-level action is needed to address
6 operational and policy differences.

7 And I think I'll read the second draft
8 recommendation, and then we can go back. I'll just finish.
9 The second recommendation would support Medicaid's role as
10 payer of last resort by requiring TRICARE to follow the
11 same coordination of benefits policies as other insurers:
12 "To protect Medicaid from improper payment of claims that
13 are the responsibility of a third party and improve
14 coordination of benefits for persons with coverage through
15 both Medicaid and TRICARE, Congress should direct the
16 Department of Defense to require its carriers to implement
17 the same third-party liability policies as other health
18 insurers, as defined in" -- this is referencing those DRA
19 provisions, "section 1902(a)(25) of the Social Security
20 Act."

21 While statutory changes are not necessary to make
22 certain changes that would improve the TPL process, the DHA

1 has the administrative authority to make some of these
2 changes. As of right now, the Medicaid and TRICARE
3 programs haven't -- first of all, they haven't been
4 coordinating benefits for over three years, despite efforts
5 to improve coordination at the agency level.
6 From the Medicaid perspective, aligning the
7 requirements with TRICARE with the requirements for other
8 third-party insurers would be administratively
9 straightforward.
10 Because Congress explicitly exempts TRICARE from
11 state and local laws related to health insurance, a
12 statutory change would be needed to extend those
13 requirements to TRICARE. This would also be consistent
14 with prior Commission recommendations to Congress to, for
15 example, change the statute to avoid Medicaid making
16 disproportionate share hospital payments to cover costs of
17 the primary responsibility of other payers. It would also
18 be possible for Congress to direct DoD to make changes
19 without a statutory change, that the recommendation doesn't
20 have to be as statutory language.
21 Similar to the first recommendation, this
22 recommendation would increase the integrity of the Medicaid

1 program and reduce cost shifting from Medicaid to TRICARE.
2 This would increase federal spending by shifting spending
3 back to TRICARE, which is wholly federal, but it doesn't
4 represent new federal spending. Again, we don't have CBO
5 cost estimates.
6 The total effects to both programs for
7 implementing all the components of this recommendation
8 would likely be greater from Recommendation 1.
9 Recommendation 1 would only reinstate the data match. This
10 one would change the timely filing limit and managed care
11 coordination benefits and so on.
12 This recommendation would change the
13 administrative demands on states. Again, they would have
14 additional administrative activities associated with
15 coordination of benefits but be returning liability from
16 any claims back to primary payer, DoD. Over time, states
17 would have more accurate data to set capitation rates.
18 It's possible that these reduced claims and capitation
19 costs would outweigh any additional administrative burdens,
20 but we don't have details on how that might net out. We
21 hope that the other changes would affect Medicaid managed
22 care enrollees by helping to support coordination of

1 benefits, and it would affect other Medicaid enrollees by
2 helping to improve coverage of patient cost sharing. And
3 it would help, again, providers by helping to assure that
4 claims are paid by the appropriate payer, improving the
5 speed and accuracy of payment, and some providers,
6 including fee-for-service and managed care providers, could
7 receive higher payment if TRICARE becomes a primary payer
8 for services provided to enrollees with both Medicaid and
9 TRICARE coverage.

10 We have also identified four points that support
11 this recommendation, if the Commission chooses to move
12 forward with it, but again I would appreciate your feedback
13 on whether there is anything we should emphasize or change.

14 The four points are: Medicaid is the payer of
15 last resort and coordinates with other insurers as a
16 secondary payer; Congress has previously taken action to
17 ensure that state licensed insurers, or I guess non-public
18 insurers, coordination of benefits policies do not
19 appropriately limit the ability of Medicaid to collect TPL;
20 TRICARE is exempted from this statute and has policies that
21 limit states' abilities to coordinate benefits and collect
22 TPL; and, Congress could take action to apply similar

1 policies to TRICARE in order to limit any cost shifts from
2 the Department of Defense to Medicaid.
3 So with that I will turn it over to you. I can
4 answer questions on the background. I can go back to the
5 first recommendation. Melanie, however you want to handle
6 this now.
7 CHAIR BELLA: Okay. Thank you, Moira. We are
8 going to start with any clarifying questions from
9 Commissioners about this body of work, or the key themes of
10 the work, and then we will turn specifically to each of the
11 recommendations.
12 So I would ask for any -- oh great. We have at
13 least three hands. So we are going to start with Kit and
14 then move to Peter and then Stacey, please.
15 COMMISSIONER GORTON: Hi. This is Kit Gorton.
16 So I am supportive of the recommendation. What I did want
17 to say, with respect to the chapter and the rationale, the
18 last time we discussed this I got confused about payment of
19 clean claims versus payment of TPL claims and the time
20 frames which are required for this. And I think the
21 chapter that was drafted was very helpful to me to tease
22 those apart. And I just want to flag for other people who

1 may have been confused by that, that what we are talking
2 about is timely payment for TPL claims, and that's an
3 important distinction that at least I got confused with
4 last time. So thank you, Moira, for writing a chapter
5 which I think clearly differentiates between the two.
6 CHAIR BELLA: Thank you, Kit. Peter?
7 COMMISSIONER SZILAGYI: This is Peter Szilagyi.
8 Can you hear me?
9 CHAIR BELLA: Yes, we can hear you.
10 COMMISSIONER SZILAGYI: Okay. Great. Thank you.
11 Thank you, Moira, for an excellent chapter and a really
12 clear presentation.
13 A couple of points. I do want to point out that
14 out of the nearly 900,000 enrollees we are talking about,
15 many of these are children. One point that we may want to
16 add to the rationale is the implication for access to care
17 for the beneficiaries, unless I have missed that. And I
18 can see some benefits, particularly for the Medicaid
19 managed care enrollees with coordination. Are there any --
20 and I didn't see this in the chapter -- are there any
21 potential downsides for access to care for enrollees?
22 Might there be delays in care in some ways? I can see some

1 advantages. For example, some providers might not be
2 Medicaid providers but TRICARE providers. So I can see
3 advantages. But might there be some disadvantages?
4 CHAIR BELLA: Moira, did you want to answer that?
5 MS. FORBES: Yeah, sorry. I was overly
6 aggressive on the muting. That's a good question, Peter.
7 We certainly can include information on the proportion of
8 children. I think that maybe was in the chapter but not
9 the presentation. There are a lot of children affected by
10 this.
11 In terms of access, let me think through what
12 those implications are. But I think that's something we
13 can try and think through and address. On the fly I don't
14 want to say the wrong thing, but I think we can, certainly
15 there's the payment angle and there may be, like you said,
16 that network angle. So we can definitely think about that
17 and maybe do a little more research, and if there is
18 something to add from that side.
19 COMMISSIONER SZILAGYI: And I do agree with these
20 recommendations, and I'm not seeing major -- you know, any
21 clear disadvantages. But I think it might be helpful to
22 point out any implications on access. Thanks.

1 CHAIR BELLA: Thank you, Peter. Stacey?
2 COMMISSIONER LAMPKIN: Hi. This is Stacey
3 Lampkin, and thank you, Moira, for a great chapter and a
4 very complete description and justification and rationale
5 here. I would just like to provide a little bit of
6 clarification on the comments about the impact on
7 capitation rates, from an actuarial perspective.
8 So from an actuary's perspective, what the
9 capitation rate needs to do is provide for reasonable and
10 appropriate provisions for the costs that the MCO is going
11 to incur under the contract. And to the extent that MCOs
12 are not able to coordinate benefits, and the capitation
13 rates may certainly be higher than they need to be because
14 they provide for that inability to coordinate, they are
15 only too low if the actuary started with data from a fee-
16 for-service environment, where the state was able to
17 coordinate and didn't make an adjustment for that for the
18 MCO.
19 So maybe a little technical but I just wanted to
20 provide for that clarification.
21 CHAIR BELLA: Thank you, Stacey. We're going to
22 go to Chuck Milligan and then Martha Carter. Chuck, are

1 you able to comment?

2 VICE CHAIR MILLIGAN: Can you hear me, Melanie?

3 CHAIR BELLA: Yes, we can hear you.

4 VICE CHAIR MILLIGAN: Great. Yeah, I'm sorry

5 about that. So great job, Moira. I think I wanted to make

6 sure I was following Peter's comment about access, and I

7 think if the concern is that, for example, a Medicaid MCO

8 or Medicaid fee-for-service program would have a pediatric

9 subspecialist in its network but the member, on the

10 Medicaid side, has TRICARE coverage, the child's claims

11 might be denied, or access to care might be denied on the

12 Medicaid side, on the theory that Medicaid should be

13 secondary.

14 And yet TRICARE might not have that very same

15 provider in its network, and so a child who might have

16 pediatric subspecialty needs might have a barrier to

17 getting care, and timely care, if the Medicaid program

18 punts it and TRICARE doesn't have that provider network.

19 So that's how I was tracking with Peter's

20 comment, and I am hoping I am tracking correctly.

21 The comment I wanted to make is when we took this

22 up a couple of months ago, I had raised the point of, you

1 know, why are we focusing so much on TRICARE? It seems
2 like this underlying issue might play out with other
3 federal entities like the VA. And I think the response at
4 the time was that might be true. We didn't have data. We
5 didn't want to kind of lean into that if we didn't have
6 evidence for it. And so we have evidence of what was going
7 on with TRICARE.
8 Moira, is that -- am I remembering that
9 correctly? Because I do think that, contextually, in the
10 chapter, it would be helpful to identify in the narrative
11 why we are focusing on TRICARE maybe to the exclusion of a
12 focus on some of the other federal delivery system sides or
13 coverage sides. But am I remembering that correctly?
14 MS. FORBES: Yes. I mean, we haven't heard of a
15 problem like this. In terms of the VA, first of all, I
16 haven't heard of a data-sharing issue like this. The VA
17 systems works a little differently in terms of what people
18 are covered for and how they get coverage, more connected
19 to their service and the reason that they are -- like their
20 service-connected disability and things like that. It's
21 just that it's not like civilian health insurance, the way
22 TRICARE is, so it functions differently.

1 So -- but I can try and be clearer. There is
2 also sort of a numbers difference in that this was a very
3 large population and sort of a single program. But yes,
4 the VA is the other large -- I mean, obviously Medicare is
5 a very large one, and we just talked about it all morning,
6 coordination with Medicare. And then there is the VA and
7 DoD, and then there are some other very small things. So I
8 can be clearer about why we are focusing just on TRICARE
9 here, as it is an obvious question about why just TRICARE
10 now.
11 VICE CHAIR MILLIGAN: Yeah. I think that would
12 enhance the chapter, but that was my only substantive
13 comment. Thank you.
14 CHAIR BELLA: Thank you, Chuck. Martha? Go
15 ahead, Martha.
16 COMMISSIONER CARTER: Hi. Yes, hi. Thank you.
17 This is Martha Carter. I had a quick question. We
18 highlighted -- Moira, we highlighted the problem of lack of
19 coordination with Medicaid MCOs, and in our draft
20 recommendations, the first recommendation just talks about
21 coordinating with state Medicaid agencies, which seems to
22 be appropriate in that context. Does the second

1 recommendation get to the problem of lack of coordination
2 with the MCOs?
3 MS. FORBES: Yes. The second recommendation
4 would. If Department of Defense or the TRICARE program was
5 required to follow the same set of policies as the private
6 sector employers, the private sector insurers -- sorry --
7 the private sector insurers have been directed to
8 coordinate with Medicaid MCOs. So if we said that TRICARE
9 needs to follow those same policies it would also be
10 required then to work with Medicaid MCOs.
11 COMMISSIONER CARTER: Great. Thank you. It just
12 wasn't clear to me.
13 CHAIR BELLA: Thank you, Martha. This is a good
14 segue into discussion about the recommendation, and I would
15 ask for Commissioners that have comments or feedback on
16 either of the recommendations, now would be the time to
17 make those specific comments.
18 [Pause.]
19 CHAIR BELLA: Okay. I see no hands. I would
20 also, Moira, reiterate the thanks for this. I mean,
21 anything we can be doing to make sure that we're staying
22 true to Medicaid being the payer of last resort and looking

1 for opportunities to eliminate cost-shifting and improve
2 data integrity, all of those things seem like important
3 things to be doing.
4 Again, they are not going to save the program,
5 particularly in light of everything else we've been talking
6 about today that is challenging the program, but really
7 important steps for us to be taking, and I think very
8 consistent with the work of the Commission in looking for
9 opportunities for efficiency and integrity and access and
10 all of those things.
11 So thank you for this work. I would ask one more
12 time if any Commissioner has any last comments, please put
13 up your little hand. But if not, and it looking like not,
14 then we will conclude this session. Thank you again,
15 Moira.
16 We are now going to offer the folks who have
17 joined us who are not Commissioners the opportunity to
18 comment. We had lots of attendees today joining us
19 virtually. Thank you again for taking the time and
20 experimenting with us in this new way of doing business.
21 I am going to ask for people that have comments
22 to put your virtual hand up and we will go through that. I

1 am also going to remind folks that you do have an
2 opportunity to provide comments via email, and if you would
3 like to do so you would send those to comments@macpac.gov.
4 Again, that is comments@macpac.gov.
5 And we are going to -- I would also ask each
6 commenter to pretend like you are there in person with us
7 and remember to please state your name and your affiliation
8 prior to your comments.
9 Great. We are going to first hear from Leslie
10 Fried. Thank you for joining today.
11 **### PUBLIC COMMENT**
12 * MS. FRIED: Great. Can you hear me?
13 CHAIR BELLA: Yes.
14 MS. FRIED: Oh great. Thank you. And my name is
15 Leslie Fried. I am from the National Council on Aging.
16 And I really appreciate this opportunity today to listen in
17 on the discussion and to comment. I want to thank Kate and
18 Kirsten and the Commission for recognizing the issues
19 related to Medicaid Savings Programs participation, and, of
20 course, Tim Engelhardt, who frequently reminds us about the
21 importance of increasing MSP participation.
22 I guess I have one big comment, and that is to

1 express my disappointment that MACPAC is not recommending
2 increasing the financial eligibility for Medicare Savings
3 Programs, especially the QMB program. Currently,
4 eligibility is at 100 percent of income. That is just over
5 $1,000 a month. And when we look at what the cost loads
6 are for hospitalization and for Part B deductibles and co-
7 insurance, it's too expensive for some people to even go to
8 the hospital.
9 And when we think about the current crisis, the
10 pandemic, we need people to go to the -- feel like they can
11 go to the hospital and get, you know, to get -- well,
12 there's not a treatment but at least get care. And if
13 folks are making decisions about saying, "Well, if I go to
14 the hospital and have to pay a Part A deductible and
15 whatever the cost of Part B deductible of cost-sharing is,
16 I can't afford it, especially if my income is just over
17 $1,000 a month."
18 So I really would urge MACPAC to reconsider and
19 maybe consider a recommendation, including increasing at
20 least the income to 138 percent of poverty, which is
21 actually the level of eligibility for the ACA and Medicaid
22 expansion.

1 Thank you, though, for your consideration of the
2 MSP participation. We think that it has been an important
3 discussion and hope you consider additional
4 recommendations. Thanks.
5 CHAIR BELLA: Thank you, Leslie. We have a
6 comment from Camille.
7 MS. DOBSON: Hi. Good afternoon. Camille
8 Dobson, Deputy Executive Director of Advancing States. We
9 represent the state aging and disability directors who
10 deliver long-term services and supports, and we have had
11 acute interest in work around increasing integration
12 options for dual eligibles for the last couple of years.
13 And I just wanted to, as you will probably not be
14 surprised, support the policy recommendations that the
15 staff had made, particularly around helping the states
16 identify and procure Medicare expertise. I wanted to
17 support Melanie's, I think your statement about the states
18 needing to take the lead, and the complexities of a state-
19 by-state approach would really, I think, overwhelm MMCO.
20 And frankly, the states need to build that expertise for
21 continuity purposes.
22 And then I also wanted to support, I thought Kit

1 made a really interesting comment about sort of a new
2 normal when we emerge from the COVID crisis, and not
3 building on old models but really looking forward to new
4 models. And I think the additional funding and the
5 flexibility that the Commission might hopefully is going to
6 recommend will put the states in a much better place. Toby
7 is right. They are going to be overwhelmed, and it has
8 already been hard for them to marshal resources to address
9 the dual eligible, but they -- it will, I think, throw into
10 sharp contrast for states that maybe haven't been paying
11 attention to it, the growing complexity and the costs of
12 serving dual eligibles.
13 And so any opportunities for simplified
14 approaches to serving dual eligibles, and, of course, more
15 funding and resources for the state will go a long way. So
16 I applaud the Commission and thank you for your support.
17 CHAIR BELLA: Thank you, Camille. Leslie, it
18 looks like you may have an additional comment, so we will
19 unmute you to see if that is the case or if your hand may
20 be up from earlier.
21 MS. FRIED: Yes. No, I do -- so this is Leslie
22 Fried, National Council on Aging, and I got so excited

1 about talking about increasing the eligibility for QMB I
2 forgot to also state that we do support the recommendations
3 as currently presented. It is important to really align
4 the income, asset, and household descriptions for LIS as
5 well as with MSP. I think that has led to quite a bit of
6 confusion. So I did want to also say that we support the
7 recommendation as currently written. That's it.
8 CHAIR BELLA: Okay. Thank you very much. We
9 appreciate that support.
10 Is there anyone else who would like to comment,
11 from the public? There are no hands but we will give just
12 a second. And then I will also offer any Commissioners the
13 opportunity to make any last comments, having heard from a
14 couple of folks from the public. So if any Commissioners
15 have anything else they would like to say, please put your
16 hand up now.
17 [Pause.]
18 CHAIR BELLA: Okay. There are no hands. So our
19 game plan for the rest of the day, we are finishing a
20 little bit early. So we will reconvene at the scheduled
21 time, which is 12:45. At 12:45 we will start with review
22 of our chapter on Medicaid's role in maternity care and

1 related issues.

2 So again, just to remind folks, come back at

3 12:45. We will run through that, we will talk about

4 countercyclical, we will talk about COVID, and there will

5 be another opportunity for public comment at the end. And

6 then once we have gone through all of those things, we will

7 take a final vote on the recommendations that you have

8 heard discussed this morning.

9 So I want to thank the staff, Anne and team, and

10 thank the Commissioners as well as all of you who have hung

11 with us this morning. And we will be back on with you at

12 12:45.

13 Thank you very much.

14 * [Whereupon, at 11:43 a.m., the meeting was

15 recessed, to reconvene at 12:45 p.m. this same day.]

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1 AFTERNOON SESSION

2 [12:46 p.m.]

3 CHAIR BELLA: Welcome back, everyone. This is
4 Melanie Bella, the Chair of MACPAC, and we are ready to
5 begin the afternoon session. So thank you again for
6 joining us. Just as a reminder of what the rest of the day
7 looks like, we are going to kick off with a panel on
8 Medicaid's role in maternity care, continuing the work that
9 we have done in this very important area.

10 We are then going to have a discussion about
11 Medicaid financing and talking about countercyclical and
12 other types of adjustments, which, as we discussed this
13 morning, is particularly timely given what we are going
14 through right now with COVID. And then we will end the day
15 talking about Medicaid's response to the COVID-19 pandemic,
16 and give some insight into things that Commissioners feel
17 are important for us as a Commission to be studying or
18 looking out for as this continues.

19 So after those three sessions we will have
20 opportunity for public comment, and after public comment we
21 will take a vote on the recommendations that were discussed
22 this morning.

1 So that is the lay of the land for the rest of
2 the day, and without any other delay I'm going to turn it
3 over to our three folks who are going lead us through the
4 next discussion, Martha, Erin, and Tamara. Thank you.
5 **### REVIEW OF CHAPTERS FOR JUNE REPORT: MEDICAID'S**
6 **ROLE IN MATERNITY CARE; SUBSTANCE USE DISORDER**
7 **AND MATERNAL AND INFANT HEALTH**
8 * MS. HEBERLEIN: Thank you. This is Martha
9 Heberlein and I will be kicking it off as we review two
10 draft chapters for the June report that focus on maternal
11 health. The first chapter is more general, highlighting
12 the role Medicaid plays in maternal health. The second
13 chapter offers a more focused examination of pregnant women
14 with substance use disorder and infants with neonatal
15 abstinence syndrome. Note that both of these chapters are
16 based off of work presented over the last meeting cycle and
17 are descriptive in nature and do not include any
18 recommendations.
19 So to begin with Chapter 5, Medicaid's Role in
20 Maternal Health. Chapter 5 begins by describing maternal
21 and infant health outcomes. It then explains Medicaid's
22 role in providing maternity care, including the share of

1 births that are paid for by Medicaid, as well as an
2 overview of Medicaid eligibility and the benefits available
3 to pregnant women. The chapter then goes on to describe
4 state-led and federal initiatives before concluding with a
5 discussion of future areas of work for the Commission.
6 So to begin with maternal and infant health
7 outcomes, approximately 700 women die annually in the
8 United States from pregnancy or related complications.
9 About 60 percent of these deaths may be preventable.
10 Pregnancy-related deaths occur over the course of pregnancy
11 as well as in the postpartum period. According to recent
12 data, about one-third of deaths occur during pregnancy,
13 about one-third occur on the date of delivery or within one
14 week, and about one-third occur postpartum. There are also
15 considerable racial and ethnic disparities in pregnancy-
16 related mortality.
17 Each year, at least 50,000 women experience
18 potential life-threatening complications in childbirth. A
19 study commissioned by MACPAC found that Medicaid
20 beneficiaries are almost twice as likely as those with
21 private insurance to experience severe maternal morbidity
22 and mortality.

1 Infants born preterm or with low birth weight are
2 at an increased risk for experiencing physical disabilities
3 and developmental impairments. Preterm birth rates had
4 been declining. However, in 2018, the rate rose for the
5 fourth consecutive year to 10 percent. In 2018, 11 percent
6 of infants born to Medicaid-covered mothers were born
7 preterm.

8 The percentage of low birth weight infants has
9 also been on the rise since 2014, and in 2018, the rate was
10 about 8 percent. That same year, about 10 percent of
11 infants born to mothers with Medicaid were low birth
12 weight.

13 So looking at Medicaid eligibility and benefits,
14 all states are required to provide Medicaid coverage for
15 pregnant women with incomes at or below 133 percent of the
16 federal poverty level. Currently, all but four states
17 extend Medicaid coverage to pregnant women with higher
18 incomes, and as of April 2019, the median eligibility
19 threshold was 195 percent of the FPL. States must also
20 extend coverage to these women for 60 days postpartum.

21 Depending upon the eligibility pathway, pregnant
22 women may be entitled to the full Medicaid benefit package.

1 However, for women covered through poverty level pregnancy
2 pathways states may limit services to those related to
3 pregnancy.
4 Although the vast majority of states provide the
5 full benefit package to all pregnant women, five states --
6 Arkansas, Idaho, New Mexico, North Carolina, and South
7 Dakota -- provide only pregnancy-related services.
8 So overall, Medicaid paid for 43 percent of all
9 births in 2018. The share of births covered by Medicaid
10 varies across states, ranging from about 25 percent in
11 North Dakota to 63 percent in Louisiana and Mississippi.
12 Medicaid paid for more than half of births in six states,
13 including Louisiana and Mississippi, but also Arizona, New
14 Mexico, Oklahoma, and Tennessee. A greater share of births
15 occurring in rural areas, among young women under the age
16 of 19, and women with lower levels of educational
17 attainment were paid for by Medicaid. Medicaid was also
18 the payer for a greater share of births among Hispanic,
19 African American, and American Indian and Alaska Native
20 women.
21 As you will recall from the last meeting, MACPAC
22 contracted with Mathematica to compile an inventory of

1 state Medicaid initiatives designed to improve pregnant
2 women's access to services and the quality of care they
3 receive. Overall, they catalogued almost 400 efforts
4 across all the states and Puerto Rico in the last 10 years.
5 We recently published the inventory as a resource on our
6 website.
7 So the inventory reported that the greatest
8 number of initiatives was in the category of covered
9 benefits, and included coverage of services such as
10 screening for postpartum depression or home visiting. A
11 considerable number of Medicaid programs also focused on
12 beneficiary education such as contacting pregnant women for
13 case management services or education regarding maternal
14 health issues.
15 Three-quarters of states have adopted a policy
16 related to eligibility and enrollment, such as the option
17 to use presumptive eligibility. A large number of Medicaid
18 programs also focused on payment models or policies, most
19 often encouraging the insertion of long-acting reversible
20 contraception, or LARC, immediately postpartum.
21 About a third of states had a policy to reduce
22 payment or not cover procedures that do not follow clinical

1 guidelines, such as early elective deliveries. Large
2 numbers of Medicaid programs relied on managed care
3 contracting strategies, such as requiring quality measure
4 reporting or tying capitation payments to outcome. Many
5 also established performance improvement projects to
6 improve outcomes among women enrolled in managed care.
7 The fewest number of states adopted particular
8 models of care which include states that have a pregnancy
9 medical home or provide group prenatal care.
10 The federal government has also focused efforts
11 on improving outcomes for pregnant women. Two grant
12 opportunities from the Centers for Medicare and Medicaid
13 Innovation have targeted maternal health, Strong Start for
14 Mothers and Newborns, and more recently the Maternal Opioid
15 Misuse, or MOM, model. I will focus briefly on Strong
16 State as Tamara will cover the MOM model in a moment.
17 Strong Start for Mothers and Newborns was a four-
18 year initiative to test and evaluate enhanced prenatal
19 care. The goal was to determine if these approaches could
20 reduce the rate of preterm births, improve health, and
21 decrease the cost of care. As you might recall from the
22 October meeting, the evaluation found that overall women

1 who receive prenatal care in birth centers had better
2 outcomes at lower cost when compared to similar Medicaid
3 enrollees who were not in Strong Start.
4 CMS has also provided a number of technical
5 assistance opportunities. For example, in July 2014, CMS
6 launched the Maternal and Infant Health Initiative, under
7 which they conducted a number of technical assistance
8 efforts such as convening learning collaboratives where
9 states could learn from each other.
10 In March 2017, the Medicaid Innovation
11 Accelerator Program launched the Maternal and Infant Health
12 Value-Based Payment Project to provide technical support in
13 selecting, designing, and testing value-based payment
14 models.
15 CMS has more recently focused its attention on
16 rural maternal health. In June 2019, CMS collaborated with
17 other partners to host a forum examining maternal health
18 care in rural communities. The agency subsequently
19 published an issue brief, and in February 2020, released a
20 request for information to learn more about the barriers
21 and opportunities for improving access, quality, and
22 outcomes for women in rural areas.

1 The Department of Health and Human Services is
2 also thinking about this issue. For example, it held a
3 series of stakeholder roundtables in the fall of 2019,
4 meeting with states, providers, plans, advocates, and
5 funders on ways to improve maternal health.
6 So as I said at the beginning, this year's work
7 was primarily descriptive. Going forward, the Commission
8 will focus on a number of areas for future study and
9 possible recommendations. To start with value-based
10 purchasing. The Commission is interested in understanding
11 how states are using value-based payment models to improve
12 the quality of maternity care. Future work will more
13 closely examine how states are designing and implementing
14 these various payment approaches.
15 In terms of access to maternity providers, the
16 Commission has expressed interest in examining the barriers
17 to expanding the use of midwives and birth centers in
18 Medicaid, given the promising results from the Strong Start
19 evaluation. The Commission is also interested in learning
20 more about the role that doulas can play in supporting
21 healthy birth outcomes in Medicaid.
22 Finally, the Commission is concerned that access

1 issues may arise, particularly in rural areas where
2 hospitals and obstetrics wards have closed, and has
3 expressed interest in the role that other providers,
4 including family physicians and midwives, might play in
5 addressing these issues.
6 The Commission is also interested in learning
7 more about how states are providing family planning
8 services. Specifically, the Commission is interested in
9 understanding the payment and other barriers to providing
10 LARC and what states have done to mitigate them. The
11 Commission is also interested in understanding how states
12 have extended family planning benefits to the individuals
13 who may not otherwise have coverage for those services.
14 Finally, the 60-day postpartum coverage period
15 has been raised as a barrier to ongoing care and sparked
16 interest at the state and federal level of extending
17 coverage beyond this period. The Commission will explore
18 the issues related to extending coverage, including the
19 interaction with the Medicaid expansion for adults, as well
20 as the provision of limited benefits to certain groups of
21 pregnant women.
22 And with that I will pass it off to Erin to begin

1 discussion of the second chapter.

2 * MS. McMULLEN: Thanks, Martha. This is Erin

3 McMullen. As part of exploring Medicaid's role in

4 substance use disorder treatment, MACPAC has previously

5 noted that Medicaid beneficiaries are disproportionately

6 affected by the opioid epidemic. Medicaid beneficiaries

7 have a higher rate of opioid use disorder than privately

8 insured individuals. However, they also receive treatment

9 at higher rates.

10 Next slide.

11 Reflecting on this information, we present an

12 overview of our draft chapter on substance use and maternal

13 and infant health. The first half of the chapter is

14 largely drawn from materials that we discussed at the

15 January meeting. Where appropriate, we also incorporate

16 findings from prior MACPAC publications on Medicaid

17 coverage of substance use disorder treatment. I am going

18 to briefly summarize the sections of the draft chapter

19 listed on this slide before turning it over to Tamara.

20 Next slide.

21 Tamara is going to further discuss some new

22 material that is listed here.

1 Next slide.

2 The chapter starts by describing the prevalence
3 of substance use disorder among pregnant women and the
4 rates at which these women seek treatment, comparing, where
5 possible, the experience of pregnant women with Medicaid to
6 those with other forms of coverage. The findings listed
7 here on this slide are based on MACPAC's analysis of the
8 National Survey on Drug Use and Health.

9 This information should look familiar as we
10 presented it at our January meeting. From 2015 to 2018,
11 Medicaid beneficiaries who were pregnant were more likely
12 to abuse, or have a substance use dependency in the
13 previous year than pregnant women with other forms of
14 coverage. At the same time, they are more likely to have
15 ever received treatment for their substance use disorder.

16 Treatment services, however, remain substantially
17 underutilized. Low treatment rates likely reflect barriers
18 to treatment, including stigma, both within and outside the
19 health care system; punitive repercussions, such as loss of
20 child custody; and limited access to providers.

21 Next slide.

22 The next section of the chapter describes

1 Medicaid coverage of substance use treatment services.
2 Much of the information draws from MACPAC's prior work that
3 mapped coverage of clinical substance use disorder
4 treatment services, such as outpatient treatment and
5 medications to treat opioid use disorder; non-clinical
6 support such as recovery services; as well as case
7 management services.
8 Generally, states do not have a separate
9 substance use benefit for pregnant women. Rather, pregnant
10 beneficiaries with a substance use disorder receive the
11 same benefits as the general Medicaid population.
12 As of 2018, MACPAC found that most states have
13 gaps in their substance use disorder coverage, covering, on
14 average, six of the nine levels of care described by the
15 American Society of Addiction Medicine, with the largest
16 gaps in coverage for partial hospitalization and various
17 levels of residential treatment.
18 However, many states are increasingly addressing
19 these gaps in coverage through Section 1115 substance use
20 disorder demonstrations.
21 Next slide.
22 The chapter then discusses availability of

1 substance use disorder treatment for pregnant and
2 postpartum women. Generally, maternity providers,
3 including obstetricians and gynecologists, as well as
4 certified nurse midwives, are not trained in addiction
5 medicine. Similarly, substance use treatment service
6 providers are rarely equipped to provide prenatal care.
7 Few specialty SUD treatment facilities are able
8 to meet the unique needs of pregnant and postpartum women.
9 In 2018, less than one-quarter of specialty substance use
10 treatment programs in the U.S. offered specialized
11 programming for pregnant or postpartum women.
12 Access to medications to treat opioid use
13 disorder is also low in both specialty facilities and
14 office-based settings.
15 Next slide.
16 Next, the chapter discusses neonatal abstinence
17 syndrome, or NAS. Infants born to women using opioids or
18 other substances may experience NAS, which is drug
19 withdrawal symptom that occurs in infants after they are
20 exposed to certain drugs in utero. Given that Medicaid
21 pays for 43 percent of all U.S. births, it is not
22 surprising that NAS disproportionately affects the Medicaid

1 program. Over 80 percent of infants with NAS are covered
2 by Medicaid. As shown on this slide, since 2004, the
3 incidence of NAS within the Medicaid program has steadily
4 increased.
5 Next slide.
6 Based on Commissioner feedback at our January
7 meeting, the chapter also describes the various Medicaid
8 authorities states can use to provide SUD treatment and
9 recovery support services to pregnant women with an SUD, as
10 well as specialized services for infants with NAS.
11 In this section of the chapter, we describe each
12 of the authorities listed on this slide and, where
13 relevant, provide examples of how states are using these
14 authorities to further tailor benefits for pregnant women
15 with an SUD and infants with NAS. For example, as
16 discussed at our January meeting, West Virginia uses its
17 state plan to pay for non-hospital-based treatment for
18 infants with NAS.
19 In the Commission's previous work, we have spent
20 significant time discussing how states are using Section
21 1115 SUD demonstrations to improve access to care. Under
22 these demonstrations, Medicaid beneficiaries, including

1 pregnant women with an SUD, have access to the full
2 continuum of SUD treatment. However, few states have
3 chosen to further target pregnant women with an SUD under
4 these demonstrations.
5 In the work that Mathematica conducted on behalf
6 of MACPAC, they did find that in Massachusetts pregnant
7 women have access to specialized services to ensure
8 coordination between acute substance use treatment services
9 and obstetrical care. A few states also use Section 1115
10 authority to extend postpartum coverage, some specifically
11 for women with an SUD.
12 We also describe the role of EPSDT for both
13 infants and mothers, including mothers ineligible for
14 Medicaid. CMS guidance specific to NAS is also summarized.
15 Finally, other authorities, including two
16 Medicaid authorities that allow states to pay for
17 residential and inpatient SUD treatment for pregnant women,
18 as well as behavioral health requirements under CHIP are
19 also discussed.
20 With that I will turn it over to Tamara.
21 MS. HUSON: Thanks, Erin.
22 Next slide, please.

1 CHAIR BELLA: Bear with us, everyone. We're
2 having, I think, our first little glitch to make sure we
3 can get the slides visible to everyone.
4 While we're getting this up and running, I would
5 just ask if Commissioners have any questions so far on
6 what's been presented. We certainly will do a robust
7 question-and-answer and comment at the end but curious if
8 anyone has any questions or comments that they want to make
9 right now on what we've heard so far.
10 [No response.]
11 CHAIR BELLA: Okay. Martha or Erin, is there
12 anything else you want to add while we're getting the rest
13 of the presentation ready to go?
14 MS. HUSON: Hi. This is Tamara. Can you hear
15 me?
16 CHAIR BELLA: We can, yes.
17 * MS. HUSON: Okay. Thank you so much. I'm so
18 sorry. My internet decided to cut out right as Erin handed
19 it over to me. So thank you for bearing with me.
20 Okay. So the chapter then goes on to describe
21 the role of the criminal justice and child welfare systems
22 as they relate to pregnant women with substance use

1 disorders.

2 Substance use disorders are widely stigmatized,
3 and the disclosure of SUD-related information can have
4 serious consequences. Pregnant women may fear disclosing
5 their SUD to health care providers for fear of loss of
6 custody of their newborn and potentially their other
7 children as well.

8 The criminal justice and child welfare systems
9 are often involved when pregnant and postpartum women with
10 an SUD seek treatment. Women make up a small proportion of
11 individuals who are incarcerated, but three-quarters of
12 those that are, are of childbearing age. In part, the
13 involvement of these systems occurs because SUD treatment
14 may be court-ordered. Depending on the state, Medicaid
15 agencies and managed care organizations may be required to
16 pay for court-ordered SUD treatment.

17 Collaboration between child welfare agencies, the
18 court, and SUD providers, however, may be limited due to
19 systemic barriers.

20 Medicaid typically pays for medical services for
21 those on parole and probation, while correctional
22 facilities must pay for health care costs while individuals

1 are confined in their facilities.

2 Federal law prohibits use of federal Medicaid
3 funds for most health care services for inmates of public
4 institutions, except in cases of inpatient care lasting 24
5 hours or more, which could include those associated with
6 pregnancy.

7 The chapter describes the role of Medicaid in
8 pre-release services. Pregnant inmates released before
9 giving birth or postpartum women leaving prison or jail may
10 benefit from being connected with Medicaid. Among other
11 things, this may improve access to family planning and pre-
12 conception care as well as SUD treatment following release
13 from jail or prison.

14 Next slide, please.

15 Child welfare agencies are often involved with
16 families affected by SUDs. Low-income children currently
17 or formerly served by the child welfare system are
18 generally eligible for Medicaid. These children often have
19 significant health, behavioral, social, and other needs for
20 which a range of Medicaid-covered services, including
21 mental health and SUD treatment, may be necessary and
22 appropriate.

1 Emerging evidence suggests that the rising rates
2 of overdose deaths are related to an increase in the number
3 of children entering foster care, as can be seen on the
4 chart on this slide. The number of children in foster care
5 has been declining, but you'll notice that in 2012, that
6 number began to rise again. Thirty-six states experienced
7 caseload increases from 2012 to 2016. One study estimated
8 that in the average U.S. county, a 10 percent increase in
9 the overdose death rate corresponded to a 4.4 percent
10 increase in the foster care entry rate.
11 Next slide, please.
12 No single agency is charged with addressing all
13 the needs of pregnant and postpartum women, and state
14 systems are generally fragmented. As such, providing
15 comprehensive services to pregnant women with an SUD
16 requires connecting women and their children with multiple
17 agencies. I'll briefly discuss the programs listed on this
18 slide, but please note each are described in greater detail
19 in the chapter.
20 Behavioral health efforts are increasingly being
21 led by the state Medicaid agency in collaboration with
22 other state and federal agencies, including the state

1 behavioral health authority and SAMHSA.

2 When Medicaid does not pay for certain SUD
3 treatment services, they are typically available through
4 the state behavioral health authority. The SAMHSA
5 Substance Abuse Prevention and Treatment Block Grant also
6 stipulates that pregnant women must be given priority in
7 treatment admissions.

8 Early intervention services can be particularly
9 important for infants with NAS, such as those provided by
10 the Program for Infants and Toddlers with Disabilities, a
11 federal grant program created under Part C of the
12 Individuals with Disabilities Education Act. Models of
13 care that incorporate referrals for infants with NAS for
14 screening and evaluation are necessary to identify
15 potential developmental delays and improve outcomes.

16 Medicaid and Title V agencies coordinate on home
17 visiting programs such as MIECHV, which support evidence-
18 based home visiting services for at-risk pregnant women and
19 parents of young children. Medicaid may pay for certain
20 components of home visiting programs if the infant or
21 mother is Medicaid-eligible. Home visiting is discussed
22 further in the chapter on Medicaid's role in maternal

1 health.

2 Addressing other social determinants of health is
3 also critical. Food assistance may be obtained through
4 SNAP or WIC. Programs addressing homelessness and housing
5 instability are typically financed by HUD and administered
6 by state and local governments. Medicaid dollars cannot be
7 used to cover room and board, but states can cover some
8 housing-related activities, such as supportive housing
9 services. Pregnant and postpartum Medicaid beneficiaries
10 with an SUD may experience additional challenges in
11 accessing safe and affordable housing, as federal policies
12 limit housing assistance for individuals with a past
13 history of drug use.

14 Medicaid agencies are also required to ensure
15 necessary transportation to and from medical appointments,
16 such as prenatal visits or SUD treatment, through the non-
17 emergency medical transportation benefit.

18 Next slide, please.

19 The chapter closes by discussing two new models
20 of care out of CMMI -- the Maternal Opioid Misuse model and
21 the Integrated Care for Kids model. We discussed these
22 models at the January meeting when we heard from three

1 states on their plans under the MOM model to address
2 barriers to care for pregnant and postpartum beneficiaries
3 with an OUD. These models both began in January of this
4 year and run for five and seven years respectively. As
5 such, MACPAC will continue to monitor states progress with
6 these models.
7 Last slide, please.
8 With that, I will turn it over to Chair Bella.
9 We welcome any questions on the content we presented today
10 or any comments you may have on the tone, clarity, or
11 messages in the draft chapters provided to Commissioners.
12 Thank you.
13 CHAIR BELLA: Thank you very much to all three of
14 you for taking us through the body of work that we've done
15 over the past few months.
16 I'm going to open it up to Commissioners and ask
17 for any comments on what was presented today or endorsing
18 additional areas that you would like to be exploring in the
19 future.
20 We're going to start with Martha Carter.
21 COMMISSIONER CARTER: This is Martha Carter.
22 First, thank you to Martha, Tamara, and Erin for

1 your continued work on this important topic. Of course, in
2 the COVID pandemic, people are still having babies, and so
3 this topic is as relevant as it ever was. And all of our
4 areas for future work remain very relevant.
5 I think we do need to pay attention to any trends
6 that are arising from the current COVID situation; for
7 example, making sure that maternal deaths due to COVID are
8 identified properly so that we can monitor trends. And I
9 think we can rely on the states that have maternal
10 mortality review committees for that and perhaps encourage
11 states that don't have these review committees set up to do
12 so.
13 Also, I think it's going to be really important
14 to pay attention to disparities in maternal and infant
15 mortality and morbidity due to COVID by race, ethnicity,
16 rurality because we need to make sure -- we just need to
17 pay attention to the disparities in health outcomes as this
18 all unfolds.
19 I believe that continued coverage for mothers
20 past 60 days postpartum is even more important at this time
21 because people need to feel comfortable getting care if
22 they are sick, and to that, the Commission did receive

1 comments on the value of extending postpartum coverage for
2 women on Medicaid from the American College of
3 Obstetricians and Gynecologists, ACOG.
4 One last comment on this chapter is I'm seeing,
5 anecdotal at this point, reports of an increased demand for
6 out-of-hospital births during the COVID pandemic on home
7 births and births in freestanding birth centers, and it
8 will be important to capture these trends and the
9 associated outcomes for Medicaid beneficiaries. Where are
10 these options available to women? Where are they not
11 available, and what are the outcomes associated with it?
12 I have comments on Chapter 6 as well on addiction
13 services. Should I hold that or continue on?
14 CHAIR BELLA: Oh, no, please feel free to
15 continue. Thank you.
16 COMMISSIONER CARTER: Thanks.
17 So I think the chapter on addiction services is
18 extremely important, and I am really glad that we are
19 delving into the issue of the foster care system.
20 We heard from Dr. Becker in West Virginia that
21 the foster care system is really overburdened in many
22 states because of children whose parents are -- they're in

1 the justice system or they have had health issues or they
2 are deceased. So coordinating care for those children who
3 are now on Medicaid is really important, and I can't
4 overstress that. We've been seeing children who come
5 without records. They've moved around from various foster
6 care placements, and the records aren't following them. I
7 think it's just a symptom of the systems being overwhelmed,
8 so we need to pay attention to that.
9 An area that I would like us to do more work on
10 is calling out the role of community health centers or
11 federally qualified health centers in providing addiction
12 services. These services are supported by grants from
13 HRSA, the Health Resources and Services Administration, and
14 SAMHSA, Substance Abuse and Mental Health Services
15 Administration, and probably also some state opioid
16 response grants and other targeted funding.
17 Right now, the health centers are doing an
18 amazing job of providing continuity of care for their
19 patients, including patients in treatment for addiction
20 during the COVID pandemic.
21 So I just want to highlight that according to the
22 Bureau of Primary Health Care, in 2018, 57 percent of

1 health centers have staff authorized to provide MAT,
2 medication assisted treatment, for opioid use disorder, and
3 there were 4,899 health center physicians, nurse
4 practitioners, physician assistants, with authorization to
5 provide medication-assisted treatment for addiction.
6 So all health centers are required to accept
7 Medicaid patients, and all health centers are required to
8 provide for maternity care. So we know that many health
9 centers are providing opioid addiction services for
10 pregnant women and coordinating their care within the
11 maternity care cycle and their addiction treatment needs,
12 and I think we need to call that out and understand how
13 that workforce plays into the need that we've discussed.
14 I think that's all I have. Thank you.
15 CHAIR BELLA: Thank you, Martha.
16 Peter and then Kisha.
17 COMMISSIONER SZILAGYI: This is Peter Szilagyi.
18 Martha, Erin, and Tamara, great chapters and very
19 nice presentations. So thank you for covering these
20 important topics.
21 I had a couple similar points to Martha Carter,
22 but I'm going to stay away from those.

1 I am glad that you put in some information on the
2 importance of preterm births and low birth weight. The 700
3 deaths are tragedies. The 700 maternal deaths are
4 tragedies, but it's really that they are the canaries in
5 the coal mine because there's 165,000 preterm births on
6 Medicaid every year. I think this is a really good
7 descriptive chapter. I think it could be beefed up just a
8 little bit by a few sentences about the impact of low birth
9 weight or preterm births for the Medicaid population, and
10 it would be really nice to have sort of a dual thrust of
11 trying to prevent maternal death as well as dealing with
12 the rising preterm births. So the more we can emphasize
13 preterm births, I think, the better because at the public
14 health level, that is an enormous morbidity.
15 The second point, which I think maybe we'll get
16 into not so much this chapter but the future work on
17 postpartum and continuity of care, I'm really glad that we
18 are starting to get deeper into two areas, home visiting
19 and the 60-day postpartum coverage.
20 There's some mention of home visiting in actually
21 both chapters, and I'm really happy about that. I do think
22 there could be a little bit more on outcomes of home

1 visiting programs because many of these programs have some
2 of the best outcomes that I have seen in the maternal child
3 health arena, and we could maybe mention a little bit more
4 of that, even in this chapter.
5 It's interesting that 25 states -- I think you
6 said 25 states are covering prenatal or postpartum home
7 visitation programs, and I would be interested in why 25
8 states and not more. What are the barriers to others
9 covering it? Is this a priority issue or whatever?
10 Also, regarding the home visitation, it would be
11 interesting, I think, to describe the number of Medicaid
12 enrollees actually receiving home visitation and perhaps
13 the number who are eligible, even in the states that are
14 offering it, and then if there's anything on outcomes.
15 As I mentioned, I'm glad that we're going to be
16 getting more into the 60-day postpartum coverage because it
17 feels to me as a clinician and a pediatrician that that is
18 an area for some policy options, and it could really help
19 maternal child health outcomes.
20 Just a couple of really quick points. I don't
21 know where to go with this, but I was surprised to see that
22 4 percent of births, 156,000 births in the United States,

1 are of uninsured mothers. My guess from prior work on the
2 uninsured is that most of these are eligible for Medicaid,
3 although I don't know that. So it's just a point that I
4 wanted to make.
5 Regarding the substance use chapter, it's
6 excellent. I guess two or three comments or questions. Is
7 there anything that you know about why other states are not
8 using more authorities to cover substance -- what are the
9 barriers for states using more authorities? Is it just a
10 workload, administrative workload or what?
11 The second point was on post-incarceration, and
12 I'm a little bit unclear about this. If a woman is on
13 Medicaid pre-incarceration, coming out, do they have to
14 apply for Medicaid again, and what are those barriers? And
15 I know there's some discussion nationally about automatic
16 reenrollment in Medicaid post-incarceration.
17 Finally, last point that Martha also made, I'm
18 really glad we're focusing on integration of care, both for
19 the elderly with duals but also for children in foster
20 care, substance use in pregnant women.
21 Thank you very much.
22 CHAIR BELLA: Thank you, Peter. Before we go to

1 Kisha, and then after Kisha is Tricia, I just wanted to see
2 if Tamara, Erin, or Martha had any responses to the couple
3 of questions that Peter asked.
4 MS. McMULLEN: Sure. This is Erin. So regarding
5 the first question around kind of why aren't more states
6 using all the different authorities that are available to
7 them to tailor their benefits for pregnant women with
8 substance use disorder, I think there are probably a few
9 different reasons why we are not seeing more of that. You
10 know, first, and I think this is a reflected in a lot of
11 our previous work, you know, in some states the provision
12 of substance use disorder services through Medicaid is
13 still a relatively new benefit. You know, we've seen a lot
14 of states build out their continuum of services over the
15 past few years, mostly through those 1115 demonstrations.
16 But, you know, there are some states that are enhancing
17 their benefit through their state plan.
18 I think another thing to keep in mind too is some
19 of the authorities in the chapter are relatively new. They
20 were created under the SUPPORT Act, so, you know, we'll
21 have to see kind of what state uptake is of those services,
22 providing care through those different authorities.

1 Around the post-incarceration issue and release,
2 so whether or not a beneficiary receives their Medicaid
3 kind of being turned back on when they are released into
4 the community, really depends on what state they are in and
5 how the state goes about suspending or terminating coverage
6 when that individual is incarcerated.
7 So we have seen a lot more states use -- they are
8 suspending rather than terminating coverage, but
9 essentially states are kind of coordinating with jails and
10 prisons in different ways to make sure that eligibility
11 resumes once that person goes back in the community,
12 whether that is through, you know, engagement with a
13 managed care organization or their local Medicaid
14 eligibility workers. It really depends on the state.
15 MS. HEBERLEIN: And this is Martha. I can speak
16 briefly to the home visiting. I think, Peter, when you
17 alluded to, in the chapter, it's 25 Medicaid programs that
18 cover some of these home visits, but there is also the
19 MIECHV program and sometimes states blend that funding and
20 figure out Medicaid will pay for certain aspects of it, the
21 more clinical pieces, and MIECHV will pay for other pieces
22 of it. So it may not be the case that those other 25 don't

1 have home visiting. It just may be that Medicaid is not
2 paying directly for those services.
3 COMMISSIONER SZILAGYI: Great. Thanks very much
4 for all those, and again, it would be really interesting to
5 look at eligible but not enrolled, if that data is
6 available, for home visitation. And thanks, Erin, for the
7 others. I recognize that there's a lot of effort at the
8 state levels, actually both for adults and children, to
9 address the issue of post-incarceration kind of automatic
10 Medicaid enrollment based on suspension rather than
11 discontinuation of Medicaid.
12 CHAIR BELLA: Thank you, Peter, for your
13 comments. Kisha and then Tricia.
14 COMMISSIONER DAVIS: Thank you. Thank you,
15 Martha, Tamara, and Erin. This is really a great couple of
16 chapters, almost books. So I really appreciate the detail
17 that was included in it.
18 I want to echo many of the comments that have
19 already been said by Martha and Peter, so I won't belabor
20 them. I really appreciate and look forward to the future
21 work that we do around doulas and birthing centers, and
22 especially as we are seeing more out-of-hospital births in

1 light of COVID, but I think in general, as a trend that we
2 might be going back to continuing to follow those and
3 follow that outcome.
4 I would like us to continue to think about
5 maternal deaths and children really as a maternal-newborn
6 dyad unit. And we kind of talk about maternity care and
7 maternal morbidity and mortality over here and then, you
8 know, talk about SIDS and low birth weight babies over
9 here, and really thinking of we want both of those outcomes
10 to be well. And so really thinking of that mother-baby
11 dyad as a unit and how we coordinate and collaborate care
12 so that both do better. And so thinking about what are
13 those things in terms of coordination of care that help
14 moms and babies do better.
15 We know that when that care team is collaborative
16 and speaking with each other, so things like the
17 pediatricians screening for depression for new moms, having
18 family physicians be involved in that maternity care, and
19 then also being involved with the babies after, and how
20 that really contributes to the health of both parties.
21 Also thinking about what are those things, especially in
22 terms of substance abuse, that get in the way of those --

1 of that collaboration. And so thinking about things like
2 Part 2 and HIPAA, and substance use treatment when we are
3 trying to care for a mom and a baby and take care of
4 substance abuse issues, and what are the barriers that get
5 in the way, in terms of confidentiality for that team to be
6 able to take care of that dyad.

7 Also, just echoing some of the comments on home
8 visitation, especially in light of COVID, it never made
9 sense to me why we ask new moms to bring their babies out
10 to a doctor, you know, just a week or two after birth, and
11 if ever there was a time to keep new moms and babies at
12 home it is now, especially in light of COVID, and what are
13 ways that we can encourage postpartum home visitation and
14 follow-up to, you know, help keep those healthy dyad units,
15 you know, at home and safe, and not with the added stress
16 of coming out, with COVID or otherwise.

17 And lastly, I just want to echo Martha's comments
18 on monitoring disparities in health outcomes and how they
19 change, or if they change in our -- in light of COVID. We
20 know that COVID really affects those who are most
21 vulnerable, in terms of chronic disease, asthma, heart
22 disease, hypertension, and we know that many of the

1 maternal morbidity and mortality is related to heart
2 disease and affecting our minority populations. And so how
3 that might be affected from the novel coronavirus. Thanks.
4 CHAIR BELLA: Thank you, Kisha. Tricia and then
5 Toby.
6 THE MODERATOR: Tricia. It looks like you are
7 self-muted, so just click on the icon with the telephone in
8 your control panel.
9 COMMISSIONER BROOKS: Okay. Can you hear me now?
10 THE MODERATOR: We can. Thank you.
11 COMMISSIONER BROOKS: Okay. Great. Anyway, I'll
12 add my congratulations to the team here on this great work.
13 And this ties into Kisha's last comment about monitoring
14 the impacts. It's important to note that the Families
15 First legislation has maintenance of effort provisions that
16 include this enrollment freeze for everyone in Medicaid.
17 It doesn't apply to CHIP. But that means that women who
18 would be losing coverage 60 days postpartum will need to be
19 kept on Medicaid. States that have expanded Medicaid could
20 move those pregnant women into the adult expansion as long
21 as the benefits are as good as they were getting in
22 Medicaid.

1 But it seems like that we want to keep our eye on
2 any way that we can do surveillance in real time to see
3 what the impact is going to be on maternal and infant
4 outcomes with extended postpartum coverage.
5 CHAIR BELLA: Thank you, Tricia. Toby?
6 COMMISSIONER DOUGLAS: Yes. Again, great work on
7 these chapters. Two just brief points. I just wanted to
8 again highlight the importance of us continuing to explore
9 the postpartum coverage extension, especially as it relates
10 to Medicaid expansion. Given what we are facing now and
11 the stressors on families with COVID into the future, with
12 multiple stressors as well as potential job -- of continual
13 job losses, this is an important piece that we are going
14 to, like Tricia said, need as much real-time assessment of
15 the implications of coverage for those who are right now
16 losing coverage 60 days postpartum and that interaction
17 with -- if Medicaid expansion was available, would that be
18 there to support with all the available services that are
19 needed.
20 And that gets into the other piece around the
21 intersection with systems, and I'm glad we're highlight the
22 fragmentation similar to what we talked about, Peter

1 highlighted with the duals. Really important to continue
2 to note that Medicaid, while we play a huge role, there are
3 so many other organizations, state, local, and federal, and
4 there is a need, a desperate need for better integration,
5 thinking of ways going forward of how those funds are more
6 integrated and aligned, whether it's with programs such as
7 the Maternal and Child block grants, the SAMHSA block
8 grants, any of the Part C funding, and WIC, just to say a
9 few. And I hope that we can continue to explore ways and
10 initiatives that are trying to integrate those dollars in a
11 better way, especially as we go forward, and these finite
12 dollars that are going to be available. Thank you.
13 CHAIR BELLA: Thank you, Toby. Any other
14 comments from Commissioners?
15 [Pause.]
16 CHAIR BELLA: Okay. I would like to reiterate my
17 thanks or congratulations for the great work. These
18 chapters are going to be really strong contributions to
19 this set of issues. And I'm particularly excited about the
20 future areas of work that have been identified. We didn't
21 talk much in the comments about the value-based piece, but
22 there is, I think, a lot of activity there and continuing

1 on that front, and obviously you have heard very strong
2 interest for looking at postpartum coverage links, both
3 sort of regardless of COVID but particularly in light of
4 COVID, and many things that have been brought up on the
5 delivery system side around doulas and in-home visits. And
6 Kisha, I really liked reminding ourselves to think of this
7 as a dyad.
8 So thank you to staff and thank you to the
9 Commissioners for the robust discussion, and we certainly
10 will be continuing to focus on this issue and these
11 populations in our next report cycle.
12 With that we are going to move into our next
13 session, which is about Medicaid financing. And so, you
14 know, there are ongoing debates about the financing
15 structure of Medicaid, and oftentimes people generally
16 debate countercyclical. We had this as a topic of
17 discussion before and wanted to bring it back. And it
18 seems just really timely and relevant to have it right now.
19 So we are going to turn to Moira who will lead us
20 through the slides and then we will open it up for
21 Commissioner comments. So Moira, thank you.
22 **### CONSIDERATIONS IN DESIGNING AUTOMATIC MEDICAID**

1 **FINANCING CHANGES IN TIMES OF CRISIS**

2 * MS. FORBES: Thanks. And I am not seeing a
3 little click. Oh, there we go.

4 So we're going to circle back on a topic that we
5 first discussed last December, which is Medicaid as a
6 countercyclical financing mechanism. At the time, the
7 Commissioners asked us to do some more analysis on some of
8 the technical design aspects, so we started doing that
9 work, but obviously in the meantime the country started
10 experiencing the COVID-19 pandemic and all of these
11 associated economic effects, mainly all the businesses
12 having to shut down and lay off all of their workers, to
13 the point where Congress actually included an FMAP
14 adjustment in the second COVID response bill, which became
15 law on March 18th.

16 So on the one hand you could say that this work
17 isn't needed because Congress has shown it can act when
18 necessary. But on the other hand the circumstances around
19 this pandemic are pretty unique. One of the things
20 Congress was responding to were reports that weekly
21 unemployment claims rose from what had been a low level in
22 February to being five times the highest number ever

1 recorded by mid-March.

2 So the fact that Congress acted so quickly in
3 this instance doesn't really mean that they would again,
4 because in previous economic downturns the changes have
5 happened over a longer period of time and have affected
6 different parts of the country differently, and we would
7 expect future downturns to be more -- well, we hope would
8 be more like that and less like the current situation.

9 So what we're talking about today is how you
10 would think about designing an automatic Medicaid financing
11 change where the situation is not as clear as right now,
12 not the 100-year event but the normal economic cycle.

13 So first I went over the federal medical
14 assistance percentage and Medicaid financing and all that
15 last December, but I'll go back over that again quickly
16 today, and in particular focus on how it works both as an
17 automatic stabilizer and as a fiscal stimulus. And I will
18 give a couple of examples of specific times, in addition to
19 the current situation, in which Medicaid has been used as a
20 fiscal stimulus. Then I will go through some of the design
21 considerations and walk through some of the different
22 measures that could be used to support an automatic

1 mechanism, with some data that we haven't shown before, and
2 then have some time at the end for questions and
3 Commissioner discussion.
4 First, a quick recap of how the federal financing
5 mechanism for Medicaid works. The federal share of
6 Medicaid spending for most health care services is
7 determined by the Federal Medical Assistance Percentage, or
8 FMAP, which is adjusted annually for each state. The
9 formula used to determine each state's FMAP provides higher
10 reimbursement to states with lower per capita incomes
11 relative to the national average, which is intended to
12 reflect states' differing abilities to fund Medicaid from
13 their own revenues.
14 The formula averages three years of per capita
15 income data to minimize the effect of year-to-year
16 fluctuations. But this also means that some of the data
17 used in the calculation are fairly old by the time the
18 calculation is done each year. At times alternatives to
19 per capita income as the basis for the FMAP formula have
20 been suggested. It is one of those data sources that can
21 be consistently measured for every state in a timely way,
22 which is important for doing the math, but it doesn't

1 correlate well with states' abilities to fund Medicaid or
2 with the demand for or cost of Medicaid. So it is not
3 great for distinguishing how well states can fund the state
4 share.

5 Automatic stabilizers, generally, are fiscal
6 policies that offset cyclical changes in economic activity
7 without additional governmental intervention. Medicaid has
8 open-ended financing: as states spend more, the federal
9 government will contribute additional federal funds.
10 Demand for Medicaid is countercyclical to economic growth.
11 That is, enrollment and spending increase when there is a
12 downturn in the economic cycle. So Medicaid is an
13 automatic stabilizer in that program spending and federal
14 spending automatically increase as demand for the program
15 increases during an economic downturn.

16 Some aspects of Medicaid financing rules that
17 limit its effectiveness of the stabilizer are that states
18 have to continue to contribute a state share and states
19 generally have less revenue in a downturn but still must
20 continue to balance their budgets. In additional, federal
21 spending automatically increases in proportion to increases
22 in state spending, but the share or percentage of federal

1 spending doesn't increase.

2 And finally, if there is a decrease in per capita
3 income in a state because the FMAP formula uses that three-
4 year average, the state's FMAP rate might not change much
5 right away, and might not change at all if the state's
6 relative per capital income stays the same compared to
7 other states.

8 Fiscal stimulus is the use of specific policy
9 changes to encourage economic growth during a recession. A
10 fiscal stimulus is an action taken in response to present
11 economic conditions so it requires legislative consensus on
12 the need for action and then, under normal circumstances
13 anyhow, some time to enact the law and distribute the
14 funds. Fiscal stimulus can be designed to address
15 particular needs or goals, which can be to help support
16 states or individuals or certain industries.

17 Medicaid has been used as a fiscal stimulus in
18 several prior economic downturns. On this slide there are
19 two examples that show the length and the amount of the
20 increase provided in the 2001 and 2008-2009 recessions. In
21 2001, Congress increased each state's FMAP by 2.95 percent
22 for five quarters, and in 2008-2009, they increased each

1 state's FMAP by a flat 6.2 percent, and also provided an
2 additional FMAP increase for states with high unemployment,
3 and that increase also lasted for nine quarters.
4 A different kind of fiscal stimulus is the
5 disaster adjusted recovery FMAP. Congress created that.
6 It is a state-specific automatic FMAP increase that goes
7 into effect if certain conditions are met. This was
8 enacted in 2010, following a series of pretty catastrophic
9 Gulf hurricanes between 2005 and 2008. A number of Gulf
10 Coast states experienced a lot of economic distress after
11 several -- a series of hurricanes happened.
12 And this provision adds a secondary calculation
13 to the annual FMAP calculation process, and it adjusts the
14 state's FMAP upward, if the state experiences a statewide
15 major disaster within the previous seven years, and the
16 regular annual FMAP calculation results in a decrease in
17 FMAP of 3 percentage points or more.
18 So switching now to thinking about designing
19 automatic Medicaid financing changes--in designing an
20 automatic FMAP adjustment, the policy choices will affect
21 the typical design consideration, such as which economic
22 indicators you'd use.

1 For example, you have to decide whether an
2 automatic increase should be based on national conditions
3 or on state-level factors, like the disaster-adjusted
4 recovery FMAP calculation takes into account whether there
5 was a state-level disaster declaration. And you have to
6 decide whether if you're looking at something that would
7 apply nationally whether the amount of an increase should
8 be the same for all states, like the 2001 stimulus bill, or
9 whether it should vary by state based on some state-
10 specific factor, like the 2008 stimulus that had a state-
11 level unemployment rate adjustment.
12 You would also have to decide whether you want to
13 design an automatic adjustment that can kick in quickly
14 based on an indicator that is available quickly, but then
15 it might also be specific to a lot of fluctuation, or if
16 you want to design an automatic adjustment that takes into
17 account longer-term trends but may be more predictable. So
18 there's tradeoffs when you make these choices.
19 Those are some of the policy considerations that
20 would drive the design, and it depends on what the goals
21 are.
22 Once those policy choices are made, then you can

1 make the technical design decisions to support them and
2 identify the best economic or other indicators in terms of
3 the availability, timeliness, reliability of the data,
4 correlation to state revenue, Medicaid enrollment, or other
5 goals.
6 Some of those technical decisions that need to be
7 made are how to identify a downturn that triggers an
8 increase, when do you start and stop an increase in federal
9 funds, and whether the increase should vary by state or
10 not. And every one of those decisions will also affect the
11 timing and magnitude of changes in federal spending and the
12 effects on the economy.
13 This is where I need to take a deep breath.
14 Okay. So this is a busy slide but for a reason,
15 and that's because we want to show visually the differences
16 between options. I didn't want to be skipping back and
17 forth between three slides.
18 One of the technical design decisions that
19 policymakers need to consider is how to identify a
20 downturn. If you want an automatic mechanism, you need a
21 way to trigger it. What makes an economic measure a good
22 indicator for this purpose is, first, the degree to which

1 changes in the measure would correlate with the changes in
2 state revenue and Medicaid enrollment, and second is the
3 timeliness and availability of the data for trend analysis.
4 So we looked at several indicators, mainly things
5 that other people have suggested for this purpose or that
6 are used in other programs, including, as shown on the
7 three charts here from left to right, gross domestic
8 product, or GDP, sales taxes, and unemployment. And then--
9 we didn't run a regression--we just looked at how these
10 indicators sort of visually correlate with the preceding
11 recessionary period, which took place from late 2007 until
12 mid-2009, and the previous Medicaid stimulus that was in
13 effect from October 1, 2008, to December 31, 2010.
14 The recession period is indicated in the brackets
15 in each of the charts and the stimulus is in the shaded
16 box. So, hopefully, I've explained what's going on in this
17 chart and what you're seeing here.
18 Now I can walk through what we saw when we looked
19 at the charts and how these measures correlate to changes
20 in state revenue, Medicaid enrollment, and what we thought
21 about the timeliness and availability of these datasets for
22 our purposes here.

1 GDP, which is the sum of all production in the
2 country and the representation of national economic
3 activity, is what's used to determine whether there's a
4 recession. A recession is defined as declining GDP across
5 two or more quarters. Although GDP can decline and
6 increase and decline again over a longer period, it can be
7 hard to determine, except in hindsight, when a recession
8 actually starts and ends.

9 Although GDP is the most direct benchmark of the
10 national economy, changes in GDP may not synchronize
11 perfectly with changes in economic conditions in each
12 state. GDP doesn't tell us anything about the effect of a
13 recession on Medicaid enrollment either. So if you look at
14 the first graph on the left, you could see that GDP goes
15 up, and then when we get to that bracketed area, that's
16 what was retroactively defined to be the recession. It
17 bobbles, and then it drops.

18 Then when the stimulus goes into effect, which is
19 the box, GDP goes back up, which is what you want. The
20 stimulus money came in, and the economy got better.

21 For the middle chart, again, what we're trying to
22 see is measures to identify a downturn here, but we're

1 looking at the performance on either side of the recession.
2 For the middle chart, which is sales tax receipts, states
3 generate revenue through sales tax and through corporate
4 and individual income taxes. All of those are indicators
5 of state-level economic activity, but sales tax revenue is
6 the most direct measure of consumer activity. It's rapid.
7 It's typically reported more frequently--monthly or
8 quarterly--than income taxes. So it's a more timely
9 indicator of changes in the state's revenues than other
10 taxes.

11 But while these data are available on a timely
12 basis, sales tax revenue vary seasonally. So it can be
13 hard to determine a trend without comparing annual data.
14 We get it fast, but it's hard to interpret quickly.

15 It's also difficult to compare sales tax
16 statistics across states due to differences in state
17 policies.

18 Finally, like GDP, this indicator does not
19 directly measure the effect of a recession on Medicaid
20 enrollment, although changes in sales tax receipts probably
21 tell us something about state need for federal assistance.

22 The last chart on the right is about

1 unemployment. The unemployment rate is calculated and
2 published monthly by the Federal Bureau of Labor Statistics
3 before the end of the following month, although I think as
4 we've all seen, we do get some reporting on the
5 applications for unemployment very quickly. So it provides
6 timely information on changes in demand for Medicaid, as
7 persons losing their employment are more likely to meet the
8 income requirements and be seeking public sources of
9 coverage.
10 You can see in that last graph that employment is
11 declining during the recession. It gets much steeper
12 towards the end of the recession, and then it really drops.
13 And then employment slowly picks up over time.
14 Other government programs, including the
15 Supplemental Nutrition Assistance Program, use the
16 unemployment rate as a trigger for an automatic federal
17 increase, but this measure tends to lag behind the business
18 cycle with the highest rates of unemployment. You can see
19 here generally occurring after the official end of the
20 recession, which you see in the graph.
21 Here is a fun slide where we put all three
22 measures on one graph. This is the threshold for starting

1 an increase. Ideally, an automatic stabilizer would have,
2 whichever metric you've chosen, some kind of threshold,
3 like the magnitude, the direction, the duration, to
4 identify when a downturn is significant enough to warrant
5 additional federal Medicaid funding as well as determine
6 when the economy on the other end has recovered
7 sufficiently to allow a return to normal FMAPs. So if
8 there's a trigger, there has to be a point at which that
9 trigger goes into effect.
10 So to provide effective fiscal stimulus to
11 states, the threshold would need to be able to signal an
12 economic downturn quickly but not be so sensitive that
13 small fluctuations would trigger frequent adjustments. So
14 we took the same three indicators -- GDP, unemployment, and
15 sales tax collections -- and looked at the change. So the
16 lines here are different because these are showing the
17 change from quarter to quarter. What we found is all three
18 change significantly every quarter, and it's difficult to
19 discern a trend unless you're looking at multiple quarters
20 of data.
21 For example, the seasonally adjusted annual GDP,
22 which is the light blue line, can change more than a whole

1 percentage point up or down from quarter to quarter, and
2 again, it's not considered a recession unless there's a
3 decline for two or more quarters. So, at that point,
4 there's already been six months of economic contraction,
5 which is a long time for the economy to be in a decline.
6 You can also see that the employment rate, the
7 dark blue line, it generally trended down during that
8 recession period between the brackets, and before that, it
9 also sort of trended down. But there's a lot of like one
10 step up, two steps down. It's difficult to sort of say
11 there's a point at which we would have had a clear signal
12 that an FMAP bump should clearly go into effect.
13 Seasonality can also make it difficult to use
14 some data, particularly sales tax data. It may not be
15 clear whether a decrease is just a seasonal change or
16 indicative of a more significant downturn. Sales tax is
17 the dotted gray line there, which is, again, difficult to
18 discern the trend there.
19 We do want to note that this is a reason why
20 nonfinancial triggers could be used or why Congress could
21 couple a nonfinancial trigger with an economic indicator,
22 as Congress just did, by looking at both a COVID emergency

1 declaration and unemployment projections to authorize a
2 temporary FMAP increase. The disaster-adjusted recovery
3 FMAP is also triggered by both a presidential disaster
4 declaration and a significant year-over-year decline in
5 FMAP.
6 Another consideration is whether the threshold
7 should be based on national- or state-level conditions.
8 With a national threshold, additional federal funding would
9 only be provided once national economic indicators meet the
10 established limits. We look to see how the two measures
11 that can really be compared across all the states, which
12 are GDP and unemployment, look compared to the prior
13 recession and to the prior stimulus.
14 What we're trying to see is whether a national
15 economic measure can be used as a proxy for economic
16 conditions in most states.
17 If you look at GDP, which is the chart on the
18 left, it's a comparison of national GDP to state-level GDP.
19 It shows that most states recover to the pre-recession
20 level of economic output at the same pace as the nation,
21 which--because the sum of state economic output makes up
22 the national economic output--those should sort of go in

1 parallel. But we're looking to see if like a small number
2 of large states disproportionately affect the national
3 total, and that does not seem to be the case. Most states
4 are on the same trajectory as the country.
5 The last recession, measured as declining output,
6 occurred from December 2007 to June 2009. At the national
7 level, economic output, while increasing, didn't return to
8 those pre-December 2007 levels until the beginning of 2010.
9 It took two quarters of expansion after the end of the
10 recession just to get back to the pre-2007 levels. But at
11 that point, over half of states had also returned to their
12 pre-recession levels of economic output. By the end of the
13 year, 45 states had returned to pre-recession levels. So
14 if you use GDP as your measure, it looks like using a
15 national measure is a reasonable proxy.
16 But if you look at one of the other indicators we
17 considered and the one that may be a better indicator of
18 the demand for Medicaid stimulus, which is unemployment on
19 the right, we know that state-level economic conditions can
20 vary significantly. The GAO has proposed increasing the
21 federal share of Medicaid spending by the same percentage
22 change in unemployment in the lowest quarter in the past

1 two years. Unemployment rates also correlate to declines
2 in state revenue, which Medicaid stimulus funding is partly
3 intended to address.
4 So we compared state unemployment rates to
5 national GDP during the previous recession and showed that
6 most states continue to experience high levels of
7 unemployment after the U.S. as a whole recovered to the
8 pre-recession level of economic output. Thirty states, as
9 well as the U.S. as a whole, reached their highest
10 unemployment rate in the same quarter as or after the
11 national GDP recovered to the pre-recession level of
12 economic output in the first quarter of 2010.
13 The majority of states didn't reach maximum
14 unemployment until three or more quarters after the
15 official end of the recession. So depending on what
16 measure you were looking at, you may have a different idea
17 of whether the states have recovered or not.
18 Finally, an automatic stabilizer must also have a
19 mechanism to revert back to the regular funding formula. A
20 number of factors need to be weighed in choosing whether to
21 provide additional funding for a fixed period of time, like
22 four quarters, or whether specific indicators should be

1 used to indicate when enhanced funding is no longer needed.
2 For example, if enhanced funding is triggered
3 based upon changes compared to a baseline, such as a
4 quarter in the previous year, then enhanced funding could
5 end when the measure is no longer changing or changing for
6 the better.
7 We just look at unemployment in this chart
8 because, as you saw in the last slide, most states hit
9 their maximum unemployment rates three or more quarters
10 after the official end of the recession, even after GDP had
11 picked up. There's also a correlation between employment
12 and insurance coverage, as I said.
13 So what we're looking at here is how many states
14 were still experiencing high unemployment, which we define
15 as greater than the 75th percentile plus 1 percentage point
16 of their long-run unemployment rates. So we're comparing
17 each state to its own employment rate over time and looking
18 to see who is still on the high end of their own long-term
19 rate.
20 As shown here, even after states' unemployment
21 rate started to decrease after the peak, most states still
22 experienced high unemployment rates for several more

1 quarters. Only 17 states had dropped below that high
2 unemployment threshold by the time the enhanced FMAP
3 expired at the end of 2010. It wasn't until the fourth
4 quarter of 2011, 16 quarters after the beginning of the
5 recession and 4 quarters after the expiration of the
6 enhanced FMAP, that the majority of the states dropped
7 below that high unemployment threshold.
8 So that concludes our presentation of the data.
9 I'm happy to go back and answer any questions about any of
10 this or just turn it back to you for discussion.
11 CHAIR BELLA: Great. Thank you, Moira. You have
12 really done a fantastic job of laying all this out in a way
13 that I think we can kind of make our way through the
14 different pieces, but you also did a great job of setting
15 context at the beginning to remind us all that we started
16 looking at this pre-COVID, and there is a need to continue
17 looking at it. Hopefully, we won't have a COVID-like need
18 again, but thank you for setting the stage so well.
19 What I'd like to say to the Commissioners, there
20 are no black and white answers here or no right or wrong
21 answers. All of the options and the factors that Moira has
22 laid out present tradeoffs, and they have different impacts

1 state by state. And they have different impacts. They're
2 state and fed. So what I'd like to see is a discussion and
3 get a sense of some areas of interest, particularly around
4 kind of the four big things that Moira went through, so the
5 measures or the triggers, if you will, to specifically
6 talking about GDP, unemployment, and sales tax, the
7 threshold of when something starts, the threshold of when
8 something stops, and then how we think about national
9 versus state. The goal would be to drive toward some areas
10 of interest where we could go back and do some modeling of
11 different scenarios and looking at tradeoffs and
12 implications. The point being, I'm hoping to get some
13 feedback from Commissioners about areas of interest within
14 those domains that would allow Moira and team to continue
15 to explore some of what she's laid out today so that we can
16 continue doing work in this area.
17 With that, I would like to turn it over to
18 Commissioner comments. Please indicate. Raise your hand
19 if you have a comment, and we still start with Peter.
20 COMMISSIONER SZILAGYI: Thank you, Moira. This
21 is really complex. At the same time, you did a wonderful
22 job explaining it.

1 Could you show Slide 10? This is where it
2 compares GDP employment, unemployment, and sales tax. I'm
3 just trying to -- in terms of the threshold, does it appear
4 to you and others that the employment seems more stable in
5 terms of a threshold than the other two measures? I see a
6 lot of kind of bouncing around by quarter and the GDP and
7 the employment. So that was one question.
8 The other, if we actually mapped Medicaid
9 enrollment on this map, what would it look like?
10 MS. FORBES: That's a good question. We can do
11 that. I mean, there were a lot of policies that went into
12 effect around Medicaid enrollment. When that increase went
13 into effect, there was a maintenance of effort tied to it,
14 but we could see what happened prior to that.
15 The big difference between the period on this
16 chart and now, of course, is that more than half of states
17 have taken up the adult expansion.
18 COMMISSIONER SZILAGYI: Right.
19 MS. FORBES: And so there may be a lot of folks
20 who already have Medicaid now who would not have had
21 Medicaid -- who would be coming on newly at that time.
22 But we can certainly add changes in Medicaid

1 enrollment to a chart like this.

2 COMMISSIONER SZILAGYI: My first question, does

3 it seem that employment seems to be a more -- "stable" may

4 be the wrong word here, but there's less fluctuations, to

5 use that for starting an increase?

6 MS. FORBES: Yes. I mean, this is showing change

7 from quarter to quarter and definitely of the three

8 measures. The direction of the employment measurement,

9 certainly the magnitude changes, but the direction, it

10 generally goes down, and then it generally goes up --

11 COMMISSIONER SZILAGYI: Yeah.

12 MS. FORBES: -- as opposed to up and down, up and

13 down like the others.

14 CHAIR BELLA: Thank you, Peter.

15 Kit and then Chuck.

16 COMMISSIONER GORTON: Hi. This is Kit Gorton.

17 Like Peter, I'm fascinated by Slide 10. What

18 jumped out at me is that while only individual indicators -

19 - and I'm not an economist, and I don't play one on

20 television -- while the individual indicators maybe are too

21 volatile or didn't correlate well, if you start to lump

22 indicators together, they line up pretty well, so just a

1 thought that there may be some combination of indicators.

2 Peter went where I want to go, which is I would

3 love to see how this impacts. I do think our role in this

4 is to say how do we tie this to Medicaid, and so on the

5 front end, absolutely this work, I would like to see more

6 of this. I'd like to see the Medicaid eligibility layered

7 onto it, and maybe a way to do it is to separate out the

8 expansion states from the non-expansion states and do two

9 graphs and see if they behave differently or the same. So

10 that was one thing I wanted to suggest.

11 But then I do think while I don't think it's our

12 job to pick the right thing, I do think we have a role to

13 play in terms of describing the options as we have done

14 many times in the past and what the tradeoffs are, which I

15 think, Moira, as you have started to do here very

16 effectively. I'd like to on the back end say, okay, how

17 does FMAP -- is FMAP the best form of stimulus? We have

18 other ways to push money out. We have supplemental

19 payments to hospitals. We have DSRIP grants. We have all

20 sorts of ways that Medicaid can push money out into the

21 economy, and so the question that I would like to see us

22 address in some future work is if you're going to use

1 Medicaid as part of your economic stimulus package, what
2 are the levers that we have beyond FMAP that might be
3 reasonable to do that?
4 CHAIR BELLA: Thank you, Kit.
5 Chuck?
6 VICE CHAIR MILLIGAN: Hi. Thank you. Great job,
7 Moira.
8 I had a couple of questions and maybe just a
9 comment after that. One of my questions is when we focus
10 on sales tax and gross receipts, I wanted to have a better
11 understanding of why we were focusing on that particular
12 form of local or state revenue. In a lot of states, the
13 way the state secures revenue varies by a lot of -- I mean,
14 state income tax, property tax, sales tax, and so on. I
15 think there are states that have low sales tax or gross
16 receipts or high sales tax or gross receipts, but they rely
17 on income from other sources.
18 For example, I work in New Mexico, live in New
19 Mexico. One of the things that's greater here and in a lot
20 of other states that are dependent on oil and gas revenue,
21 as the price per barrel goes down, there's a pretty
22 profound effect on the state general revenue. Just as a

1 rule of thumb, in New Mexico, every one dollar change in
2 the price per barrel is a $40 million state general fund
3 impact.
4 And that's kind of bottomed out lately. I think
5 a sales tax and gross receipts tax focus would miss that
6 kind of local impact, and I'm wondering, is it because it's
7 more readily available data? Is it because it's perceived
8 to be more sensitive and real-time? But I wanted to have a
9 feel for why, among all of the sources of local revenue,
10 the focus here on sales tax and gross receipts?
11 MS. FORBES: You are right. It is available and
12 it is timely. But I think all of the -- for all of the
13 reasons that you mentioned, first of all, what sales tax is
14 varies by state, and then the amount that sales tax
15 contributes to state revenues varies. I mean, I'm from a
16 state that doesn't even have sales tax.
17 So we included it here because it has been
18 suggested, but I think for all of these reasons, I don't
19 know that a real strong case can be made that it should be
20 the leading indicator for when one triggers or stops an
21 increase. But we have -- it's been mentioned and so we put
22 it up here. I think it's helpful to see what some of the

1 issues are with the data. It is easily available, which is
2 a plus.
3 VICE CHAIR MILLIGAN: Yeah, no, and I think it
4 probably is, you know, more real-time. It's not an annual
5 filing, all of that. But I do think, and maybe just for
6 everybody's kind of awareness, do I think that it has its
7 own bias across states, because of just state revenue
8 mixes. My second question is about unemployment. This
9 might be a longer answer and so, you know, handle it
10 however you want to handle it. But it seems like the
11 nature of employment has changed pretty profoundly. It
12 seems like there's a lot more people in kind of a gig
13 economy, you know, independent contractor, not employed. I
14 don't know about their eligibility for unemployment. I
15 don't know about the reporting for unemployment. And so
16 I'm wondering whether that is fundamentally changing and
17 varies a lot by kind of whether states have tourism-related
18 or agriculture-related or other related employment forms
19 that are not sort of traditional employer payroll type
20 models.
21 Any brief kind of comment on that?
22 MS. FORBES: It's not something that we looked

1 into as we were doing this, but it's certainly something I
2 think that we are all becoming a lot more aware of,
3 certainly the discussions around how the recent package is
4 being pushed out and how states are sort of grappling with
5 the immediate situation. So it's definitely something. I
6 mean, it's a good point, which is thinking about how states
7 are affected, both what information is available, like how
8 are these different things captured, and so what
9 information would be available for some sort of automatic
10 mechanism, and secondly, how does the distribution of these
11 kinds of jobs vary by state. What do we know about that?
12 I think those are both good question that we can look into
13 as we do further work on this. They are not things that we
14 did at this stage but we can certainly follow up.
15 VICE CHAIR MILLIGAN: Thanks. And then my
16 comment, my closing kind of piece on this is, I do think
17 that this is going to be important work to look at and to
18 start doing some scenario modeling and planning. And one
19 of the elements that I will be interested in learning about
20 as that work progresses is the extent to which more of a
21 countercyclical financing model might obviate the need to
22 do these 6.2 percent stimulus package-related bumps,

1 because that, in some ways, is a workaround to the fact
2 that we don't have countercyclical financing, where, you
3 know, revenue is cratering at the time that Medicaid
4 enrollment might be increasing. And I think I'm going to
5 be interested in seeing whether, as the work progresses, a
6 different financing model might reduce the need for these
7 kind of one-time heroic acts by Congress to do something as
8 a bump.
9 Thanks for the work, Moira.
10 CHAIR BELLA: Thank you, Chuck. Bill has a
11 comment.
12 COMMISSIONER SCANLON: No. First, I mean, I
13 think you've given us a tremendous amount to think about
14 here. This is a topic that has been discussed for a long
15 time. I'll have to confess that I started work on health
16 policy in 1975, and the first project I worked on was a
17 countercyclical FMAP formula. So it's been of particular
18 personal interest sort of to me since then.
19 I think all the points that have been raised are
20 all valid and they just point to the complexity of trying
21 to reach some kind of conclusion. I mean, the idea, to
22 where Chuck was going a moment ago, is something that is

1 automatic. It doesn't require sort of an act of Congress.
2 It doesn't require someone to sort of recognize that we
3 sort of have data that now indicate that we have a problem,
4 and also that we have data that indicates that the problem
5 is over and automatically we revert to some better steady
6 state.

7 That's a real challenge, I think, I mean, in part
8 because of the lags in collecting data. You know, Moira,
9 you mentioned a number of times that sales tax data are
10 readily available. I think it may not be such a terrible
11 measure if you're thinking about a national trigger. I
12 think if you're considering something that you would try to
13 do for -- with state-specific adjustments it would not be a
14 good measure, sort of because as Chuck has indicated, the
15 extreme variations sort of in sales tax policies that exist
16 sort of across states.

17 The comment I wanted to make was, I mean, if
18 we're opening up sort of, kind of big thinking, that we
19 think about sort of these adjustments in the context of
20 what we know about FMAP and what we potentially sort of
21 identify as some issues with FMAP, we know that states vary
22 significantly in terms of the need that exists within the

1 states. It's the question of not just the numbers of
2 persons with low incomes but it's also the cost of health
3 care, as sort of well as the types of persons that are low
4 income. If you have a disproportional population of
5 Medicaid-eligible that is older or have more disabilities,
6 your costs of care are going to be much higher.
7 There's a question of also sort of states varying
8 significantly in terms of their level of effort. Sort of
9 what share of their sort of, we'll call it their GDP, they
10 are investing in their Medicaid programs. A question that
11 I think we put on the table is how should these things be
12 thought about when there is a need for something to adjust
13 to what you might think of as a negative shock, like a
14 recession, when revenues are now being constrained, states
15 are in more dire circumstances. Some are going to be in
16 greater dire circumstances than others, and to what extent
17 should that be part of the thinking in terms of what a good
18 adjustment would be. Thanks.
19 CHAIR BELLA: Thank you, Bill. Tricia.
20 COMMISSIONER BROOKS: -- that little button
21 clicked here. So yeah, great job, Moira. This is really
22 interesting. I just want to make three quick comments.

1 One is another factor that impacts this would be what's
2 happening to the uninsured rate, although it's much harder
3 to get that data in real time, but I think it figure into
4 the need, which is going to translate into increased demand
5 for Medicaid in the states.
6 The other point I want to make is that if there
7 were to be something that is systemically available to --
8 as stimulus for states, that it is critical that any
9 maintenance of effort provisions be tied to those, because
10 the reality is the extra money is to help states to, you
11 know, spread their limited state dollars to be able to meet
12 increased demand.
13 And then the third point is that it was a nice
14 surprise for all of us that in this particular FMAP bump,
15 in Families First, that CHIP is included. CHIP was
16 expressly excluded in both ARRA and the ACA's MOEs. And
17 yet we have not told states that they need to have the same
18 MOE requirements in CHIP, even though they are getting the
19 enhanced funding. So I think that's an important point to
20 keep in mind going forward.
21 And I just have to give kudos to Melanie for
22 raising this topic before Christmas, and we're all thinking

1 hey, the economy is cooking along. We're -- you know, why
2 now? But the reality is that this could not be more
3 timely, so thanks for this work.
4 CHAIR BELLA: Thank you, Tricia. So Moira,
5 you've heard a lot. I just want to pick up on some key
6 things, and one is, Bill, I do think that we have an
7 opportunity to do some big thinking here, and I would
8 encourage us to do that. Also kind of reiterating, I think
9 we can't -- Kit mentioned we could add value with some
10 descriptive work, which I think is very true. The work
11 you've done here is incredibly valuable and should
12 definitely be spread so that people were beginning to sort
13 of beat this drum.
14 And then to the extent that you've gotten
15 feedback that would allow us to take it a step further,
16 looking at some of the various options. So I'm thinking a
17 little bit about the modeling that we did for DSH, that
18 looked at different factors, whether to use Medicaid or
19 uninsured, and there were state-level impacts. And taking
20 this, allowing us to get a glimpse into some of the
21 implications and the tradeoffs of using different
22 approaches, again not, Kit, to your point, not because we

1 think we can pick the, quote, "right one," but just to help
2 us take that thinking to the next level and begin to
3 understand some of the tradeoffs around timeliness and lag
4 and how automatic it is, and, you know, helping us
5 understand where we might want to continue to hone in on
6 this work.
7 So is there anything else that you want to ask
8 us, or do you feel like you have enough direction from this
9 conversation that can take this work to the next phase?
10 MS. FORBES: No. This is helpful. I think there
11 is definitely a couple of ideas here that we can work on
12 and some specific things we can go back and research, and
13 also some things, I think, that are -- it sounds like are
14 maybe less important. So I think that's all helpful.
15 Also something I should have mentioned at the
16 beginning and neglected to was that Chris Park and Jerry Mi
17 spent a lot of time collecting and organizing and thinking
18 about the best way to present all of this data, because
19 there's a lot of things going on here. So anyhow, I do
20 want to acknowledge them, even though we didn't want to
21 have a lot of people trying to present this at the same
22 time.

1 We will all work on this going forward, and I
2 think this fall we can definitely bring some more
3 information back to help you continue thinking about this.
4 CHAIR BELLA: Okay. Thank you, Moira and Chris
5 and Jerry. This is really fantastic.
6 Okay. We are leading into a very, also related
7 and very, obviously, timely -- that's kind of an
8 understatement -- topic, which is Medicaid's Response to
9 COVID-19. So again, the purpose is not that we think we
10 have any magic bullets here, and certainly like this stuff
11 is changing, as we discussed this morning, hourly. So what
12 we're doing here is sort of grounding us all in what's
13 going on to date, and thinking about, as a Commission, what
14 do we think our role is, in terms of monitoring this.
15 Particularly I would suggest some of the longer-term
16 impacts that we want to be thinking about, so that we
17 understand what information we want to be collecting now so
18 that we can have thoughtful discussions about this as the
19 impacts continue certainly past whenever we get through
20 this.
21 So with that I am going to turn it over to Erin,
22 Joanne, and Kayla, who are going to walk us through some of

1 the information and then we'll have a discussion with
2 Commissioners.
3 ### **MEDICAID'S RESPONSE TO THE COVID-19 PANDEMIC**
4 * MS. McMULLEN: Thanks, Melanie. Good afternoon.
5 This is Erin McMullen. Today, Joanne, Kayla, and I are
6 going to discuss Medicaid's response to the coronavirus, or
7 COVID-19 pandemic.
8 Medicaid plays an important role in federal and
9 state responses to public health emergencies. The
10 flexibility of the Medicaid program allows states to design
11 and modify their programs according to their specific
12 needs, and respond to disasters and emergencies. As you
13 will hear shortly, most states have already made changes to
14 respond to COVID-19.
15 Before describing COVID-19 specific responses, we
16 are going to first summarize the federal statutory
17 authorities that allow CMS and states to further tailor
18 their response to COVID-19. We will also describe Medicaid
19 authorities available to states to further assist with the
20 COVID-19 response, steps taken by CMS and states to date,
21 recent congressional action, and other considerations for
22 Medicaid in responding to the pandemic.

1 Before we get started, I just want to take a
2 minute to note that a lot of the COVID-19 related actions
3 summarized in this presentation and meeting materials are
4 rapidly changing. Since we finalized our slides earlier
5 this week, much has already changed. So wherever possible,
6 we will provide you with an update on those changes in our
7 oral remarks.
8 So the federal government has three vehicles for
9 declaring an emergency in the event of a public health
10 emergency or disaster. A lot of the actions that Joanne
11 and Kayla are going to discuss shortly wouldn't be possible
12 if these statutory authorities had not been exercised. The
13 use of these authorities enables the Secretary of HHS and
14 CMS to exercise a number of emergency powers that allow
15 states to further tailor their response to COVID-19.
16 First, under the Public Health Service Act, the
17 Secretary of HHS has the ability to declare a public health
18 emergency if they determine one exists. A declaration
19 under the Public Health Service Act does not require a
20 formal request from state or local governments, and it
21 allows the Secretary to conduct various activities in
22 response to the declared emergency. This includes

1 modifying the practice of telemedicine, making grants, and
2 conducting investigations into the cause, prevention, or
3 treatment of a disease. On January 31st, the Secretary of
4 HHS declared a public health emergency under this
5 authority.

6 The Robert T. Stafford Disaster Relief and
7 Emergency Assistance Act, or the Stafford Act, allows the
8 President to declare an emergency or a disaster at the
9 request of the governor or chief executive of a state or
10 territory. Use of the Stafford Act is needed to mobilize
11 FEMA, to coordinate disaster relief efforts in affected
12 states. FEMA assistance is available to states with the
13 federal government providing a 75 percent match for
14 disaster-related costs, such as activating emergency
15 operation centers. On March 13th, absent a request from
16 states, the President declared an emergency under the
17 Stafford Act.

18 Finally, the National Emergencies Act authorizes
19 the President to declare a national emergency without a
20 specific request from a state. Declarations under the
21 National Emergencies Act don't provide any specific
22 emergency authority and instead relies on emergency

1 authorities provided in other parts of federal statute. On
2 March 13th, the President declared a national emergency
3 under Sections 201 and 301 of the National Emergencies Act,
4 and Section 1135 of the Social Security Act, which is of
5 particular importance to Medicare, Medicaid, and CHIP. It
6 allows the secretary to waive various provisions in those
7 programs, as well as different provisions related to HIPAA.
8 So that's a good segue into our discussion of
9 responses to public health emergencies using Medicaid
10 authorities. Some of these authorities listed on this
11 slide may only be used if one or more of the statutory
12 authorities I just discussed are activated. So under the
13 state plan, states could simplify the enrollment and
14 renewal process to expedite enrollment in an emergency or
15 disaster. In order to waive certain provisions of
16 Medicare, Medicaid, and CHIP requirements under Section
17 1135 of the Social Security Act, an emergency or disaster
18 must be declared by the President either under the Stafford
19 Act or the National Emergencies Act, and a public health
20 emergency must be declared by the Secretary of HHS.
21 Under Section 1135, the Secretary can waive
22 certain requirements, many of which are specific to

1 providers, including Medicare conditions of participation
2 or other certification requirements, and EMTALA or HIPAA
3 requirements. Generally, Section 1135 waivers are specific
4 to an affected state Medicaid program. However, in past
5 disasters CMS has implemented specific waivers or
6 modifications under Section 1135 on a so-called blanket
7 basis, when it has been determined that all similarly
8 situated providers in an area need that waiver or
9 modification. Providers exercising under blanket waivers
10 or modifications must do so in good faith, absent any fraud
11 or abuse.
12 Section 1135 is only used for certain provisions
13 in federal law. Many state laws, including those related
14 to state licensure requirements and scope of practice are
15 not affected by these waivers. As discussed later in this
16 presentation, many states have also taken separate actions,
17 typically by evoking state-specific public health emergency
18 powers to address the COVID-19 pandemic.
19 In the event of a disaster or emergency, a state
20 may request a new Section 1115 demonstration waiver or
21 amend an existing demonstration to provide coverage to
22 additional populations or to expedite enrollment.

1 Section 1115 waiver authority has been used to
2 assist in the response to disasters, both natural and
3 manmade. For example, Section 1115 waiver authority was
4 used to assist state responses following the terrorist
5 attacks on September 11 and after Hurricane Katrina.
6 In an emergency, Section 1915(c), home and
7 community-based services waivers may also be modified with
8 the submission of an Appendix K. Among other things,
9 Appendix K may be used to increase the number of
10 individuals served under a waiver or expand provider
11 qualifications or the pool of providers who can deliver
12 services.
13 Finally, states can modify their managed care
14 contracts to allow for greater flexibility related to prior
15 authorization requirements or temporarily suspend out-of-
16 network requirements.
17 With that, I'll hand it over to Joanne.
18 * MS. JEE: Thanks, Erin.
19 This is Joanne Jee. Commissioners, next, we're
20 going to describe some of the actions taken by HHS and CMS
21 to respond to the COVID-19 pandemic.
22 Using the emergency powers in Section 1135

1 authorities that Erin mentioned, HHS has waived several
2 provisions of the Social Security Act. Examples of these
3 waivers include certain conditions of participation for
4 providers, requirements that providers are licensed in the
5 state in which they are providing services, and others that
6 are listed in your memo.
7 In addition, CMS has released a fact sheet on
8 providers who can receive blanket waivers. They mostly
9 pertain to Medicare providers, but we mention this here,
10 given that Medicaid agencies rely on Medicare standards.
11 Examples of providers that blanket waivers apply
12 to include critical access hospitals, skilled nursing
13 facilities, and acute care hospitals. The fact sheet
14 describes the specific provisions waived for each of the
15 provider types, and we include information on the providers
16 as well as the waivable provisions in your meeting
17 material.
18 Just to give you an example, though, with respect
19 to critical access hospitals, CMS has waived the 25-bed
20 limit and the 96-hour length-of-stay limit.
21 Next slide.
22 In addition to approving blanket waivers, CMS has

1 been working with states on Section 1135 waiver requests.
2 To help states in submitting these, CMS issued a COVID-19-
3 specific waiver template. It describes waivable provisions
4 in five categories, and they are Medicaid prior
5 authorizations in fee-for-service, long-term services and
6 supports such as waivers of pre-admission screening, state
7 fair hearing timelines, provider enrollment and screening
8 requirements, and reporting and oversight deadlines.
9 As we mentioned and as you know, the state of
10 play is evolving rather rapidly. So the last bullet on
11 this slide is already out of date, but as of today, 41
12 states have approved Section 1135 waivers.
13 Next slide.
14 CMS has also issued guidance on and approved
15 state Section 1915(c), Appendix K submissions. As Erin
16 mentioned, using this appendix, states can modify home and
17 community-based service waiver programs in several ways,
18 including with respect to access and eligibility, services,
19 payments for services rendered by family caregivers,
20 provider qualifications, and other modifications as we
21 describe in your memo. As of today, 14 states have
22 approved Appendix K's.

1 So now I'll turn it over to Kayla, who will
2 discuss some additional CMS and state actions.
3 * MS. HOLGASH: Thanks, Joanne.
4 This is Kayla Holgash.
5 So in addition to the state plan and waiver
6 activities Joanne just discussed, CMS has also issued
7 clinical and technical guidance for care facilities and
8 labs, billing and coding specifications, and coverage
9 clarification.
10 For example, all non-emergent inspections have
11 been suspended to allow survey and accrediting
12 organizations to focus on immediate jeopardy complaints and
13 targeted infection control to address the spread of COVID-
14 19.
15 Additionally, CMS directed nursing homes and
16 hospitals to restrict entry of all non-essential personnel,
17 all visitors except in certain cases, to cancel all group
18 dining and all other group activities, to screen all staff
19 every shift, and to adhere to all other CDC infection
20 control guidance.
21 CMS also posted a fact sheet detailing some
22 mandatory and optional benefits that may be relevant for

1 diagnosing and treating COVID-19, cost sharing and premium
2 rules, and covering services provided in other states.
3 Other guidance has included FAQs on the 6.2
4 percentage point increase to the FMAP, which addresses some
5 of the related conditions, applicability, and operational
6 issues, and Joanne will discuss some provisions of this
7 enacting legislation momentarily.
8 Lastly, CMS has encouraged states to use
9 telehealth to deliver services, noting that there is broad
10 flexibility in Medicaid to do so, and the guidance
11 reiterates that states are not required to submit a state
12 plan amendment or coverage or payment of telemedicine
13 services if they elect provider payment parity. And it
14 provides guidance on when states do need to file a SPA
15 along with sample language.
16 Next slide, please.
17 On this slide, you can see some temporary actions
18 states have taken to increase access to care in response to
19 this crisis, some of which were enacted before federal
20 legislation was passed.
21 For example, to expand telehealth use, Maryland
22 is recognizing a beneficiary's home or other secure

1 location as an originating site. A few states have
2 eliminated Medicaid cost sharing for COVID-19-related
3 testing and directed other insurers to do the same.
4 Sixteen states required insurers to cover early
5 prescription refills, and 12 opened special enrollment
6 periods for people to apply for coverage through the
7 exchanges, which, of course, may find some people eligible
8 for Medicaid.
9 And then all states, D.C., and the territories
10 declared state or public health emergencies to access
11 additional funding, equipment, and personnel.
12 Finally, other activities that could affect
13 Medicaid beneficiaries include states establishing drive-
14 through testing sites as well as some other actions that
15 Joanne will discuss now.
16 MS. JEE: Thanks, Kayla.
17 This is Joanne again.
18 Congress has enacted three new laws related to
19 the pandemic. I'm going to focus on the two that include
20 Medicaid provisions.
21 The first is the Families First Act. It made
22 four key changes. It requires state Medicaid and CHIP

1 programs to cover COVID-19 testing with no cost sharing.
2 It creates a state option to cover uninsured individuals
3 for the purpose of COVID-19 testing during the emergency
4 period and provide states with 100 percent FMAP for doing
5 that.

6 The Families First Act provides for a temporary
7 6.2 percentage point increase to the FMAP during the
8 emergency period, and this was referenced in the previous
9 session.

10 To receive the FMAP increase, states and
11 territories must meet certain maintenance-of-effort
12 requirements. These include that they must maintain
13 eligibility standards and procedures in place as of January
14 1st, 2020. They may not increase premiums to levels higher
15 than were in place on that date, and they may not terminate
16 eligibility during the emergency period unless individuals
17 request it or leave the state. And this is what Tricia was
18 referring to in the previous session.

19 Here, I just want to take a moment for a quick
20 clarification to something that was in your meeting memo,
21 and that is to say that states may not increase premiums
22 for any population subject to them within their programs.

1 The last thing I'll mention here about the
2 Families First Act is that it provides additional funding
3 to the territories for Fiscal Years 2020 and 2021.
4 Next slide.
5 The CARES Act is the broad-reaching stimulus
6 bill, which was passed last week. I think it was last
7 week. It also addresses several Medicaid provisions. It
8 includes key Medicaid extenders. It extends the spousal
9 impoverishment protections for beneficiaries using home and
10 community-based services, and funding for the Money Follows
11 the Person demonstration program and the Certified
12 Community Behavioral Health Clinic demos through November
13 30th, 2020.
14 The CARES Act delays DSH cuts until December 1st,
15 2020. So DSH allotments will be reduced by $4 billion
16 starting then, running through the end of Fiscal Year 2021,
17 and then by $8 billion in each fiscal year 2022 through
18 2025.
19 The CARES Act clarifies that states may provide
20 coverage through the new optional COVID-related group
21 authorized in the Families First Act to populations with
22 Medicaid coverage that is not considered minimum essential

1 coverage. This includes, for example, individuals with
2 Medicaid coverage for TB-related services, those with
3 Medicaid breast and cervical cancer program coverage, and
4 certain medically needy individuals. The law also states
5 that individuals who would be eligible for Medicaid through
6 the new adult group, if their state had expanded, can be
7 covered.
8 Next slide.
9 Additionally, the CARES Act provides for Medicare
10 and Medicaid payment for home health services that are
11 certified by nonphysicians, specifically nurse
12 practitioners, clinical nurse specialists, and physician
13 assistants. It allows for Medicaid home and community-
14 based services to be provided in acute care hospital
15 settings if certain conditions are met.
16 Finally, the CARES Act aligns privacy rules in 42
17 CFR Part 2 which apply to substance use disorder treatment
18 records and HIPAA which applies more generally to protected
19 health information.
20 Given the Commission's interest in and prior work
21 in this area, staff will be sure to monitor any forthcoming
22 guidance as well as implementation of this provision.

1 Next slide.

2 Finally, we wanted to mention some additional
3 federal actions related to behavioral health and public
4 charge. So related to my last point about SUD
5 confidentiality, in response to the COVID-19 pandemic,
6 SAMHSA issued guidance to reiterate policy that if
7 providers determine that a bona fide medical emergency
8 exists, patient consent requirements for disclosure of SUD
9 information do not apply.

10 SAMHSA also issued guidance that opioid treatment
11 programs can provide patients multiday supplies of
12 medication to treat opioid use disorder, depending on where
13 patients are in their treatment rather than daily doses.
14 They also issued guidance that buprenorphine prescribing
15 can occur via telehealth.

16 Finally, the United States Citizenship and
17 Immigration Services, or USCIS, issued an alert stating
18 that individuals subject to public charge determinations
19 will not be adversely affected by using COVID-19-related
20 services and encourages them to seek any needed care. The
21 alert also says that individuals subject to public charge
22 may submit a statement for consideration that describes how

1 certain preventive measures, such as quarantine, or
2 voluntary shutdown by employers or schools has affected
3 them.
4 Commissioners, that completes our presentation,
5 and so I'll turn it back to you for your discussion.
6 Thanks.
7 CHAIR BELLA: Thanks to all three of you. We
8 realize this is a moving target and changing all the time.
9 So you've done a great job of capturing what we know so far
10 and giving us a really solid foundation for this
11 discussion.
12 I'm going to turn to Commissioners to see who
13 would like to have a comment, and we will start with Darin
14 and then go to Kisha.
15 COMMISSIONER GORDON: Thank you for this update.
16 We know everything is real fluid here.
17 I hope you can answer a couple of questions for
18 me, though. So it appeared that the 100 percent of FMAP
19 for the uninsured, I think you had said, if you can just
20 tell me if I heard it correctly, that the CARES Act
21 clarified that that would be available to states for the
22 expansion population if they had not expanded. Did I hear

1 that correctly?

2 MS. JEE: Hi, Darin. This is Joanne.

3 Yes, I believe that's correct.

4 COMMISSIONER GORDON: Because I know there was

5 some confusion about that, so I was just making sure. So I

6 appreciate you clarifying that.

7 The other question, my last question actually,

8 wasn't there some action as it related to the MFAR-proposed

9 regulations as well, and if so, can you update the

10 Commission on that as well?

11 MS. JEE: Sure. So as far as I know, there was

12 some consideration of addressing that rule through

13 legislation, but I don't believe -- that wasn't included in

14 the legislation that's been enacted. It may still be on

15 the table for future congressional consideration, and we do

16 hear that there's more work to be done by Members of

17 Congress.

18 COMMISSIONER GORDON: Thank you.

19 CHAIR BELLA: Thank you, Darin.

20 Kisha, then Kit, then Sheldon.

21 COMMISSIONER DAVIS: Hi. I think I had one

22 question and then a couple comments.

1 Actually, back to Darin's question about
2 providing Medicaid coverage for those who would be
3 eligible, even if the state hadn't expanded, can you
4 elaborate on that a little bit, if you even know how that
5 would work or how someone would access that?
6 MS. JEE: Well, that coverage for uninsured
7 individuals, it's just for COVID-related testing. It's a
8 state option. So a state would need to adopt the option,
9 which I believe they do through state plan amendments.
10 And I think just yesterday, or maybe it was this
11 morning, I believe Arizona was the first state to adopt
12 that state plan option.
13 COMMISSIONER DAVIS: Okay. So it would be
14 expanding coverage, but still related to COVID-related
15 health events, not more broadly than that?
16 MS. JEE: You're correct in that it's very
17 limited. It's for COVID-related testing.
18 COMMISSIONER DAVIS: Okay. Thank you for
19 clarifying.
20 So my comment, I know Maryland and many other
21 states have opened their open enrollment period because of
22 this to allow more persons to access health care coverage,

1 but the federal government as a whole has not done that for
2 all of the exchanges. If there's any encouragement that we
3 can give for the federal government to open up more broadly
4 or all states individually to open up access for people to
5 be able to access open enrollment and potentially be able
6 to access Medicaid through that, as people are losing their
7 jobs, there's no time like now when they're going to need
8 health insurance for COVID or all of the other things, the
9 regular health issues that come, and to use this as an
10 opportunity to encourage more folks to be able to take
11 advantage of that resource and also encouraging states that
12 have not expanded Medicaid to do so and really take
13 advantage of having that safety net available for the
14 citizens of their states.
15 And I would like us as MACPAC, as we continue to
16 follow COVID over time, to really look at if there are
17 differences in access and testing and treatment and
18 outcomes in expansion versus non-expansion states and how
19 having that access to care makes a difference. Those
20 younger folks are the ones that are losing their jobs, and
21 they'll have less access to health care. Those restaurant
22 workers are the ones that are really just not having access

1 to care and were living on the fringes already and really
2 could benefit from health coverage.
3 Also looking at providers and so really
4 appreciate that the expansion that has happened to allow
5 Medicaid to cover telehealth, but would also like to see
6 encouragement for parity and payment between Medicare and
7 Medicaid. That happened with the Affordable Care Act, but
8 many states have lessened that parity. I know for my
9 former practice and other practices that parity between
10 Medicare and Medicaid payments is what kept providers in
11 the system, and as more patients are seeking Medicaid for
12 their health insurance, we want to make sure that there's
13 adequate access because there's enough providers in the
14 system who are accepting Medicaid to go do that. And
15 having parity of payments is one way to do that.
16 I think that is all that I had. Thanks.
17 CHAIR BELLA: Thanks, Kisha. That's a really
18 good list. Thank you.
19 Kit, then Sheldon, then Leanna, then Tricia.
20 COMMISSIONER GORTON: Hi. This is Kit Gorton.
21 Joanne, a question. With respect to the CARES Act changes
22 for 42 CFR Part 2, are those tied to the public health

1 emergency or was there some other end date put on them, or
2 is it just open-ended?
3 MS. JEE: I'm going to punt to Erin for that one.
4 MS. McMULLEN: Yeah. Sure. It's my
5 understanding that it's open-ended. Essentially it looks
6 like that under the changes to the Public Health Service
7 Act that individuals would still need to consent to
8 disclose their information, but then similar to HIPAA, once
9 that original consent is obtained that they would be able
10 to then further share information for the purposes of
11 treatment, payment, or health care operations. However,
12 HHS has about a year to kind of align their regulatory
13 structure to allow for this change. So it's something that
14 we will definitely stay on top of in the coming months.
15 COMMISSIONER GORTON: Okay. So that's good to
16 know. I think especially important is that this is
17 something we've talked about. I don't know that we've ever
18 -- the Commission has ever gone so far -- I'm pretty sure
19 we haven't made any recommendations here, and I think part
20 of what held us back from that was concerns about privacy
21 and the impact that was talked about in the material
22 substance use during pregnancy session. These things have

1 wide-ranging consequences. So I think we will want to pay
2 attention to what changes as this rolls out so that we can
3 be able to provide Congress with feedback as appropriate.
4 CHAIR BELLA: Thank you, Kit. Sheldon and then
5 Leanna.
6 COMMISSIONER RETCHIN: Yeah. I'm going to agree
7 and double down on Kisha's remarks about the reimbursement
8 parity for, I guess, primary care with Medicare. But just
9 in general express concern about the health care workforce
10 capacity. We already have low participation rates in
11 Medicaid pre-COVID. They are just being swamped, and they
12 are fearful. So just in terms of optimizing the workforce,
13 and particularly providers, I don't know if you mentioned
14 the scope of practice laws. I know CMS, a couple of days
15 ago, relaxed the scope of practice. But much of that they
16 still defer to the states, and I just wonder if you have
17 any sense about whether states are also moving in that
18 direction.
19 I also saw the blanket waiver on Stark, and it
20 seemed appropriate. But just in general I would just
21 express concern over the capacity issue, especially for the
22 Medicaid beneficiaries.

1 CHAIR BELLA: Thank you, Sheldon. Leanna.

2 COMMISSIONER GEORGE: Okay. This is Leanna. My
3 question is around the 1915(c) waiver in Appendix K. I
4 don't know all the details about Appendix K or what's in
5 it. But one thing I know from lived experience is that as
6 a parent to a child who is receiving 1915(c) services, I
7 could not be a direct support professional as a family
8 caregiver to that child under normal circumstances, because
9 she is a minor.

10 My question is, with all the concerns going on
11 right now, when you consider individuals who may be
12 immunocompromised as children, is there any kind of relief
13 or functionality in there so that states could say, okay,
14 for this situation we can allow Mom to be that DSP and get
15 paid for it, to that child, knowing that Mom is out of work
16 right now because, you know, everything that is going on.
17 So that might be one way to help the family save the
18 mortgage or the rent or something like that. Speaking
19 broadly, but is that something that could be done through
20 Appendix K so that, you know, families can stay together?
21 You know what I'm trying to say, I'm sure.

22 MS. JEE: This is Joanne. So there is something

1 within Appendix K about payments for services provided by
2 family caregivers who are not already permitted under the
3 waiver. You know, I don't know all the full details of
4 that but I could, you know, see what information is
5 available and, you know, come back to you with that later.
6 I don't know if Erin or Kayla, you have anything to add to
7 that.

8 MS. McMULLEN: I guess -- this is Erin -- the
9 only thing that I would add to what Joanne said is that
10 with the use of the Appendix K, states have to submit an
11 Appendix K for each HCBS waiver that they have. So that
12 ultimately would allow them to tailor kind of how they want
13 to structure waiver services, given the pandemic, for each
14 different type of population that they are serving.

15 So I think, you know, Joanne mentioned earlier
16 how many states had went ahead and submitted Appendix K's.
17 A lot of them have had to submit multiple ones to
18 accommodate their various waivers.

19 COMMISSIONER GEORGE: Thank you.

20 CHAIR BELLA: Thank you. Leanna, did you have
21 any other questions?

22 COMMISSIONER GEORGE: That was mostly it, just

1 because I know right now, we already have a short supply of
2 DSPs, direct support professionals, so if that is something
3 that a parent can come in, get little bit of payment for to
4 support the family and fill the void while they are
5 unemployed, you know, that's -- I thought that would be
6 helpful.
7 CHAIR BELLA: Great. Thank you. Tricia, then
8 Peter.
9 THE MODERATOR: Go ahead, Tricia. You are
10 unmuted.
11 CHAIR BELLA: Tricia, if you are talking maybe
12 you are muted on your own phone.
13 [Pause.]
14 CHAIR BELLA: Okay. Why don't we go to Peter and
15 we'll come back to Tricia. So if you could unmute, Peter,
16 please.
17 COMMISSIONER SZILAGYI: Hello. Thank you. This
18 is a really important presentation and incredibly helpful.
19 I wanted to dig a little bit deeper about two issues. One
20 is telemedicine and the other is monitoring changes after
21 COVID. And the first picks up on some of the comments that
22 Kisha and Sheldon were making. And I wanted to focus a

1 little bit on primary care providers, pediatricians, family
2 physicians, internists.
3 So one group of health care providers are
4 absolutely swamped, the ones who are actually taking care
5 of patients in the emergency departments, ICUs, hospitals,
6 et cetera. Another group of providers, and this includes
7 Medicaid providers, are essentially wilting from lack of
8 visits and lack of income. Just as an example, there are -
9 - I do not have data on this but -- pediatric practices
10 across the country, to a large extent, have stopped taking
11 in-person visits except for kids less than 2 years of age,
12 if they need other vaccines, or urgently need to be seen.
13 So that's about 80 percent of their visits that are down.
14 Pediatric practices have not only laid off a lot of their
15 staff but some are, you know, almost bankrupt. And I
16 suspect family physicians and some adult practices are the
17 same.
18 But everybody is heading toward telehealth, and
19 my question has to do with state-level versus federal-level
20 policy levers. So there are very specific issues that are
21 challenges for telehealth -- variations across states, what
22 they will pay for, restrictions for telehealth, parity in

1 telehealth visits versus in-person visits. Many
2 organizations or states are not allowing telehealth for new
3 patients but only existing patients, and what happens with
4 telephone visits and not just video visits? And there are
5 other very specific examples.
6 So my question, to Joanne, I know you did a great
7 chapter on telehealth, is to what extent are there sort of
8 state-level versus potential federal-level policy levers?
9 And then the other point I wanted to make is
10 there may be permanent changes in various parts of the
11 health care system because of COVID, even after the country
12 recovers from COVID. Telehealth is one example. Use of
13 preventive services may be another. And it might be
14 helpful since access is an important part of MACPAC to be
15 following this and to try to relate it to changes due to
16 COVID.
17 MS. JEE: Hi, Peter. This is Joanne. Yeah, a
18 good question about telehealth. So, you know, there is a
19 lot of flexibility for states right now to provide services
20 over telehealth in their Medicaid programs, and that was
21 sort of a key point that was made in that chapter that you
22 referenced. That flexibility is still there, and I think

1 states are really busy right now amending their telehealth
2 policies in Medicaid to encourage much broader use of
3 telehealth.
4 Kayla mentioned one that was Maryland. I think
5 that, you know, Massachusetts, Louisiana, Mississippi,
6 Tennessee, Ohio, you know, those are some other states that
7 have -- where the Medicaid director or the governor has
8 issued orders for more expansive use of it.
9 Does that help?
10 COMMISSIONER SZILAGYI: And how about at the
11 federal level? And we're also hearing about literal
12 pediatricians just essentially going bankrupt.
13 MS. JEE: Right. So in Medicaid there are no
14 restrictions on use of telehealth. There's no restriction
15 that limits -- there's no limit for use of telehealth in
16 rural areas. Sorry. That's the best way to say it. There
17 was a rural health restriction in Medicare. At a federal
18 level, in response to COVID-19, there have been a lot of --
19 there's been a lot of loosening up of the Medicare
20 telehealth policies. And so to the extent that state
21 Medicaid programs rely on those Medicare policies, and
22 there are some that do, that may help to loosen some of

1 those restrictions in Medicaid as well.

2 COMMISSIONER SZILAGYI: Mm-hmm. Thanks.

3 CHAIR BELLA: Great. Thank you, Peter. We're

4 going to go back to Tricia and then Fred.

5 COMMISSIONER BROOKS: Can you hear me now?

6 CHAIR BELLA: We can hear you.

7 COMMISSIONER BROOKS: Oh, great. Sorry about

8 that. I switched my audio method and obviously didn't do

9 it right.

10 I just wanted to go back to Darin's comment or

11 question about MFAR, because I think this is really

12 important. The bump is estimated to be maybe $36 billion

13 in stimulus to the states, but some estimate that if CMS

14 were to implement MFAR now that there would be a loss of

15 federal funding, between $24 and $31 billion. So I think

16 this issue is really important. And I know we, as a

17 Commission, recommended not proceeding with that particular

18 rule, but I think we need to keep making that particular

19 point.

20 On a more positive note, though, it was great to

21 see that the eligibility -- proposed eligibility rule that

22 we were expecting to drop any day has been withdrawn, so

1 that's something we don't have to keep our eye on at the
2 moment.
3 But the last comment is that I really want to
4 commend the Medicaid side of CMS under Calder Lynch's
5 leadership. I really feel like they have risen to the
6 occasion. I think the disaster SPA template which has some
7 of the most common things that states might do, the low-
8 hanging fruit, if you will, to offload during this time,
9 that they are going to be struggling to not only finance
10 Medicaid but to keep up with the demand. I just think
11 everything that the agency has been doing in that regard
12 really needs to be highlighted, and we need to thank them
13 for their commitment and dedication during this time.
14 CHAIR BELLA: Thank you, Tricia. Fred and then
15 Chuck.
16 COMMISSIONER CERISE: Just a comment on the --
17 kind of a follow up on Tricia's remark. The speed of the
18 blanket waivers I think was nice to see. Those came out
19 quickly and addressed a lot of issues that a lot of
20 hospitals were struggling with collectively. And so that
21 was nice to see.
22 To Sheldon's point about the advanced practice

1 providers, that does tend to be a state issue, and our
2 state has been slow to respond, as I think a number of them
3 have been. We are still pending some requests for
4 supervision changes to allow some flexibility in practice
5 while practicing on a campus, and those are still pending
6 with the Texas Medical Board. But the federal response, at
7 least to the blanket waivers that came out, that was quick.
8 And then I will just pile on one other comment
9 that a number of people have made, and Peter most recently,
10 about, you know, the changes in practices and kind of
11 keeping an eye on that. We have seen, you know, a lot of
12 remote care. Whether that's, you know, home health remote
13 care, we're monitoring pregnant women at home now, giving
14 them blood pressure machines and monitoring at home. I
15 think kind of when the dust settles to be able to look at
16 what practices are out there, to see how that may influence
17 practice and coverage in the future will be important.
18 CHAIR BELLA: Thank you, Fred. Chuck?
19 VICE CHAIR MILLIGAN: Hi. I wanted just to pick
20 up on some of the themes about telehealth in particular,
21 and the pail of this work. I do think that one of the
22 elements of an 1135 is that providers who are not

1 necessarily licensed in a given state can serve Medicaid
2 beneficiaries in that state. Telehealth is a clear example
3 of that. And I do think that as we build out our thoughts
4 of how to keep an eye on everything that's going on here
5 it's going to be, I think, useful to identify which of
6 these potential short-term 1135-related changes that really
7 increase access, and also kind of increase surge capacity
8 in general.

9 And, you know, Fred, I think about your
10 experience with Katrina and when you were in Louisiana
11 dealing with that, having the ability to use surge capacity
12 with telehealth and licensure maybe outside the state to
13 help. I think some of these elements that we're seeing as
14 public emergency-related changes, MACPAC eventually might
15 want to consider weighing in on whether they should become
16 permanent parts of the Social Security Act and not need a
17 public emergency or waiver.

18 So I do want to just flag. I think we're going
19 to have work to do down the road to think through what
20 we're observing now that might be a good change in the
21 program more generally, and going back to Kit's comment
22 this morning around how do we build a better system from

1 what we learn in this process.

2 So I just wanted to make that comment.

3 CHAIR BELLA: Thank you, Chuck. I do not see any
4 other Commissioner hands so I will provide a few wrap-up
5 comments. First of all, I want to say thanks again to
6 Erin, Joanne, and Kayla for getting this in front of us.
7 This is going to be an issue that we're going to want to
8 keep coming back to in a couple of different forms. And I
9 do want to recognize what Tricia and Fred have said about
10 the responsiveness at the federal level. I would also say,
11 like, if you're in a state Medicaid agency right now your
12 life is really hard, and so thanks to all those folks as
13 well.

14 A couple of things that come to mind. Clearly,
15 like this stuff, as we said, is moving so rapidly, and our
16 job is not to be policing that, so to speak. But one of
17 the sort of short-term areas that might be of interest to
18 the Commission, and it fits in with our theme of sort of
19 waivers and authority and transparency, is just
20 understanding how state requests are -- what's happening to
21 various state requests. So, you know, states have
22 requested many things. Some of them have been granted

1 through the 1135. Some of them are available through the
2 blanket waivers, although that's more Medicare.
3 So there are other things that are either going
4 to go through a state plan or they are going to have to go
5 through an 1115, and having some ability to understand
6 what's happening to those requests, a level of transparency
7 that I think isn't there today, most likely because people
8 just can't keep up, right? But understanding -- making
9 sure that when states are asking for things that are
10 reasonable that there are vehicles for them to get that,
11 that the public is aware of that, and that it's not somehow
12 caught up in something that's not timely.
13 So that feels like a short-term area that I would
14 like to ask that the Commission is kept informed on that
15 front.
16 Longer term, and just picking up on the themes
17 that many of you have said, clearly this is going to have
18 an impact on all the high-level things that we are here to
19 keep an eye on, which is access, and related to access is
20 capacity, and outcomes of the population and financing.
21 Specifically, like all the things we talked about this
22 morning, we couldn't get through those conversations

1 without talking about COVID. And when we look at the duals
2 population and other at-risk populations, high-need
3 populations, or whether we're looking at child and maternal
4 health, all of those things are going to be impacted.
5 And, you know, I will also go back to what Kit
6 said this morning. Like, let's come out of this stronger.
7 And when we're putting all this money in to rebuild, let's
8 be mindful of the things where we think the system can come
9 up stronger or the populations are at greatest risk, so
10 that we understand, as a Commission, what areas we want to
11 be particularly focused on. And obviously underlying all
12 of this is the state capacity theme, which we talk about at
13 every single meeting, without fail.
14 And so the last thing I would say is I think
15 there's kind of a corollary here. There's sort of this
16 silver lining view where there are -- this is -- you know,
17 you have a situation like this and many things that have
18 been off-limits in the past are no longer off-limits. And
19 you can oftentimes really make positive, lasting change to
20 the status quo, which is the current system, because you
21 have no choice. And so thinking about it in that vein I
22 think is going to be really positive.

1 The opposite of that is there is also a chance
2 that some of these things have unintended, negative impacts
3 on the program. So keeping an eye, for example, on all the
4 money that's being dumped into the system, whether it's
5 going to hospitals or providers or expected to go to health
6 plans in the next package, making sure that -- I think our
7 job is to make sure that Medicaid is well represented and
8 we monitor the impact of that on Medicaid, both the
9 beneficiaries and the providers and institutions that are
10 willing and able to serve this population sustainably.
11 So I don't need to keep babbling on. I think we
12 all are coalescing around common themes here. All of that
13 is to say, you know, it's not our job to be monitoring and
14 reporting day to day what's going on here. It is our job
15 to be always clear with each other about the areas that we
16 want to continue to pay attention to, because we think
17 those are the ones that are going to have the greatest
18 impact on the Medicaid program. And, therefore, that's
19 where we want to focus our attention.
20 So thank you very much for that. More to come on
21 this body of work, for sure.
22 And now we are going to open it up to the public

1 for comments. So I would remind folks that if you would
2 like to make a comment, raise your little digital hand, and
3 we will unmute you. And I would also remind folks that you
4 are able to submit comments through email as well, and that
5 address again is comments@macpac.gov.
6 So right now, we will give it a little bit of
7 time in case people are orienting themselves to raising
8 their hand.
9 I feel like I'm in a regular meeting because no
10 one is raising their hand, but -- oh, excellent. Thank
11 you. We do have comments from Ellen Breslin.
12 **### PUBLIC COMMENT**
13 * MS. BRESLIN: Yeah. Hi. Thank you very much for
14 this presentation today. Can you hear me?
15 CHAIR BELLA: Yes, we can hear you.
16 MS. BRESLIN: Oh, perfect.
17 I always thought that when we've initiated every
18 delivery system reform incentive payment program, district
19 programs for the states, and so many of the members who are
20 under 65, managed care-eligible, have benefitted from large
21 investments in the system. I've always been eager to see a
22 similar investment for dually eligible individuals.

1 When you were speaking about that earlier today,
2 I wonder if you have imagined a similar pathway.
3 Thank you.
4 CHAIR BELLA: Thank you, Ellen.
5 Just to make sure I'm understanding. A similar
6 pathway for supporting those efforts?
7 MS. BRESLIN: I think twofold. One, a similar
8 pathway to the extent that we truly invest in the
9 development of practices, new processes, infrastructure,
10 just like we focused on care delivery reform for the under
11 65, say, in New York or Massachusetts, where I'm very
12 familiar with those programs, and where we incentivized the
13 providers to really step up their game, to raise the bar on
14 how they were providing care.
15 I'm wondering if we might consider making a
16 similar move to support the dually eligible populations, to
17 support the providers who provide care to them.
18 I don't want to go on too much, but I hope that
19 gives you an indication of the question.
20 CHAIR BELLA: Yes, it does. Thank you.
21 You may have heard this morning. I think that's
22 very similar to comments that a couple Commissioners --

1 Sheldon made, and I know it's consistent with Peter's
2 comments, that even Kisha make as well, so yes.
3 Thank you, Ellen, for that comment.
4 Is there anyone else who would like to comment on
5 the discussions we just had or anything from this morning?
6 [No response.]
7 CHAIR BELLA: Okay. I see no other hands. Thank
8 you all for sticking with us this long.
9 **### VOTES ON RECOMMENDATIONS FOR INTEGRATING CARE,**
10 **MEDICARE SAVINGS PROGRAMS, AND TRICARE**
11 * CHAIR BELLA: We are now going to move into the
12 final part of the meeting, which is to take a vote on our
13 recommendations. We will take a vote on each specific
14 recommendation, and, Anne, I know you're going to lead us
15 through the vote. Chuck, I believe you have a comment to
16 make as well.
17 Do you want to go first, Chuck?
18 VICE CHAIR MILLIGAN: Yes. Let me do the
19 conflict of interest statement first. So I'm going to be
20 just reading a brief paragraph before turning it back to
21 Anne for the recitation for the vote.
22 On March 17th, the MACPAC Conflict of Interest

1 Committee met by conference call to apply our conflict of
2 interest policy with respect to each Commissioner's
3 reportable interests. Both the conflict of interest policy
4 and the Commissioners' reportable interests are posted on
5 the MACPAC website.
6 As a result of that review, the Conflict of
7 Interest Committee determined that for purposes of our
8 votes today, no Commissioner has an interest that presents
9 an actual or potential conflict of interest related to
10 those recommendations that are under consideration today.
11 So that's the conflict of interest statement
12 prior to taking our votes.
13 CHAIR BELLA: Great. Thank you, Chuck.
14 Anne, I will turn it to you.
15 EXECUTIVE DIRECTOR SCHWARTZ: Okay. Thanks,
16 Melanie.
17 Kirstin, if you could advance the slide.
18 We will take a recorded vote on each
19 recommendation in turn, and I believe if you can advance
20 the slide, you can see the first recommendation that we
21 talked about this morning. There we go.
22 So for the purposes of the record, I will read

1 what's on the slide: "The Centers for Medicare and
2 Medicaid Services should issue sub-regulatory guidance to
3 create an exception to the special enrollment period for
4 dually eligible beneficiaries, eligible for Medicare-
5 Medicaid Plans. This exception would allow such
6 individuals to enroll on a continuous monthly basis for
7 purposes of switching plans or disenrolling under the
8 special enrollment period, Medicare-Medicaid Plan enrollees
9 should be treated the same as other dually eligible
10 beneficiaries in Medicare Advantage."

11 So I will now call the roll. Commissioners, you
12 can choose to say "yes," "no," or "abstain." Just wait for
13 your name.

14 I don't believe Tom Barker is here, but I will
15 just check. Tom Barker?

16 [No response.]

17 EXECUTIVE DIRECTOR SCHWARTZ: Okay. Not present.

18 Melanie, I'll come back to you.

19 Tricia Brooks?

20 COMMISSIONER BROOKS: Yes.

21 EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

22 COMMISSIONER BURWELL: Yes.

1 EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?
2 COMMISSIONER CARTER: Yes.
3 Sorry. It took a while to unmute.
4 EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?
5 THE MODERATOR: Sorry. Can you say that name
6 again?
7 EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise.
8 COMMISSIONER CERISE: Yes.
9 EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?
10 COMMISSIONER DAVIS: Yes.
11 EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?
12 COMMISSIONER DOUGLAS: Yes.
13 EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?
14 COMMISSIONER GEORGE: Yes.
15 EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?
16 COMMISSIONER GORDON: Yes.
17 EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?
18 COMMISSIONER GORTON: Yes.
19 EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?
20 COMMISSIONER LAMPKIN: Yes.
21 EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?
22 VICE CHAIR MILLIGAN: Yes, Anne.

1 EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?
2 COMMISSIONER RETCHIN: Yes.
3 EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?
4 COMMISSIONER SCANLON: Yes.
5 EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?
6 COMMISSIONER SZILAGYI: Yes.
7 EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?
8 COMMISSIONER WENO: Yes.
9 EXECUTIVE DIRECTOR SCHWARTZ: And Melanie Bella?
10 CHAIR BELLA: Yes.
11 EXECUTIVE DIRECTOR SCHWARTZ: Okay. That's 16
12 yeas and one not present.
13 Clara, is it possible to keep the Commissioners'
14 mics open, or is that going to create a problem? We have
15 five of these. It's kind of painful.
16 THE MODERATOR: Yes, for sure. I'll leave them
17 open. There's a few that I shut immediately, but there's a
18 few I also left open. So the ones at the beginning, I may
19 have to do again. Yeah.
20 EXECUTIVE DIRECTOR SCHWARTZ: Okay. Sorry. I
21 know the names are in alphabetical order by first name, and
22 I've got them by last name.

1 Okay. Kirstin, if we can have the next slide.

2 Again, for the record Recommendation 2.2 reads,

3 "Congress should provide additional federal funds to

4 enhance state capacity to develop expertise in Medicare and

5 to implement integrated care models."

6 So Tom Baker is not present.

7 Tricia Brooks?

8 COMMISSIONER BROOKS: Yes.

9 EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

10 COMMISSIONER BURWELL: Yes.

11 EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

12 COMMISSIONER CARTER: Yes.

13 EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

14 COMMISSIONER CERISE: Yes.

15 EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

16 COMMISSIONER DAVIS: Yes.

17 EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

18 COMMISSIONER DOUGLAS: Yes.

19 EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

20 COMMISSIONER GEORGE: Yes.

21 EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

22 COMMISSIONER GORDON: Yes.

1 EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

2 COMMISSIONER GORTON: Yes.

3 EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

4 COMMISSIONER LAMPKIN: Yes.

5 EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

6 VICE CHAIR MILLIGAN: Yes.

7 EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

8 COMMISSIONER RETCHIN: Yes.

9 EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

10 COMMISSIONER SCANLON: Abstain.

11 EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

12 COMMISSIONER SZILAGYI: Yes.

13 EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

14 COMMISSIONER WENO: Yes.

15 EXECUTIVE DIRECTOR SCHWARTZ: And Melanie Bella?

16 CHAIR BELLA: Yes.

17 EXECUTIVE DIRECTOR SCHWARTZ: Okay. That's 15

18 yeses, one abstention, and one not present.

19 Okay. That was a lot faster. Thank you.

20 Okay. I think we need a new slide deck, please.

21 If someone can advance the slide. Thank you. All right.

22 Again, for the transcript, "Congress should amend

1 Section 1902(r)(2)(A) of the Social Security Act to require
2 that when determining eligibility for the Medicare savings
3 program, states use the same definitions of income,
4 household size, and assets as the Social Security
5 Administration uses when determining eligibility for the
6 Part D low-income subsidy program. To reduce
7 administrative burden for states and beneficiaries related
8 to Medicare savings program redeterminations, Congress
9 should amend Section 1144 of the Social Security Act to
10 require the Social Security Administration to transfer
11 continuing low-income subsidy program eligibility data to
12 states on an annual basis."
13 Okay. I will call the roll again.
14 Tom Barker is not present.
15 Tricia Brooks?
16 COMMISSIONER BROOKS: Yes.
17 EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?
18 COMMISSIONER BURWELL: Yes.
19 EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?
20 COMMISSIONER CARTER: Yes.
21 EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?
22 COMMISSIONER CERISE: Yes.

1 EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?
2 COMMISSIONER DAVIS: Yes.
3 EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?
4 COMMISSIONER DOUGLAS: Yes.
5 EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?
6 COMMISSIONER GEORGE: Yes.
7 EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?
8 COMMISSIONER GORDON: Yes.
9 EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?
10 COMMISSIONER GORTON: Yes.
11 EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?
12 COMMISSIONER LAMPKIN: Yes.
13 EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?
14 VICE CHAIR MILLIGAN: Yes.
15 EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?
16 COMMISSIONER RETCHIN: Yes.
17 EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?
18 COMMISSIONER SCANLON: Yes.
19 EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?
20 COMMISSIONER SZILAGYI: Yes.
21 EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?
22 COMMISSIONER WENO: Yes.

1 EXECUTIVE DIRECTOR SCHWARTZ: And Melanie Bella?
2 CHAIR BELLA: Yes.
3 EXECUTIVE DIRECTOR SCHWARTZ: Okay. That's 16 in
4 favor and one not present.
5 Okay. Moving on to TRICARE. Could I have the
6 next set of slides? If someone could advance the slide to
7 the recommendation. Thank you.
8 Okay. From the TRICARE chapter, this
9 recommendation is "The Centers for Medicare and Medicaid
10 Services should facilitate state Medicaid agency
11 coordination of benefits with the Department of Defense
12 TRICARE program by working with the Department of Defense
13 to develop a mechanism for routinely sharing eligibility
14 and coverage data between state Medicaid agencies and the
15 Defense Health Agency."
16 Okay. Tom Barker is not present.
17 Tricia Brooks?
18 COMMISSIONER BROOKS: Yes.
19 EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?
20 COMMISSIONER BURWELL: Yes.
21 EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?
22 COMMISSIONER CARTER: Yes.

1 EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

2 COMMISSIONER CERISE: Yes.

3 EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

4 COMMISSIONER DAVIS: Yes.

5 EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

6 COMMISSIONER DOUGLAS: Yes.

7 EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

8 COMMISSIONER GEORGE: Yes.

9 EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

10 COMMISSIONER GORDON: Yes.

11 EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

12 COMMISSIONER GORTON: Yes.

13 EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

14 COMMISSIONER LAMPKIN: Yes.

15 EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

16 VICE CHAIR MILLIGAN: Yes.

17 EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

18 COMMISSIONER RETCHIN: Yes.

19 EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

20 COMMISSIONER SCANLON: Yes.

21 EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

22 COMMISSIONER SZILAGYI: Yes.

1 EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?
2 COMMISSIONER WENO: Yes.
3 EXECUTIVE DIRECTOR SCHWARTZ: And Melanie Bella?
4 CHAIR BELLA: Yes.
5 EXECUTIVE DIRECTOR SCHWARTZ: Okay. Sixteen
6 yeses and one not present.
7 Okay. Last one, best one, "To protect Medicaid
8 from improper payment of claims that are the responsibility
9 of a third party and improve coordination of benefits for
10 persons who have coverage through both Medicaid and
11 TRICARE, Congress should direct the Department of Defense
12 to require its carriers to implement the same third-party
13 liability policies as other health insurers, as defined in
14 Section 1902(a)(25) of the Social Security Act.
15 Tom Barker is not present.
16 Tricia Brooks?
17 COMMISSIONER BROOKS: Yes.
18 EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?
19 COMMISSIONER BURWELL: Yes.
20 EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?
21 COMMISSIONER CARTER: Yes.
22 EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

1 COMMISSIONER CERISE: Yes.

2 EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

3 COMMISSIONER DAVIS: Yes.

4 EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

5 COMMISSIONER DOUGLAS: Yes.

6 EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

7 COMMISSIONER GEORGE: Yes.

8 EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

9 COMMISSIONER GORDON: Yes.

10 EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

11 COMMISSIONER GORTON: Yes.

12 EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

13 COMMISSIONER LAMPKIN: Yes.

14 EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

15 VICE CHAIR MILLIGAN: Yes.

16 EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

17 COMMISSIONER RETCHIN: Yes.

18 EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

19 COMMISSIONER SCANLON: Yes.

20 EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

21 COMMISSIONER SZILAGYI: Yes.

22 EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

1 COMMISSIONER WENO: Yes.
2 EXECUTIVE DIRECTOR SCHWARTZ: And Melanie Bella?
3 CHAIR BELLA: Yes.
4 EXECUTIVE DIRECTOR SCHWARTZ: Okay. I have 16 in
5 favor and one not present.
6 Okay. That concludes the voting, and you can
7 kill those mics. Thank you very much.
8 Melanie, I'll hand it back to you.
9 CHAIR BELLA: Thank you, Anne.
10 That's a wrap for our first virtual care meeting
11 ever. So I want to say thanks to Jim at MACPAC. I know he
12 spent a ton of time getting this set up for us, as did the
13 rest of the staff practicing, and certainly, Anne, I want
14 to thank you for making it possible for us to still conduct
15 our business, in light of everything else going on.
16 The staff did tremendous work, as usual, and it
17 just demonstrates the importance of us continuing to focus
18 on issues important to the Medicaid program and to the
19 population that relies on it that we are here to serve.
20 So, with that, one last round of thanks to the
21 Commissioners for staying so engaged during our first
22 digital endeavor, and hopefully, this won't become an

1 ongoing thing. I will look forward to seeing all of your
2 faces when we are next together in the meantime.
3 Hope everyone stays safe, and thank you again.
4 With this, we are adjourned. So thank you very much.
5 * [Whereupon, at 3:28 p.m., the meeting was
6 adjourned.]
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