PUBLIC SESSION

Via GoToWebinar

Thursday, December 10, 2020
10:31 a.m.

COMMISSIONERS PRESENT:

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

2 [10:31 a.m.]

3 CHAIR BELLA: Great. Welcome, everyone, to the
4 December MACPAC meeting. Thank you for joining us. We are
5 going to start off this morning with a panel, looking at
6 the role of Medicaid in improving health equity. It is a
7 big focus of our work on the Commission and so very much
8 appreciate our panelists being with us this morning, and
9 the staff for putting this together. And with that I will
10 kick it over to you to get us started.

11 ### **PANEL: THE ROLE OF MEDICAID IN IMPROVING HEALTH**
12 **EQUITY**

13 * MS. HOLGASH: Great. Thank you. So in its July
14 email blast, the Commission committed to addressing racial
15 and ethnic disparities in our work, the need for which can
16 be seen by a number of factors, such as the
17 disproportionate rates of COVID-19 infection,
18 hospitalization, and death within communities of color, and
19 the greater risks of mortality and morbidity associated
20 with labor and delivery among Black and other people of
21 color. And while disparities, of course, in health care
22 and outcomes extend far beyond the Medicaid program, 60

1 percent of Medicaid and CHIP's 96 million beneficiaries
2 identify as a race or ethnicity other than white.
3 So as we update and conduct new analyses we are
4 focusing on three policy questions: (1) How do the
5 experiences of Medicaid beneficiaries, including coverage,
6 access, and quality, differ by race and ethnicity? (2) How
7 do policies and practices affect outcomes and use of
8 services by race and ethnicity? (3) What role can Medicaid
9 play in reducing or eliminating health disparities among
10 racial and ethnic groups?
11 In continuing to lay the foundation for this
12 work, we are very fortunate to have a group of
13 distinguished guests joining us, and before providing brief
14 introductions, I want to thank your panelists for sharing
15 their time and expertise with us on a topic that draws not
16 only on their years of professional experience in this
17 field, but also on their personal resources as Black women,
18 so thank you all.
19 First, we will kick things off with Jamila
20 Michener, and she will focus on the historical relationship
21 between racism, health, and health policy, highlighting key
22 opportunities within Medicaid policy to address these

1 inequities. Among other things, Jamila is an associate
2 professor at Cornell University, as well as the co-director
3 of the Cornell Center for Health Equity and the PRICE
4 Initiative, which is the Politics of Race, Immigration,
5 Class, and Ethnicity. She is also the author of a recent
6 book entitled *Fragmented Democracy: Medicaid, Federalism,*
7 *and Unequal Politics*.

8 Next, we will get a state perspective from Dena
9 Williams Hasan, who currently serves as the Director of
10 Policy and Program Support for the District of Columbia
11 Department of Human Services. She leads efforts to
12 increase housing and economic stability and improve the
13 continuum of care for uninsured and Medicaid populations
14 within the District, which no doubt pulls on her previous
15 experience as a program director for D.C.'s Medicaid
16 agency. And just a heads up that
17
18 *[The audio for this portion of the meeting briefly cut off.*
19 *What follows is based on the speaker’s notes.]*
20
21 Dena can only be with us for her presentation, so we’ll
22 take advantage of her insight while we have her.

1 Finally, we'll hear from Adrienne McFadden, who uses her
2 medical and law degrees to advance health equity, and
3 currently serves as the vice president and chief population
4 health officer of national Medicaid programs at Humana.
5 As is our custom, after hearing from, and engaging with our
6 panelists, we have time dedicated for further Commission
7 discussion. So without further ado, I turn it over to you,
8 Jamila.
9
10 *[End of lost audio]*
11
12 CHAIR BELLA: Kayla, just to let you know we
13 missed probably three minutes. You just cut out. I am not
14 sure that we need you to repeat it, but just to let you
15 know, we did miss a little bit of what you had to say.
16 MS. HOLGASH: My apologies. Thank you.
17 CHAIR BELLA: That is no problem. I think we can
18 go right into the panelists. I am sorry to interrupt you.
19 DR. MICHENER: No problem. And if, for some
20 reason, I cut out, because who knows -- we are living in
21 this age of technology where it happens -- feel free to
22 wave your hands and do other silly things to make it clear

1 to me that no one can hear me. But thank you for that
2 introduction, Kayla, and thank you to all of the
3 Commissioners for having me here today.
4 I really want to focus in, in the brief time that
5 I have, on sort of laying some groundwork and creating a
6 context for us to think about Medicaid and health equity,
7 specifically racial equity, in a larger context. So I
8 would say that my perspective today is probably going to be
9 the 30,000-foot view, and hopefully some of the other
10 panelists, and in the discussion that unfolds can take us
11 to sort of different levels of specificity as we try to
12 think through Medicaid through the lens of racial equity.
13 So for purposes of clarity, I want to start by
14 sort of naming structural racism, talking about structural
15 racism, which is really where my emphasis is going to be
16 today, and making it clear sort of what the contours of
17 that are. I think that we can use a phrase like "racism"
18 quite often, especially because of what is happening in our
19 world in these last several months. We are not always
20 talking about the same thing when we use that term, so I
21 think it is important to sort of clarify.
22 My focus on structural racism really emphasizes

1 this. It is not about what is in anyone's heart or mind.
2 It is not about intentions. It is not about motives. It
3 is really a set of institutional, organizational, and
4 structural patterns, as the language implies.
5 Structural racism, as a form of racism, is
6 especially pervasive and pernicious because it is not about
7 individual people changing. It is not something that can
8 be addressed through implicit bias training or simply
9 informing people about the proper practices, although there
10 is a place for those things. But because it is operating
11 through organizations and institutions themselves,
12 structural racism can be hard to pinpoint. It can be
13 difficult to understand, at times, precisely where it is,
14 what it is, how it is operating. It is easily elided and
15 it is often unnoticed, especially by people who are not
16 directly affected by it.
17 But even people who are directly affected by it
18 don't necessarily know and realize that it's operating in
19 their lives and affecting them. And the biggest takeaway,
20 I think, that is important and something that I will
21 emphasize throughout the next few minutes as I speak, is
22 that structural racism, because it is multifaceted and

1 doesn't have sort of institutional boundaries per se, it
2 operates across multiple different institutions, it has
3 cascading effects, meaning that as structural racism
4 operates in one realm, like the housing market or the labor
5 market, it affects people's lives in ways that have
6 implications for other realms. So what is happening in
7 legal systems, what is happening in schools, all of those
8 things have implications for what happens, for example, in
9 health care, and in particular with Medicaid.
10 So this kind of reality of the institutional
11 nature of structural racism, and of its cascading effects
12 across institutions, is something that I want us to keep in
13 mind, because I think it is really crucial as far as
14 indicating a general approach to how we think about racism
15 and Medicaid and health equity. And that approach suggests
16 that while we intend to silo this topic -- like we are
17 going to have a panel and it is going to be about Medicaid
18 and health equity, and then that panel ends and we go to
19 the next panel, and that is about something else and we are
20 not thinking about equity anymore and we are not thinking
21 about racism anymore -- and that can be the way that our
22 minds operate, because we have these sort of analytical

1 distinctions that help us to sort of make sense of the
2 world. That's how we work.
3 But that is not how structural racism works. It
4 doesn't stop at the boundary of this panel. And so in the
5 next panel I have no idea what your other panels are about
6 -- I should have looked, right -- but if you are talking
7 about the legal system, for example, well, that matters
8 too. Who has access to the civil legal resources that
9 allow them to understand the full range of long-term care
10 benefits that they may have, or may not have, depending on
11 decisions they make about what to do with their assets now,
12 or what have you?
13 There are all sorts of domains, if we think about
14 housing and 1915 waivers and how they do or don't apply to
15 housing. And we can apply this logic in domain after
16 domain after domain, because of the way that structural
17 racism operates, because of how multi-institutional it is.
18 It means that we nearly always need to have an equity lens
19 when we're thinking about Medicaid.
20 I want to say something that I sometimes get
21 pushback from people when I say, but I think is important
22 to say. I am the sort of person who thinks that we ought

1 to say the quiet part out loud, because we benefit from
2 that sort of straightforwardness, which is this: Medicaid
3 is a racialized health program. Now racialization involves
4 the extension of racial meaning to something that we might
5 not think of as being explicitly about race. Something
6 that, on its face, is either supposed to be colorblind or
7 neutral, is, in law, in writing, or it is thought of that
8 way by many people. But when institutions like that take
9 on racial meaning, we call them racialized institutions.
10 Now I realized, through experience, that when I
11 use this language people push back. You know, scholars,
12 fellow scholars of mine, practitioners, certainly journal
13 reviewers of journal articles, they say, "We don't like
14 this." And the pushback comes from a good place. It comes
15 from the concern that by pointing out or saying the ways
16 that Medicaid has racial meaning, that somehow we are going
17 to mock it. We are going to mar its status and perhaps put
18 a target on its back or something like that.
19 But I would say that the evidence, the weight of
20 evidence that we know have about Medicaid and what shapes
21 its form, its design, and the policies that structure it
22 don't allow us to avoid the reality that it is a racialized

1 program, which is only to say that it has racial meaning.
2 Whether we want it to or not, whether it was written that
3 way into law, which you won't see that if you look at the
4 original statute that gave birth to Medicaid.
5 And so on paper, perhaps not, but in reality,
6 yes, irrespective of its sort of facially neutral status,
7 race has been a central factor shaping the policies,
8 discourse, design, and implementation of Medicaid, and
9 shaping public perceptions of it.
10 So I want to briefly explain what this means and
11 why it is important for us all to keep it in mind, in hope
12 that it gives you a useful lens through which to examine
13 the work that you do.
14 First, let's just consider a basic reality, which
15 is that Medicaid -- and this is something I know we all
16 know, but it is worth point out and explicating in a little
17 bit of detail -- Medicaid is a program that
18 disproportionately directs resources to people of color.
19 If we just, for example, think about non-elderly adult
20 beneficiaries, 30 percent are Latinx, 20 percent are Black,
21 10 percent are made up of additional non-white ethnic and
22 racial groups, like Asian, Native, and multiracial.

1 Altogether, Black, Latinx, Asian, Native, and
2 multiracial Americans represent the majority of Medicaid
3 beneficiaries in at least 25 states, sizeable portions of
4 the beneficiary population in most other states, so
5 anywhere between 30 and 49 percent. There are only 8
6 states that have Medicaid populations that are composed of
7 less than 30 percent people of color.
8 So, all across the nation, Medicaid is a program
9 that is directing resources disproportionately to people of
10 color. Whether we want it to or not, this means that the
11 program has racial repercussions and meanings, and it can
12 affect the way the program is viewed by political elites,
13 by the public, the way it is implemented by bureaucrats,
14 and certainly -- and this is where my research really
15 focuses -- the way it is experienced by beneficiaries.
16 And so we can't get around those realities, and
17 consider some of the ways that this matters for the form
18 that Medicaid takes as a program. Racial attitudes,
19 preferences, and demographics affect crucial decisions
20 about Medicaid's trajectory as a policy. There are more
21 studies that confirm this than I can go over in the short
22 time that I have. I just want to give you a few examples.

1 We have evidence, for example, that racial
2 divides in health care opinions widen dramatically as soon
3 as President Obama became associated with health care
4 policy. So when you ask people about policies they look
5 very similar to what we see in the ACA, like Medicaid
6 expansion, but you don't mention Obama, or you ask them
7 about what they would think about those policies under
8 another President, like President Clinton or President
9 Bush, versus -- and this is an experimental context --
10 versus when you ask people about those policies and you
11 associate it with Obama. Just the association with
12 President Obama -- with a Black person -- decreases
13 significantly support for those programs, across partisan
14 lines. So it is not just about partisan differentiation.
15 Another example: Medicaid expansion decisions
16 are correlated with state-level racial attitudes. So when
17 state residents have a lower racial sympathy and higher
18 racial resentment, they have stronger resistance to
19 Medicaid expansion. Medicaid expansion also has variable
20 support on the basis of race. White Americans are much
21 less likely to support Medicaid expansion than people of
22 color. Over and above that, when we look at Medicaid

1 expansion decisions on the state level and the way those
2 decisions are correlated with public opinion, what we find
3 is that Medicaid expansion decisions are correlated with
4 white public opinion, but completely uncorrelated with the
5 preferences of people of color.
6 Governors, when they expand Medicaid, are more
7 likely to be rewarded politically in states where the
8 Medicaid population is overwhelmingly white, and they are
9 not as likely to be rewarded politically when the people
10 benefitting from expansion are people of color.
11 I could go on but won't because time is short.
12 All of these patterns point to the ways that Medicaid is
13 racialized, and all of them link up to the barriers to
14 access and to care, either because it means that the
15 program has less likelihood of being expanded or because it
16 shapes the way people within the program think about
17 themselves and understand what they are experiencing, the
18 way that bureaucrats who are influencing and affecting the
19 people in the program treat those people.
20 And so I want to wrap up by saying that when we
21 think about Medicaid and health equity, the reality of
22 structural racism is such that Medicaid itself is a

1 racialized program, and we can't limit our scope when we
2 think about Medicaid to just sort of what is written, what
3 is on paper, what is on the books.
4 I will end with this example. We have had
5 heightened emphasis on race in the context of COVID-19, and
6 I think that has amplified Medicaid's standing as a
7 racialized program. I have really seen this in the last
8 few weeks as talk of a vaccine has heightened, and as I
9 have had people, including Medicaid beneficiaries who I
10 have interviewed over the years, reach out to me to ask me
11 if I trust the vaccine and if I would take it. All of
12 these people have been Black. They are deeply concerned
13 about whether Black Medicaid beneficiaries are going to be
14 used as guinea pigs, to test the vaccine, when they
15 probably weren't in the studies that assessed its veracity.
16 They have mentioned things like the Tuskegee experiment,
17 but they have also just mentioned their experiences with
18 Medicaid, and have said, "Look, if this is the way that I
19 get treated when I go to the Medicaid office, why should I
20 trust the government to give me this vaccine."
21 Medicaid plays a role in structuring the larger
22 context of structural racism in the U.S. in a way that, for

1 example, Black Medicaid beneficiaries think about their
2 relationships to the state, the levels of trust that they
3 have, et cetera, et cetera. And all of this matters for
4 implementing policies and interventions like vaccines that
5 ultimately affect health equity in the long term.
6 I am going to stop now because I don't want to go
7 over time. I have a ton more to say, but I hope that we
8 can get into more details about some of these issues in the
9 discussion period. Thank you.
10 MS. HOLGASH: Dena, we can go straight to you.
11 * MS. HASAN: Okay. Perfect. Thank you for
12 inviting me to join this discussion. This is extremely
13 interesting to me. And thank you for -- Jamila, your
14 comments were spot-on. I really, really appreciate those.
15 So I'll give a little bit of background quickly
16 about me, give some context around D.C., and share a couple
17 of things that we're doing in D.C. linking homelessness to
18 health care, overall well-being, et cetera.
19 So most of my experience is in the Medicaid
20 space. I worked for CMS and for the D.C. Medicaid agency
21 for about ten or so years. One of my last projects there
22 was as the director of the state innovation model planning

1 grants. As we looked at the ways to leverage Medicaid, to
2 move toward health reform and better payment, et cetera, et
3 cetera, it was clear over and over again that, you know, we
4 can do as much as we can in the health care space and
5 insurance space, but if we really want to tackle poverty
6 and really want to tackle overall well-being, it's not in
7 the doc's office. It's not how much you pay doctors. It's
8 really in the social determinants of health.
9 So then I transitioned to the Department of Human
10 Services that's responsible for D.C.'s response to
11 homelessness and prevention of homelessness and also for
12 economic security, for entitlement programs such as TANF
13 and SNAP, and then also we do Medicaid eligibility
14 determinations there.
15 So as I've been there, it has been eye-opening as
16 we look at the history of racial inequities in D.C. and
17 nationally and then particularly in the housing and
18 homelessness space. So we do know that for homelessness,
19 homelessness is only the tip of the iceberg where the
20 majority of the ice below water is all of the structural
21 and racial things that have been ingrained into our
22 national system.

1 When I think about this, the quote that I like to
2 give first before I get into the nitty-gritty is a quote
3 that came out of The Atlantic magazine from Ta-Nehisi
4 Coates, so I'd like to read it to you really quick, which
5 really helps frame it for me. The comment was: "If you
6 sought to advantage one group of Americans and disadvantage
7 another, you could scarcely choose a more graceful method
8 than housing discrimination. Housing determines access to
9 transportation, green spaces, decent schools, decent food,
10 decent jobs, and decent services. Housing affects your
11 chances of being robbed and shot as well as your chances of
12 being stopped and frisked....Housing discrimination is hard
13 to detect, hard to prove, and hard to prosecute."
14 I think that quote alone really sums up what
15 we're experiencing now with homelessness here in D.C. and
16 nationally.
17 We do know that this has been happening for about
18 two centuries or so, and then in 1968 we had the Fair
19 Housing Act, and many of the racist policies -- but by that
20 time it was too late, and many of the policies were
21 ingrained in how we determined housing and people's access
22 to affordable housing.

1 A good case study is D.C. where, you know, if we
2 look at the percentage of African Americans in D.C. or
3 residents about 70 percent, and with that 70 percent, D.C.,
4 the capital, was known as the "Chocolate City." If we look
5 at a lot of the urban renewals that have happened over the
6 past 20 years, which have led to gentrification where
7 Caucasian individuals with higher pay have forced a lot of
8 African Americans with lower economic status just to move
9 out, and now D.C. is around 47, 48 percent of African
10 Americans here, though when we look at the percentage of
11 those that are experiencing homelessness, it's about 80 or
12 so percent. So we have some, you know, big discrepancies
13 there.
14 So in 2015, when Mayor Muriel Bowser came into
15 office, one of her key platforms was to make homelessness
16 rare, brief, and nonrecurring. That was described three
17 months after she came into office, and the Homeward DC plan
18 where one of the key initiatives in that plan was to
19 leverage the big lever of Medicaid, which is really
20 powerful in D.C., as a third of the population is on
21 Medicaid or so, leverage Medicaid spending to pay for
22 housing supportive services that are available to our

1 homeless populations and also used the funding to help
2 prevent homelessness in the first place. So I'll dig into
3 that to describe how we're using the 1959 to accomplish
4 that. Then I'll also talk about some programs we have in
5 place in response to COVID, which is impacting our African-
6 American residents at a rate higher than our other
7 residents.
8 We're looking to launch a new Medicaid benefit in
9 April of 2022 that's similar to what you've seen in New
10 York and Washington state and Connecticut in other
11 programs. We'll use Medicaid funding under 1959 to pay for
12 housing navigation and housing stabilization services.
13 Right now those services are currently paid via local
14 funds, and they include such things as working with clients
15 to find housing, working with clients to gather
16 documentation for housing, helping them navigate completing
17 their housing application, finding a unit that meets their
18 needs. Their needs may be making sure they're on a bus
19 line to get to their doctor, they're in a house that is
20 close to their kids' school, different things like that.
21 And then when a client is placed in a house, what
22 we call "leased-up," it may happen with a whole myriad of

1 things, which include applying for Medicaid, applying for
2 other services that they need access to; it also helps them
3 with landlord negotiations and figuring out what it means
4 to be a consistent and a good leaser in an apartment. It
5 helps them with dispute resolution, all the different
6 things that happen out of the health care system that keep
7 a person in housing, because we know that if you don't have
8 a house, accessing health care, remaining employed, having
9 healthy, long-term relationships is really, really
10 difficult.
11 So that has -- just thinking about that and
12 moving this homeless services benefit to the Medicaid space
13 has been extremely challenging, one, because it is
14 marrying, as I'm sure you guys know -- it's marrying two
15 distinct different parts of the system that do not work
16 well together and do not talk well together, do not use the
17 same language, et cetera. So we've had to educate our
18 Medicaid friends on what it means to be homeless, what
19 homelessness is, and we've had to also on the human
20 services side really talk about payment methodology, value-
21 based payment, what it means, what ought it mean, what it
22 means to track measures against outcomes, those types of

1 things that we normally don't do in the human space.

2 We've also seen some difficulty when we're

3 thinking about sharing across data. So, you know, Medicaid

4 uses MMIS, a claims-building system, and some of the

5 richness of the data that we contain -- that have from the

6 homeless services side, there's really no HCPCS code for

7 it, really no ICD-10 for it. There's really nothing to

8 capture that, so we're trying to figure out how to capture

9 it, and also the best way to get information about homeless

10 information over to medical providers, and then information

11 from the medical providers as far as admission to ERs,

12 admission to hospitals, et cetera, over to our homeless

13 service providers, and then having both of those

14 information weave into the business practices, what they're

15 going to do.

16 Dr. McFadden, we were actually on a panel in 2017

17 in NASHP where we talked about the same types of things as

18 far as information sharing, and D.C. has a health

19 information exchange where, within that, there is a patient

20 profile where, in addition to the person's fee-for-service

21 or MCO and what medications they're on and when they were

22 last at the ER, we're also working to have a field there

1 that says whether or not the person is in a homeless
2 shelter, if they have access to refrigeration, who their
3 homeless case manager is, which has been particularly -- as
4 we're moving toward that, will be particularly helpful for
5 hospital discharge planners, that, you know, in a number of
6 cases they're discharging individuals to homeless shelters
7 where they don't meet medical eligibility criteria, but
8 should not be recuperating within a homeless shelter. So
9 it's like, okay, this person is homeless, and we need to
10 make sure we ask that in our intake process. And then if
11 they're going to discharge to a shelter because the person
12 can't go to a private residence, which shelter should they
13 go to? We do have shelters that are closely linked with
14 primary care services, so we link them to that; or a
15 homeless shelter that is also close to some outpatient
16 health care that the client needs access to. Or if that's
17 not -- or if moving to a shelter isn't appropriate, looking
18 for respite care that is very limited in D.C., but just
19 that recognition of having to do discharge planning and
20 medical services of a client's housing and security.
21 It's moving along pretty slowly, as you may
22 imagine, because just even talking has proven challenging

1 because we still use different terms and all that. But I
2 am really confident that we'll get there, and we'll look at
3 other states to see what their best practices are with
4 documentation, because we know the devil is in the details,
5 and the SPA, the regulations are only this small. It's the
6 actual doing it that causes some trouble sometimes.

7 And then as we know, COVID-19 has really impacted
8 our most vulnerable populations, and in D.C., African
9 Americans. So we have two strategies that DHS is
10 responsible for on the homeless services side that we're
11 using to respond to COVID. The first is we run isolation
12 and quarantine sites, and those are sites for any
13 individual that has a COVID-positive diagnosis, is a close
14 contact of someone who is confirmed positive, or is
15 exhibiting COVID-like symptoms, and can't safely isolate or
16 quarantine in their own home. So the majority of those in
17 there are individuals that are from a homeless shelter or
18 literally unhoused, which means they're living in a place
19 that's not intended for human habitation. And many of
20 these clients are either eligible for Medicaid or they're
21 on Medicaid.

22 So as far as information sharing, we're trying to

1 figure out a way while they're there at the site for about
2 two weeks or so, how we ensure that their Medicaid -- that
3 their health care provider knows that they're there. How
4 do we make sure that their MCO knows that they're there?
5 How do we make sure that those clients that have time-
6 regimented health needs -- dialysis, chemotherapy -- that
7 they're connected and transported in a safe way to their
8 sessions, so that everyone is connected as far as where
9 their client is?

10 This has also been extremely important for our
11 clients that have behavioral health and substance abuse
12 needs, making sure that their behavioral health provider
13 knows that they're there and can have a number for them,
14 can constantly reach back and forth to them, and the client
15 knows how to reach back and forth to their behavioral
16 health and substance abuse provider.

17 That program is going well. We have on site,
18 behavioral health consultants, they help with dispute
19 resolution and helping clients successfully maintain and
20 continue in isolation or quarantine. It is hard. You're
21 in a room for two weeks. And then we also have Unity
22 Healthcare, who is one of our biggest FQHCs, outpatient

1 primary care clinics in D.C., there seven days a week to
2 call clients every day to see how they're feeling and for
3 those that need help administering their medications, Unity
4 commissions PPE and help with helping clients with their
5 meds. That's the first.
6 The second, which is actually bigger and more
7 complex, is a program that we've launched to separate
8 individuals that are at most risk of severe COVID health
9 complications. This is the program that we call the
10 "Pandemic Emergency Program for Highly Vulnerable
11 Individuals." That's a mouthful. We call it PEP-V, and
12 that program is where we use three distinct hotels, and we
13 look at clients that are 55 years and older, homeless
14 individuals, or those that are of any age that have one of
15 the CDC's list of those that make you more likely for
16 severe COVID outcomes, so uncontrolled diabetes, COPD, and
17 all the other comorbidities. We ask the client if they
18 want to go. If they say yes, they are then moved to a
19 hotel. And then while they're there, they have access to
20 health care, behavioral health care, case management, et
21 cetera, et cetera.
22 That has also proven somewhat difficult for

1 managing the extreme health needs of our clients that no
2 one seemed to be tracking, Medicaid providers, no one
3 seemed to be tracking, because they weren't engaging in the
4 health care system, but they were in a shelter. And the
5 majority of clients there are African American and do not
6 trust the health care system.
7 So as far as information sharing, we are talking
8 with behavioral health, similar to what we were doing at
9 ISAT, and trying to find a way to, once the public health
10 emergency ends, reengage them with -- or engage them with
11 the health care system; and that it's meaningful and that
12 it can be sustained.
13 That's all that I have, and I may have gone on a
14 little bit of a tangent here, Kayla, so I'm sorry about
15 that. But that's how we're addressing racial equity, an
16 example in D.C.
17 MS. HOLGASH: Okay. Thank you.
18 * DR. McFADDEN: Good morning. I'm Adrienne
19 McFadden. I'll just go ahead and jump right in. Just a
20 sentence about me, because I think Kayla cut out when she
21 was doing introductions. I'm an emergency physician by
22 training and background. I've been passionate about

1 systems transformation to be able to better serve
2 historically disenfranchised, marginalized populations for
3 my entire career and have been interested in health equity
4 and the complexities of health equity even before I had the
5 vocabulary to really articulate what that was.
6 Currently, I'm with Humana and serve as their
7 vice president of Medicaid clinical. I'm their national
8 population health officer. So I'll be speaking to you from
9 the lens of the way that managed care organizations are
10 able to address health equity for the Medicaid population.
11 And so I thank you this morning for allowing me
12 to talk about this because it is a passion point for me.
13 It is a complex area. It's costly in more ways than just
14 financial. And it's really important, and so I'm always
15 happy to speak about it. And I really also want to thank
16 my co-panelists for all their really great information that
17 they provided, and certainly there's some convergence of
18 what I'm going to share with what they have already shared
19 with you.
20 And so from our standpoint as a managed care
21 organization that serves Medicaid members, we recognize
22 that the issues of health equity are particularly

1 significant for our Medicaid members, and we have
2 intentionally built our health plan benefits and programs
3 with this lens in mind. And so we have a couple of
4 commitments that are not necessary Medicaid specific but I
5 think are important to point out because they certainly
6 inform our approach to health equity in our Medicaid
7 program.
8 And so one of those is what we call our "human
9 care approach," which is a commitment to addressing the
10 most important needs of our customer in order to simplify
11 their ability to achieve their own best health, and that
12 really for me provides the articulation that we allow that
13 member to really provide their own context instead of
14 assigning it to them.
15 The other commitment we have is something that we
16 call our "Bold Goal," and that's really a commitment that
17 we have to the communities that we serve. And so we've
18 committed to improve the health of the communities we serve
19 by making health easier. And so these two commitments
20 really inform our multipronged approach to health equity in
21 our Medicaid program, which I'll briefly review for you
22 today, and I know we have time limits, and so I'll try my

1 best to be succinct. But once I start and get going, I
2 might go a little bit over. But I would be remiss if I did
3 not note that this approach that I will lay out for you
4 today is still under development, and it's constantly
5 evolving because we're always measuring efficacy of the
6 things that we've already implemented and the things that
7 we're consistently putting in place.

8 And so I think what I'll lay out for you is that
9 we're going to kind of briefly review six buckets of sort
10 of activities that we're doing to address health equity in
11 our Medicaid populations. I would say the first three I
12 would group together are sort of cross-cutting initiatives
13 that are really important across everything that we do, and
14 the other three are things that I'd really like to
15 highlight because of the work that we've doing really going
16 deep in those areas and will probably invoke some of the
17 information that Jamila and Dena have talked about already.

18 And so the first thing I want to talk about is
19 just really sort of the strategic and organizational mind-
20 set of integrating health equity into what we do. And so
21 we are aware that providing services that really account
22 for and are sensitive to an individual's culture and

1 language preferences can certainly bring about positive
2 health outcomes, particularly for diverse populations. And
3 so we've really been evolving our ability to incorporate
4 the National CLAS standards into our Medicaid population
5 health strategy.
6 The second bucket of work that we have been doing
7 is really about collaboration, and I'll briefly talk about
8 it, but I'm certain we can go over it more as we sort of
9 have our question-and-answer period. But I think any of us
10 on this panel and any of us here on this call today would
11 say that the complexity of health equity and the issues
12 that belie it are things that -- something that no one
13 individual can solve by themselves, no one organization can
14 solve by itself, and so it really necessitates
15 collaboration in so many different ways with so many
16 different organizations and entities. And so we really
17 focus on our collaboration with states, with providers,
18 with community organizations, and other stakeholders. And
19 I just want to take a moment to really talk about our
20 collaboration with states.
21 So to be a successful managed care organization
22 for serving a Medicaid population, there is no way that you

1 can try and do that in a vacuum without deep collaboration
2 with your state partners. And that goes even further than
3 just the Medicaid agencies. There are other agencies that
4 certainly are involved, and I think as Dena was talking
5 about, you know, when we talk about human services, that
6 also is an adjunct to the services that we're providing and
7 making sure that we're providing -- and closing gaps in
8 social needs as well is really important to be able to
9 serve the Medicaid membership well.
10 But there's also a sort of underlying entity
11 there where there is a network of states' health equity
12 offices and infrastructure that exist that sometimes are
13 not tapped into, and so there's a network of approximately
14 46 different state offices of minority health and minority
15 health entities that are doing some great work on the
16 ground in individual states, and so we recognize that the
17 ability to collaborate with these entities, in addition to
18 the other state entities that are involved in the Medicaid
19 populations, can really bolster our ability to make some
20 meaningful progress towards eliminating health disparities
21 and making progress towards health equity.
22 The third cross-cutting bucket, I think, that's

1 important to talk about -- and I'm sure we'll get into a
2 lot of conversations about this because this is an area
3 that I think is extremely important to everything that we
4 do, and that's data analysis and quality improvement. And
5 so you can't really solve a problem until you understand
6 the size of the problem. And so we are continually
7 developing and evolving our ability to leverage
8 disaggregated data by race, ethnicity, language
9 preferences, and other sort of demographic sort of
10 identities to be able to track and report clinical
11 utilization and quality metrics, to make disparities more
12 evident, and also to be able to benchmark our progress
13 against that.
14 Again, that is something that we're constantly
15 evolving and developing because oftentimes we have some
16 gaps in the data that we receive, particularly some
17 enrollment forms and other sources, because oftentimes
18 there will be some hesitation to be able to identify those
19 particular demographics on the forms.
20 But these data are also really important to
21 measure effectiveness of the programs that we do as well,
22 and it really allows us to sort of compare our ability to

1 match our network of providers in their racial and ethnic
2 makeup as well as their cultural and linguistic abilities
3 to the needs of our membership as well, as to really being
4 able to understanding the makeup of not only our provider
5 community, but also our membership community.
6 So that's why data, I think, is so key and
7 important as to not only sort of creating the programs and
8 processes that we have in place, but just continuous
9 quality improvement that we also implement.
10 So I'm going to kind of change directions a
11 little bit from that sort of crosscutting grouping of three
12 that we talked about and talk about three that I think
13 we've really made some great progress and going deeply in.
14 The first, I think, Jamila sort of pointed out
15 was sort of need to remove barriers to access to care. So
16 I think that that's a really important one, but access can
17 come in so many different forms.
18 The first and most obvious one is, are there
19 enough providers to provide the preventive services or
20 other services that are needed for our Medicaid enrollees?
21 So virtual care and telehealth solutions have offered a
22 really great pathway to increasing access to care for our

1 rural and underserved populations. That is becoming
2 increasingly important in light of COVID as well, and we've
3 seen increasing uptake in utilization and stickiness of our
4 virtual care services in the population.
5 The second is I think when we think about access,
6 sometimes the providers are available, but sometimes
7 transportation is a barrier, distance is a barrier. Just
8 getting to the provider could be a barrier, and in addition
9 to being able to support transportation needs, we also have
10 utilized the mobile vans as a solution to get care to where
11 our members are and meeting them where they are, both
12 physically and in their needs. So that has been a useful
13 tool for us to get care that is much needed to members in
14 rural areas and underserved urban areas as well.
15 Then, the third one that I think is often
16 forgotten about is really access at a time that is most
17 convenient to the life of our members. What do I mean by
18 that? Sometimes there's a provider available.
19 Transportation is not necessarily an issue, but what
20 happens if this is an hourly worker who has to just decide
21 between taking off work to be able to get their preventive
22 care, preventive services, or health care? And that means

1 by missing a day at work, they actually miss the income
2 that comes with that because they don't have paid time off
3 or leave.

4 So being able to leverage innovative solutions
5 and incentives to be able to have our provider community
6 have extended hours or after-hours access for our members
7 is really important being able to remove barriers to access
8 as well.

9 I think when we talk about some of these other
10 issues around systemic racism and bias and other things, I
11 think it's really important that we take some time to focus
12 on the work that we've done to support the health care
13 workers, diversity and cultural competency activities.

14 We hear a lot about implicit bias and disparate
15 treatment and distrust of the health care system by these
16 historically disenfranchised populations and for good
17 reason, with some of the history that has been there and
18 that exists. These concepts are really inextricably
19 related to the diversity and the cultural sensitivity of
20 the health care workforce that's providing some of the care
21 in some of the systems that are in place to be able to get
22 this care, and I believe that they're partially mitigated

1 by making sure and in supporting the fact that we have a
2 more diverse and culturally sensitive workforce.
3 That is sort of also something that is
4 multifaceted, right? Not all health care workforce lives
5 within the physician office nor the medical office nor a
6 hospital. We also have providers that influence the health
7 care and the medical provision of care in our own plans
8 where we have care coordinated and care managers who are
9 helping to navigate the care that our members are
10 receiving.
11 We take an internal look first where we have a
12 culture of diversity and inclusion that starts from our
13 enterprise level and trickles down and imbues across all of
14 our lines of business, but specifically for our plans, we
15 take this sort of diversity and inclusion lens to make sure
16 that we are recruiting staff that is diverse and culturally
17 sensitive and reflective of the members that we're serving.
18 Not only that, we make sure that we have
19 plentiful training in the onboarding process and ongoing
20 training to make sure that our staff is really living the
21 values of making sure that they understand the impact of
22 implicit bias and the importance of cultural competency and

1 the social needs being addressed and social determinants of
2 health and the impact that has on our members as well as
3 trauma-informed care and some of these things that we
4 really need to start to address on the front end. So we
5 make sure that we have a very robust process for staff
6 recruitment and training in that vein.
7 The other thing is we also support our provider
8 network to provide education and toolkits for providers and
9 practices in that same realm. So we make sure that we have
10 a very robust library of educational materials for our
11 providers so that they too at their interest can involve
12 themselves and whatever meaningful education they want with
13 regard to these issues like implicit bias and cultural
14 competency.
15 Then I want to take a moment to really talk about
16 something that I think we have really gone very deeply and
17 done a great job, and that's addressing the upstream causes
18 of poor health and the social determinants of health.
19 I really kind of want to take a little bit of
20 time to dissect this a little bit, kind of going back to my
21 clinical roots a bit.
22 One of the key concepts that we take with

1 addressing social determinants of health here is making
2 sure that we regard gaps in social needs in an analogous
3 way to the way we regard gaps in clinical care, because as
4 we've heard about the social, the economic, the
5 environmental factors in combination, certainly account for
6 much more than the medical care account for when it comes
7 to health outcomes as a determinant of health.
8 By regarding these things in an analogous way,
9 that means we also have to have a rigorous way of
10 addressing it, just like we would with clinical care gaps.
11 So when we think about a person coming into a
12 physician's office, the first thing that they do is make
13 sure that there is screening and diagnosis to understand
14 what clinical needs that there are.
15 We need to do the same thing for social needs as
16 well, and so we've made sure that we've instituted a broad
17 screening process to not only identify screening for social
18 needs, but to make sure we understand sort of the true
19 scope for what the needs are within our membership
20 population.
21 We've incorporated social needs screenings not
22 only in just our everyday interactions, but in our core

1 clinical tools such as our health risk assessments, our
2 comprehensive assessments, and we built out social needs
3 assessments as well.
4 So that allows us to really do some comprehensive
5 screening amongst all of our members, and just from an
6 enterprise level, this really showed how much impact we've
7 had because we, in just this year alone, have been able to
8 do over 3.5 million screenings of social needs amongst all
9 lines of businesses. So it's been something that we've
10 really integrated into the way we need to do our work.
11 Now, once you screen and identified a problem,
12 the last thing you want to do is just say "you have a
13 problem" and leave it alone. So we want to make sure that
14 we have a way to address those needs that we've identified,
15 and if we can't address it ourselves, we want to make sure
16 that we have a network of referral partners who will be
17 able to address those needs for our members. We've been
18 working very closely with our physician partners, our
19 community partners, to really test and scale interventions
20 that treat, on a more broad level, social needs, not just
21 for the community, but for our individual members.
22 And we've also employed and deployed specialized

1 staff to work, specifically dedicated to addressing unmet
2 social needs for our members, particularly those who we've
3 identified throughout tools as being at highest risk for
4 adverse impact of social determinant to health barriers.
5 So once we get past the ability to be able to
6 either refer or address those needs, the other thing that
7 we have to do is make sure that we're measuring or tracking
8 to make sure whatever we've intervened on or referred to
9 have intervened on is making a difference and those gaps
10 are being closed. So we certainly have instituted a
11 tracking process for completed referrals and making sure
12 that we continually engaged with those members so that we
13 understand that those social gaps have been closed.
14 Then, the final thing that I'll touch on as time
15 has gone short and I know I've probably gone on much too
16 long, but is the fact that we want to make sure that we
17 treat these social needs analogously to clinical care by
18 making sure that we have levers such as alignment.
19 We're one of the largest value-based
20 organizations in the United States, and we have some really
21 deep expertise and experience in value-based models, and so
22 we're exploring innovative payment models with value-based

1 care or outcomes-based financing to better align incentives
2 of not only our Medicaid plans, but our community-based
3 organization, our physicians and clinicians and others to
4 help better address unmet social needs.
5 So I will stop there, making sure that we're okay
6 with time.
7 CHAIR BELLA: Thank you both.
8 Just a note for the Commissioners, Dena was not
9 able to stay, but, Adrienne and Jamila, if we run a few
10 minutes over, do you have a hard stop at 11:30? It's okay
11 if the answer is yes. It's just so we know how to plan.
12 DR. McFADDEN: I can go a couple minutes over.
13 DR. MICHENER: As can I.
14 CHAIR BELLA: Okay, wonderful.
15 Let's start with Commissioner questions. Darin
16 and then Kisha and then Kit.
17 COMMISSIONER GORDON: Thank you both for your
18 presentations.
19 When you're talking about data, one thing that I
20 -- and I totally agree that that's incredibly important.
21 Until you measure it, you don't know how bad the problem
22 is.

1 But I just heard recently the dynamic that can
2 play out in this particular situation, there is a large
3 national player in the health care world who had developed
4 this AI tool to basically identify high utilizers and what
5 it would do. In essence, they would have care managers
6 that would partner with them. They would help the
7 providers know who those folks are and would have some
8 interventions.
9 The challenge, what ultimately came to their
10 understanding, was because historically there was
11 underutilization by certain minority groups that the tool
12 was incomplete. It was, in essence, ignoring a whole
13 population group because it was looking at historically
14 higher utilization as an indication for intervention versus
15 the lack of utilization.
16 I don't know if you can talk about your
17 experience, Jamila as well, this idea that as a Commission,
18 we love the data, but here we have a situation where it's
19 the lack of representation of data and utilization that's
20 actually -- if we don't account for that, it could lead to
21 interventions that miss the mark. But I would love to hear
22 both of your all's perspectives in regard to that.

1 DR. McFADDEN: Sure. I'm happy to weigh in and
2 then certainly will defer to Jamila as well.
3 I think that's a really important concept, and it
4 gives me an opportunity to brag a little bit about just how
5 integrated equity and the lens of equity is in our
6 organization. So we are the only major managed care
7 organization to have taken the EqualAI pledge. So we
8 recognize that there is a challenge to making sure that
9 when we are relying upon data and modeling in predictive
10 analytics into AI, that we must take into account that
11 there can be some opportunity for bias and inequity to
12 sneak in.
13 So by taking the EqualAI pledge, we've certainly
14 signed on to our commitment to make sure that that is not,
15 indeed, a barrier that will be a challenge for us because
16 that is something that we are keenly aware of as being sort
17 of a potential misstep when we are looking at data to sort
18 of help inform our programs and processes.
19 DR. MICHENER: Yes. And I would just add, I
20 guess, two things. One, I think the question is really an
21 important one, and it's worth keeping in mind that sort of
22 that data can't save us and algorithms can't save us and AI

1 can't save us unless we're thinking really critically about
2 all of those things.
3 The larger point I made about institutional
4 racism is such that it will also permeate those barrier
5 systems, and because those systems sort of have an air of
6 objectivity when it permeates, then we almost don't know
7 it. So there's a great book called "Algorithms of
8 Oppression," and it's about the way that Google Search
9 Engine can actually perpetuate racism, because you put in
10 the first few words, and what comes up next is a function
11 of a set of systems that's already in place. The
12 algorithms underlying those search engines are just
13 reflecting what's already existing in society, but then
14 they're also redefining it and perpetuating it.
15 That's the case with data. We have to always
16 think about it critically, and I would say two things. One
17 is it's important to think capaciously about what data
18 consists of, and although it's difficult, I would make a
19 case for being open to the value of nonquantitative data as
20 well as quantitative data.
21 I'm a mixed methods social scientist. So I use
22 plenty of qualitative data and plenty of quantitative data,

1 lots of big administration datasets, but also in-depth
2 interviews with hundreds of people all across the country.
3 Honestly, when I think about analyses of some of the big
4 quantitative administrative datasets that I've done, often
5 I wouldn't have been able to make any sense of what I was
6 finding in those if I weren't also talking to people.
7 I think it's really important to keep in mind
8 that there are different kinds of data we can collect, and
9 while qualitative data is challenging and there are some
10 difficulties to systematically collecting it, it's really
11 important because it brings people's voices into the
12 process who are actually experiencing these systems. So
13 it's not just about cataloging the characteristics and the
14 outcomes associated with those people, but it's about
15 incorporating their voices. And I think that's crucial.
16 The second thing I would say really quickly is
17 that we can also bring people into the process of helping
18 us to critically assess kind of the data collection
19 mechanisms that we have.
20 One of the things, for example, when I interview
21 Medicaid beneficiaries, that they sometimes say to me is
22 "They ask me to fill out all these forms, and they're

1 asking me all these personal questions. And I don't trust
2 them. What do they want to know about these things that
3 had nothing to do with health care for? Who are they going
4 to tell?”
5 So we're all like, "We have to ask people
6 questions about their social conditions so we can help
7 them," and then when we ask people those questions, they're
8 putting that in the context of their larger experience with
9 the world and with the government, which says, "I don't
10 trust you. Why are you asking me these things?"
11 And so guess what? You don't get great
12 compliance on the questions. I've had people say, "I just
13 say whatever. I don't tell them what's really going with
14 me. I don't trust them. Are they going to go back and
15 tell the government? Are they going to tell Child
16 Protective Services if I tell them that I'm housing
17 unstable and then maybe my children will get taken away
18 because I have rodents in my" -- I mean, there are all
19 sorts of ways that people understand that the information
20 that is being collected can be weaponized to harm them.
21 So we won't even get good data if we don't
22 understand what the questions mean to people when we ask

1 them, and so even as we're constructing surveys and even as
2 we're imagining data collection processes, we should
3 actually be involving the people who are the targets of
4 these instruments, these survey and other data collection
5 instruments, and asking them how they would respond to that
6 kind of information so that we can creatively adjust and
7 adapt to their needs.
8 COMMISSIONER GORDON: Thank you.
9 CHAIR BELLA: Thank you very much.
10 All right. We're only going to ask our guests to
11 stay about five minutes over. That means we have about six
12 minutes for four Commissioners. So you all have 90 seconds
13 to ask a question and get a response. So please be
14 succinct. I'm saying this to our Commissioners, not to our
15 panelists.
16 All right. Kisha, Kit, Peter, and Sheldon.
17 COMMISSIONER DAVIS: Thank you, Melanie, for the
18 warning. So I will only ask one very pointed question
19 instead of going on, on a lot of different tangents.
20 First, thank you both and Dena too who wasn't
21 able to join us. This was just an excellent panel, and we
22 can follow up some of those questions with the

1 Commissioners after.

2 But my question is for Adrienne. You mentioned
3 value-based care, and I think that that is something that
4 is growing in the Medicaid space. And I would love for you
5 to just talk a little bit more about how value-based care
6 marries with health equity and the potential for health and
7 harm. What are some of those unintended consequences that
8 we want to kind of be aware of in that space?

9 DR. McFADDEN: Yeah. That's a really good
10 question and probably a little bit complex and maybe too
11 much for 90 seconds of an answer.

12 But I think what I would say is value-based care
13 is really an instrument that I think can be really
14 leveraged to be able to allow the permission space, so to
15 speak, of our physicians and clinicians to be more deeply
16 involved in the overall context of health for the members
17 and the patients that they're seeing.

18 So when we create value-based incentives for them
19 to get involved and not just the medical concerns, but also
20 the social concerns that are impacting their health-related
21 needs, then that allows them incentives and aligns their
22 incentives to be able to really treat the whole person,

1 which honestly, as a physician myself, I know that my
2 colleagues really want to do, anyway. Certainly, that's
3 what we aspired to do when we were green and wet behind the
4 ears and going into the medical profession, but certainly,
5 circumstances don't necessarily allow the space and the
6 freedom to do that. But value-based incentives allow for
7 understanding the whole person and being able to treat the
8 whole person, and I think that starts to get at more of the
9 underlying determinants that lead to some of these
10 inequities.

11 So they're able to then also build out capacity
12 and capabilities within their offices themselves to do
13 these value-based arrangements and also have partnerships
14 in the community so that they have referral mechanisms to
15 be able to go the step further to treat some of these
16 health-related social needs for their patients. So I think
17 that's one aspect.

18 The other aspect is that we're starting to get a
19 little bit more sophisticated in our value-based incentives
20 and understanding that some of these are very much targeted
21 to just that, just the social needs, and not necessarily
22 the clinical needs, so being able to start to exercise the

1 muscles of doing some screenings in the provider's office
2 for social needs because the provider is probably much more
3 trusted than perhaps the managed care organization asking
4 about some of these things, the social questions. And so
5 being able to incentivize the providers and their staff to
6 be able to be more alerted to some of these needs of their
7 patients, I think, is also really important to be able to
8 address health equity.
9 CHAIR BELLA: Thank you. Kit, and then Peter.
10 COMMISSIONER GORTON: So thank you for coming.
11 Adrienne talked about a diversity lens for workforce, and
12 Jamila talked about hearing the voices. I want to build on
13 that, really just make a comment, and then I have a
14 request.
15 So the comment is for you and for the members of
16 the audience, so look at the faces on the screen. We
17 haven't done it already. The Commission staff has been
18 managed, in terms of diversity, really very well. We have
19 a very diverse staff, women of color in leadership, and we
20 do pretty well there. The Commission itself, not so much.
21 The GAO is in the process of -- they don't
22 recruit, right, so they look for volunteers -- but they are

1 in the process of accepting applications for people who
2 want to be on the Commission. And so it falls upon those
3 of us who know that the Commission needs to have diversity
4 to recruit people to volunteer.
5 And so my request is for both our panelists as
6 well as for Dena to consider whether you could serve on the
7 Commission and help us address this equity issue, and as
8 well for people in the audience who might want to put their
9 names forward. As well, we should include people with
10 physical disabilities and other people who are in groups
11 that are not well represented on the Commission, although
12 they are part of our service population.
13 So I just want to say, one of the things that
14 people say is, "Nobody ever asked me." So we are asking
15 now. We really would like people to come forward. Not
16 everybody has time and not everybody has the interest to
17 sit through this kind of stuff. But if you have the time,
18 if you have the interest, if you are willing to think
19 openly, think deeply, and state a point of view, then we
20 would welcome your application and the staff can help
21 anybody who is interested do that.
22 CHAIR BELLA: Thank you, Kit. Just to clarify,

1 the applications are not open right now but there will be a
2 notice that goes out in January for service beginning later
3 in 2021. And so just reinforcing Kit's message that we are
4 anxious to be a more diverse Commission so hoping to get a
5 lot of new applicants for this next cycle.
6 Okay. Thank you, Kit. Peter, and then Sheldon
7 for the close.
8 COMMISSIONER SZILAGYI: Just very quickly. This
9 was really an amazing session. Thank you so much.
10 Kind of a big question about benefits and
11 payments. I am a primary care pediatrician. I have taken
12 care of low-income Medicaid enrollees for my entire career.
13 And in terms of benefits, we have all recognized the role
14 of social risks and social needs, and we need to figure out
15 what Medicaid should cover. So a policy lever is enhancing
16 benefits. How do you address the counter-argument that
17 although it is within the medical purview to screen for
18 depression, it is not within the medical purview to pay for
19 housing? So that is a question about benefits.
20 And a question about payments, is I have been
21 intrigued for two decades about risk adjustment and
22 incentivizing payments to address social risks. How

1 important and how much of a magnitude do you think we
2 should consider for risk adjusting and incentivizing
3 payments specifically for addressing social needs as
4 opposed to the typical medical purview? So two related
5 questions.
6 DR. MICHENER: Adrienne, do you want me to jump
7 in there?
8 DR. McFADDEN: I will you jump in and then I will
9 fill in.
10 DR. MICHENER: I will be short and leave more
11 space for you. I mean, I think that the question of what
12 is within the medical purview and what isn't, you know,
13 underlying that question, I may be overarching, is a
14 recognition -- and maybe this is like a super-scholarly,
15 hyper analytical thing to say -- but the fact of the matter
16 is the medical purview is a social construct. We decide
17 what is within that purview and what isn't, and what we
18 decide isn't neutral. It has implications. So if we say
19 we want the medical purview to be narrow, that means that
20 social determinants like housing will be outside of it, and
21 that has implications for racial equity, and for other
22 kinds of equity -- socioeconomic equity, et cetera.

1 If we say that we want it to be wider and we
2 incorporate housing, there is lots of rationale for doing
3 so. We know there are direct relationships between housing
4 and health outcomes, and we know that there are more
5 indirect relationships between things like Medicaid policy
6 and housing outcomes. Those relationships go both ways,
7 right? You see, for example, fewer evictions in places
8 where Medicaid has expanded, and we also see better health
9 outcomes in places where there are fewer evictions.
10 So those relationships are deeply intertwined,
11 and I think there's lots of kind of at least empirical
12 rationale for saying that. You can't just untangle,
13 disentangle them and say no, they are separate things and
14 we only want to look at the medical, because they are
15 entangled.
16 But the choice of how broad or narrow we want our
17 framing to be with respect to the medical purview is just
18 that. It is a choice, and acknowledging it as such, and
19 pinpointing its implications with respect to racial equity
20 is really crucial.
21 Adrienne, I will leave the rest to you.
22 COMMISSIONER SZILAGYI: I agree with you, by the

1 way.

2 DR. McFADDEN: Yes, I agree as well, Jamila, and
3 I would say, just from a standpoint of a payer, I think
4 that is one of the reasons that we have really started to
5 dig into the social determinants of health parity, as
6 really trying to pressure-test the reception of how
7 individuals who really receive, starting to really treat
8 them as the intertwined sort of circumstances that they
9 really are.

10 And so really kind of having that same sort of
11 process for directing gaps in social needs, like housing or
12 homelessness, as Dena was talking through with D.C., are
13 really important. And so I do think it is a conversation
14 that is continuing to evolve, so I do think that the
15 constructs are one that, as Jamila so eloquently put, are
16 things that we have sort of softly put on there, and they
17 are starting to blur the lines between those more and more
18 each day.

19 As for the risk adjustment question that you had,
20 I think that is such a timely question. Our chief medical
21 officer actually recently did a publication in concert with
22 one of the academic institutions in sort of looking at

1 social risk adjustment as a tool and a potential for being
2 able to really address more comprehensively social needs.
3 So I think that is certainly something that people are
4 starting to consider more as well, and we have certainly
5 looked at that internally here at Humana.
6 CHAIR BELLA: Sheldon, you have the last
7 question.
8 COMMISSIONER RETCHIN: If you can hear me I am
9 going to just defer to the next session. I have got
10 something. I want to build on Peter's point.
11 CHAIR BELLA: Okay. Adrienne and Jamila, we
12 could go on and on. Please don't think that we are trying
13 to rush things. We want to be respectful of your time.
14 And I will say, Jamila, we take seriously your point about
15 like this conversation can't end with this panel. If it
16 makes you feel interested, our panel after lunch is all
17 about postpartum coverage and extension of postpartum
18 coverage in Medicaid. So I can guarantee you we will be
19 talking about structural racism and disparities and
20 equities in access in that panel, and I think we are really
21 trying to hold ourselves accountable for having it permeate
22 all of the work that we do.

1 And so I would say to both of you, if you are
2 amenable I know we would love to come back and get your
3 input as our work progresses, and I would hope that neither
4 of you would be shy to call us out on things and to say
5 "you need to be doing more in this area."
6 But with that, thank you so much for spending
7 time with us today, and we really, really appreciate it.
8 DR. MICHENER: Thank you, everyone.
9 DR. McFADDEN: Thank you.
10 DR. MICHENER: This was a really good session.
11 Thank you.
12 **### FURTHER DISCUSSION BY COMMISSION**
13 * CHAIR BELLA: Thank you. Okay. I think we are
14 going to use the rest of our time to talk, as a Commission,
15 understand areas of interest, give you some ideas on what
16 we would like to take from this to continue to seed our
17 future work.
18 Sheldon, I will start with you.
19 COMMISSIONER RETCHIN: Yeah. Can you hear me?
20 CHAIR BELLA: Yes.
21 COMMISSIONER RETCHIN: Yeah. I am going to go
22 back to really the session and the discussion around

1 housing, and build on what Peter was talking about, but
2 with a specific ask. And that is we know that Medicaid
3 coverage in expanded states or counties, particularly in
4 California, from the work from Heidi Allen, that Medicaid
5 expansion reduced the rate of evictions. We know that
6 evictions, that our epidemic -- read Matthew Desmond's
7 Pulitzer Prize-winning book on the subject -- and
8 disproportionately affects people of color.
9 And I bring this up because many of you probably
10 know that in three weeks there will be a tsunami of
11 evictions unless they extend the CDC's directive to put a
12 moratorium on evictions. And imagine this tsunami of
13 evictions coming right in the middle of the COVID epidemic,
14 right in the middle of the dead of winter. I just feel --
15 and I am just putting this out to my fellow Commissioners,
16 and maybe to Anne and you, Melanie -- is this something we
17 should weigh in on? It's directly related to health
18 outcomes. And I don't see any movement by the current
19 administration to extend the directive, and I think it is
20 something that is directly tied to Medicaid and to our
21 purpose. So I raise that issue for whether a letter or
22 some sort of communication to the appropriate people.

1 CHAIR BELLA: Okay. Thank you, Sheldon. Kisha.
2 COMMISSIONER DAVIS: Thank you, Sheldon, for
3 bringing that up. I would support you on that, if that is
4 the direction that we want to take. I definitely would be
5 supportive of doing something like that, even just listing
6 the evidence that relates evictions to Medicaid.
7 I think what really struck me around the panel
8 was thinking about how that influences our work, as we
9 think about health equity, and, you know, Jamila's point at
10 the very beginning, and Melanie, you touched on it just at
11 the end, you know, we don't want health equity to be a
12 section of our day and then we move on to other things.
13 And so just thinking, for us and for the staff,
14 how we be intentional on making sure that health equity is
15 a thread that runs through everything that we do, thinking
16 about even our own training, as we think about retreats and
17 things for the Commissioners, ourselves, you know, doing
18 some implicit bias training or digging a little bit deeper
19 for our own knowledge on how structural racism impacts the
20 Medicaid system, and so how that is informing our work.
21 But also when we are thinking about countercyclical, and
22 when we are having talks about DSH, that we are also

1 speaking out loud about the racial impacts of that, and
2 intentional about speakers that are coming to talk before
3 us.
4 You know, I don't want the only speakers of color
5 that we see in a meeting to be the ones who are talking on
6 health equity, and so how do we be intentional that we are
7 making sure that that representation that we see in our
8 client base is represented in the panel, of Commissioners,
9 as Kit has mentioned, but also in the panelists of speakers
10 that we talk to, and the breadth of experience that we pull
11 on as Commissioners to inform the work that we do.
12 CHAIR BELLA: Thank you, Kisha. Other comments?
13 Fred, I think I see your hand. Yeah. We can't hear you.
14 COMMISSIONER CERISE: I am a little off-center
15 but I'm figuring it out. But I am looking straight at the
16 camera now, you might notice.
17 So first I appreciate the session, and Kisha, I
18 appreciate your comments on that. I do think, and Melanie,
19 with your leadership, we do feel that we are putting this
20 lens on other conversations.
21 I want to follow up on Sheldon's comment on
22 housing, because I struggle with this a bit, you know,

1 where does Medicaid end and where does the health kind of
2 program end, and then were do the social programs begin?
3 And there is so much overlap.
4 You know, fundamentally, we have to come to grips
5 with the fact that we have got to be able to shift some
6 dollars. The health care economy consumes so much of the
7 GDP. And I know Medicaid can't do that itself, but, you
8 know, one of the areas -- and one of our speakers, Hasan,
9 talked about it, and that is transitional housing. I know
10 there are some opportunities in Medicaid to support that.
11 I guess I would ask, you know, what is that and how far can
12 you go with that space? Maybe that is something to look
13 at.
14 We have worked, for instance, with the Salvation
15 Army for respite care, people being discharged from the
16 hospital. And what is a relatively small dollar for the
17 health care system is a big dollar for some of these
18 community-based organizations. So those seem like some
19 easy things to do, you know, respite care, or to be able to
20 facilitate discharges to homeless shelters. But then how
21 far can you go with that to be able to stabilize somebody
22 so that it doesn't end with just some brief period of

1 respite or some brief period of post-discharge, but then to
2 get connected to real sustainable housing.
3 And so maybe there is something in that space of
4 transitional housing we could explore. Because I do
5 struggle with, you know, can we take on homelessness as the
6 Medicaid program, and, you know, that is where it would go
7 because it is such a huge issue.
8 CHAIR BELLA: Thank you, Fred. Peter, and then
9 Chuck.
10 COMMISSIONER SZILAGYI: Well, continuing the
11 conversation. I am sorry.
12 CHAIR BELLA: Did you want to make a comment,
13 Anne, on Fred's point?
14 EXECUTIVE DIRECTOR SCHWARTZ: Yes. Just quickly
15 I wanted to mention that we did do a brief a while back on
16 Medicaid's role on housing that we could revisit to look at
17 the policy issues whose potential is not fully realized.
18 And also we do have an opportunity, at the January meeting,
19 to talk about a report to Congress by the Secretary on
20 housing, homelessness, and SUD. So stay tuned for that.
21 CHAIR BELLA: Thank you, Anne. Peter, and then
22 Chuck.

1 COMMISSIONER SZILAGYI: Yeah. This may not be
2 coherent but I have just been struggling with this issue of
3 the social component, which is such a huge impact on
4 ultimately health outcomes and the medical component. If
5 we look at European countries, Western European countries,
6 if you add up the amount of money that they spend on social
7 programs plus medical programs, it is actually similar to
8 America. It is just that they spend the majority on social
9 programs and a minority on medical programs. And when you
10 look at America, it is kind of flipped, but the total
11 amount of spending is the same.
12 So as I am struggling with short-term
13 improvements or tweaking in the Medicaid program, which I
14 think we deal with, for good reason, frequently, I am
15 struggling with what are the bigger fixes, the really
16 fundamental bigger, long-term fixes to improve the health
17 outcomes of this country. It just feels to me that we have
18 to somehow marry the social programs and the medical
19 programs in a better way.
20 And I don't know -- and this is why I said this
21 is going to be incoherent, because I don't know what that
22 means for MACPAC for long term. Should we be relating more

1 with other programs, the social programs, and housing is
2 just one example, but there are many others, you know, when
3 we look at sort of long-term planning as opposed to sort of
4 short-term policy levers.

5 CHAIR BELLA: Thank you, Peter. Chuck, and then
6 Martha, and then we will go for some public comment before
7 we wrap up.

8 VICE CHAIR MILLIGAN: This was a great panel and
9 very thought provoking, and I echo the comments about
10 making sure to pull this work through, or this issue
11 through everything that we do. The one comment I wanted to
12 make, with respect to kind of where Fred and Peter just
13 took us, is I do think this has direct implications to our
14 discussion later in this meeting around countercyclical
15 financing. And I do, by the way, I'm supportive if we want
16 to send a letter regarding the eviction issue that Sheldon
17 raised.

18 With the countercyclical financing, I just want
19 to connect a couple of dots there. States, as a safety net
20 for many of these "non-medical program" are implicated or
21 affected by the recessions that hit state revenue. And so
22 not only do we see issues around how recessions hit

1 Medicaid but to the extent that other forms of the safety
2 net, other dimensions of the safety net are not inside of a
3 Medicaid benefit they are more vulnerable to state actions
4 in a recession where state revenue is down.
5 And so I do think that one mechanism we have to
6 try to link these is just that particular issue of how the
7 countercyclical financing might work in ways that amplify
8 the effect of economic distress. So that was the comment I
9 wanted to make.
10 CHAIR BELLA: Thank you, Chuck. Martha.
11 COMMISSIONER CARTER: I don't remember how much
12 work we have done in this area, Anne, but I would like to
13 see, or like to dig in a little bit in terms of the types
14 of social support services that are currently possible in
15 Medicaid. I agree with the whole conversation about
16 expanding what is covered by Medicaid, but right now what
17 is possible?
18 For example, translation services are hugely
19 important and cut across racial and ethnic groups. And I
20 was pleased to hear Adrienne -- no, I'm sorry -- yeah,
21 Adrienne, from Humana, talk about how they had incorporated
22 that into their services, the CLAS Standards. But that is

1 not across the board, and I don't know that it is required,
2 and I think that kind of service is a huge barrier to
3 access to care.
4 So within what is possible, I'm not sure we have
5 even got a really good analysis of what is out there and
6 what can be done and where could we push those boundaries.
7 CHAIR BELLA: Thank you, Martha.
8 I have some concluding comments, but first I want
9 to go to the public and see -- oh, Kisha, I'm sorry. I
10 didn't see you. Kisha, go ahead, and then we'll go to
11 public comment.
12 COMMISSIONER DAVIS: Just one kind of closing
13 thing to follow up here on some of what Fred and Peter
14 brought up, and Sheldon, too. When we think about how we
15 save money in Medicaid, a lot of it is by having fewer
16 people in Medicaid, and the way that you do that is by
17 improving the education system earlier on. And so really
18 thinking about upstream, if we do better on housing, when
19 we do better on education, when we do better on community
20 safety, the downstream effect of that is there are fewer
21 people who are needing these safety net services. And I
22 think as MACPAC, it's okay for us to say not all of that

1 spending needs to come from Medicare, and, you know, having
2 that sort of recommendation or acknowledgment that we
3 really, if we're trying to take better care of our
4 communities, then we need to be encouraging some of these
5 other programs to really step up to the plate, because
6 what's happened now, as Peter mentioned, is it all just
7 comes back to Medicaid, and now we have to figure out how
8 to pay for housing and we have to figure out how to pay for
9 transportation to get patients to things. And that's
10 because we haven't invested in a robust transportation
11 system, and we haven't brought education -- you know.
12 So I think those are some of the things that are
13 important for us to look at, how Medicaid touches many of
14 these other social services and how they may need to be
15 stepping up as well, as Medicaid is also kind of filling in
16 the gap in that in-between time.
17 CHAIR BELLA: Stacey.
18 COMMISSIONER LAMPKIN: Thank you. I don't want
19 to downplay the social services side of that. I agree with
20 many of the comments. But to bring it back maybe a little
21 bit more directly to the kinds of things that we normally
22 look at and consider on our plate, I'd like to suggest that

1 we think about whether there's some workforce initiative
2 type things that could be meaningful kind on a smaller
3 scale than reinventing the whole system, but, you know, are
4 there particular provider types, particular parts of the
5 country that would be really impactful if we can figure out
6 how to improve the size of the workforce or the location of
7 the workforce in a way that's impactful for equity?
8 CHAIR BELLA: Darin, did I see this going up? Do
9 you have a comment, a last comment?
10 COMMISSIONER GORDON: Yeah, I think Kisha raises
11 a very, very good point. But I would say it's worth noting
12 -- and I know, Anne, you talked about the work that has
13 been done on this before. But there was a lot of activity
14 over the last few years by a lot of the different health
15 plans in putting money toward housing. And it's been
16 creative, and they all take different flavors, and in some
17 cases it depends on the funding in the state, state
18 leadership as well. But I think it's worth, you know,
19 looking at some of the things that are currently going on
20 out there, and others have talked about this as well, but
21 in the context of just the agency, health plans have been
22 doing something across the country as well in this space,

1 and I think it's worth having a better understanding of
2 those activities when we think about housing and Medicaid.
3 EXECUTIVE DIRECTOR SCHWARTZ: If you have any
4 thoughts about how we can get the information out of the
5 plans in something more than a PR type way, I am all ears,
6 because that has been our stumbling block.
7 COMMISSIONER GORDON: We know that, in some work
8 that we've done, we just reached out to them and had some
9 great conversations about what activities they're doing.
10 It may not go to the level of detail you want, but it was
11 pretty eye-opening to us just by picking up the phone and
12 saying we'd like to better understand how you all are
13 engaging and how is it working. What do you think the
14 barriers are to success? Why it works in some geographies
15 versus others, what are key components, the necessary
16 components to making it work? And we have found that they
17 have engaged meaningfully in that discussion.
18 CHAIR BELLA: Thanks, Darin.
19 I'm going to turn now to the public and see if
20 anyone has public comment. If you do, please hit the
21 little hand button, and we will see that and unmute you.
22 Again, this is an opportunity for public comment,

1 if anyone would like to make any comments based on what
2 we've heard this morning.
3 Okay. I'm not seeing -- oh, yes, great. We do
4 have someone ready to speak, if we could unmute Loren,
5 please.
6 **### PUBLIC COMMENT**
7 * MR. ANTHES: Yes, hi. Loren Anthes with Center
8 for Community Solutions in Cleveland. I really appreciate
9 some of the comments about how Medicaid can't be used to
10 address all these social determinant issues. You know, I
11 think oftentimes what I've seen in policy lately is that
12 Medicaid just becomes a funding source to displace spending
13 that would have taken place on the state or local levels.
14 And so I'm curious about the Commission's general approach
15 to making recommendations in other policy spaces, for
16 example, something like a national source of income
17 protection law. Is something like that or anything that
18 may address some of the issues around like housing
19 generally something that the Commission would put forward
20 or try to work with other, you know, national groups or
21 agencies around when it comes to trying to address some of
22 the long-term costs associated with social determinants?

1 CHAIR BELLA: Anne, do you want to answer that?
2 And I think we're always willing to work with others. We
3 are little bit more limited in what we can -- where we can
4 make an official formal recommendation about something
5 that's much broader than Medicaid, but, Anne, what else
6 would you add to that?
7 EXECUTIVE DIRECTOR SCHWARTZ: I guess I would just
8 echo that the Commission in its published work and its
9 public meetings can talk about anything related to Medicaid
10 and CHIP. In terms of recommendations, we do try to focus
11 more narrowly on direct effects. And we've tried in our
12 work to sort of show how Medicaid touches up against and
13 interacts with different systems, and there's always more
14 work to do in that area.
15 CHAIR BELLA: I think we are always open to
16 collaborating on these issues that have such a cross-
17 effect, though, on Medicaid. So I appreciate that comment.
18 We have a couple more folks interested in
19 speaking. Could we unmute Nataki, please? If you could
20 introduce yourself and your organization, that would be
21 great.
22 MS. MacMURRAY: Good morning. My name is

1 Nataki MacMurray. I'm calling on behalf -- or, rather,
2 work with the Office of National Drug Control Policy, and I
3 had a question. Actually, just as I was thinking about the
4 question, I just went to Google to see if MACPAC has
5 actually put anything else out about this. But earlier in
6 the year, when the healthy adult opportunity waiver was
7 introduced, it kind of symbolized a movement to try and
8 incorporate some work eligibility requirements into what we
9 have typically seen as a program to support folks who have
10 the greatest need. And I wanted to find out from the
11 Commission your thoughts on that and whether or not the
12 Commission is going to have any comments or the ensuing
13 administration about attempts to add in such eligibility
14 requirements such as work or education or folks who have
15 substance use or mental health disorder needs, the need to
16 fill their time with treatment, things such as that. So if
17 the Commission could just share your thoughts on not just
18 the healthy adult opportunity waiver, but also similar
19 thoughts to add in eligibility requirements for Medicaid.
20 Thank you.
21 CHAIR BELLA: Anne, do you want to -- I mean, the
22 Commission did send a letter to CMS on work requirements

1 focusing on transparency and the need to evaluate and to
2 have a solid base of understanding to support policy change
3 in that regard. That letter is available publicly.
4 I think as far as what we'll be commenting on
5 with regard to the incoming administration is, you know, we
6 will be waiting to see what that administration is
7 signaling, what it wants to do in that regard, before we
8 would be committing to what we might do in anticipation of
9 that. So I think we are anxious to see the policy changes
10 and direction that the new administration puts forward, and
11 then we will plan our actions or what we think we need to
12 say or not say based on that.
13 But, Anne, I would welcome you to elaborate on
14 that.
15 EXECUTIVE DIRECTOR SCHWARTZ: Yes, I believe our
16 comments regarding the implementation of the Arkansas work
17 requirements were made in 2018, and that letter is on our
18 website.
19 CHAIR BELLA: All right. We have one last
20 comment, it looks like, from Renée.
21 MS. HUGHES: Renée has not entered the audio PIN,
22 so I won't be able to unmute.

1 CHAIR BELLA: Okay. Renée, hopefully you're
2 hearing that and you can see if you have an audio PIN that
3 you can enter so we can unmute you. And if for some reason
4 that doesn't work, we can always take your comments via
5 email or we can take comment at the end of the day about
6 anything we have talked about today.
7 MS. HODIN: Can you hear me now?
8 CHAIR BELLA: Yes, wonderful.
9 MS. HODIN: Oh, terrific. Okay. I tested it
10 about three times, but great. Yes, hi. This is Renée
11 Markus Hodin, and I am with the Center for Consumer
12 Engagement in Health Innovation at Community Catalyst. And
13 I wanted just to make two brief comments, one of which I
14 entered in the question section when the panelists were
15 still on, but I wanted to lift it up a bit.
16 First was I really appreciated this conversation,
17 and I particularly very much I wanted to lift up the
18 comment by Dr. Michener about the qualitative angle here,
19 so looking at how do we better engage with, learn from
20 beneficiaries, from Medicaid beneficiaries, if there's a
21 way for MACPAC to support those sorts of efforts, that
22 would be terrific. I wanted to support that.

1 And then, secondly, again, this was a question
2 more for the panelists, but I have been thinking a lot
3 recently about Dr. Ibram Kendi's books around, you know,
4 being anti-racist. And I wanted to encourage, I guess, in
5 this situation now, encourage the Commissioners that when
6 you circle back with the panelists, to use that as a lens.
7 You know, what are the kind of highest-value anti-racist
8 Medicaid policies that MACPAC could be behind rather than
9 there's a lot of different things you could do, but what
10 could we do that is most directly anti-racist?
11 Thanks so much again for the conversation. It
12 was very much appreciated.
13 CHAIR BELLA: Thank you, Renée. I think that is
14 a great comment for us to end on. I mean, there are lots
15 of sort of smaller tactical things that we talked about,
16 but we also need to be keeping on our mind, and also
17 looking to the long term. So on the smaller tactical
18 things, just to recap a little bit, I don't want to lose
19 the point that Darin brought up about data and that the
20 panelists confirmed. You know, we did do a session at our
21 last meeting about data, or the lack thereof, and
22 continuing to sort of push on that front I think is going

1 to be important for us.

2 Also, the value-based conversation, and Kisha's
3 question about that I thought was really important, and the
4 responses on how we tie that together, also the social risk
5 adjustment, the housing, these are all threads of our work
6 that we can be more explicit and more deliberate about.
7 But more importantly just overall is the representation and
8 thinking this lens and everything we do and everybody we
9 talk to and all the things that we put forward.

10 Closing out then with thinking, again, what Renée
11 just said, what can we do that would be most anti-racist,
12 and I will just put my two cents in. I also would be
13 supportive of a layer around evictions, as Sheldon
14 suggested, so perhaps that's something we can take a look
15 at as well.

16 So, Kayla, you've gotten an earful of a bunch of
17 hopefully helpful areas of interest from the Commission.
18 Do you have any last comments for us as we conclude this
19 session?

20 MS. HOLGASH: I think I just want to thank you
21 for having meaningful discussion about it, and I'm excited
22 to begin and see where we can go next. So this has been

1 very helpful.

2 CHAIR BELLA: Well, thank you for putting this
3 panel together. I really appreciate that. And I know you
4 did a lot of prep work beforehand, so thank you very much
5 for that.

6 Thank you to the public who participated this
7 morning, and to the Commissioners, we are going to take a
8 break now, take a lunch break. We'll be back at 1:00 p.m.
9 We will start promptly at 1:00 p.m. with the discussion
10 around postpartum coverage. Thank you all very much.
11 We'll see you in a little under an hour.

12 * [Whereupon, at 12:06 p.m., the meeting was
13 recessed, to reconvene at 1:00 p.m. this same day.]

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1 AFTERNOON SESSION

2 [1:00 p.m.]

3 CHAIR BELLA: Welcome back, everyone. Just
4 another 30 seconds or so and then we'll get started.

5 [Pause.]

6 CHAIR BELLA: All right. Welcome back, everyone.
7 Thanks for joining the afternoon session of MACPAC. This
8 is a meaty subject area for us, so I don't want to lose any
9 more time.

10 Martha, I'm just going to turn it right to you
11 and have you lead us through it. Welcome.

12 **### EXTENDING POSTPARTUM COVERAGE: ADDITIONAL**
13 **ANALYSIS ON MANDATORY VS. OPTIONAL APPROACHES**

14 * MS. HEBERLEIN: Thank you.

15 So today we are going to continue our discussion
16 towards a recommendation on extending the postpartum
17 coverage period, with a particular focus on whether it
18 should be mandatory or a state option.

19 Before I start, I want to note that MACPAC uses
20 pregnant and postpartum women, as these are the terms used
21 in Medicaid statute and regulations. However, other terms
22 are being used increasingly, as they are more inclusive and

1 recognize that not all individuals who become pregnant and
2 give birth identify as women.
3 I will begin today by briefly recapping the
4 decisions that were reached during the last Commission
5 meeting before describing some of the key considerations
6 and the remaining issues that are before the Commission
7 today. I will conclude with next steps.
8 So, in October, I presented several options for a
9 package of recommendations to extend the postpartum period.
10 During the discussion, the Commission came to agreement in
11 several areas. The first was to extent the postpartum
12 period for 12 continuous months. The second was to mirror
13 this extension in CHIP, and the third was to reiterate an
14 earlier recommendation by the Commission requiring full
15 Medicaid benefits for pregnancy-related Medicaid
16 eligibility pathways.
17 The Commission was left with the key decision as
18 to whether to make the extension mandatory or provide
19 states with an option to extend the postpartum coverage
20 period. Also, while not discussed in detail in October,
21 the Commission may want to weigh in on the financing.
22 To inform your deliberations, you asked for

1 further information in a number of areas, including
2 additional detail on how an extension might impact health
3 equity and continuity of care, on who would be affected by
4 the extension, and how the effects would differ by state.
5 Today I will present available information in these areas.
6 As has been discussed previously, significant
7 racial and ethnic disparities exist in maternal and infant
8 health outcomes. Black, non-Hispanic, and Indigenous women
9 have two to three times higher pregnancy-related death
10 rates compared to white non-Hispanic women. Researchers
11 have also documented racial differences in risks of severe
12 maternal mortality and morbidity. Women of color are also
13 at greater risk of giving birth to a preterm or low-
14 birthweight baby.
15 While certainly not the only factor, as was
16 discussed during the last panel, gaps in coverage can
17 contribute to these poor outcomes. Despite gains in
18 coverage following the implementation of the Affordable
19 Care Act, disparities have persisted.
20 There are also racial and ethnic disparities in
21 insurance status and continuity of care when you look
22 specifically for women spanning the preconception to

1 postpartum period.

2 For example, one study found that three-quarters
3 of white, non-Hispanic women were continuously insured.
4 This was in comparison to 55 percent of Black, non-Hispanic
5 women, 50 percent of Indigenous women, and about 20 percent
6 Hispanic speaking -- Hispanic -- sorry -- Spanish-speaking
7 women.

8 So extending the postpartum coverage period would
9 provide women, including many who may otherwise become
10 uninsured, with new coverage options.

11 As discussed in October, almost 29 percent of
12 women -- I'm sorry. Almost 29 percent of women experienced
13 a change in coverage from delivery to postpartum, with
14 about 13 percent reporting being uninsured in the
15 postpartum period. In states that chose not to expand
16 Medicaid, the preconception rate of uninsurance was nearly
17 double that of expansion states, and the postpartum
18 uninsurance rate was nearly triple that of expansion
19 states.

20 Looking more closely at women specifically in the
21 postpartum period, the rates of uninsurance among new
22 mothers range from almost 30 percent in Texas and about 20

1 percent in Georgia and Oklahoma to less than 4 percent in
2 the District of Columbia, Hawaii, Massachusetts, Vermont,
3 and West Virginia.

4 Commissioners, there are additional state-level
5 data on your materials.

6 I also want to note that these uninsured numbers
7 include individuals who are not citizens and would not
8 likely be eligible for Medicaid under a postpartum coverage
9 extension because of their residency status or length of
10 stay in the U.S.

11 A forthcoming study from the Urban Institute and
12 the Commonwealth Foundation will look at the implications
13 if the postpartum coverage period was extended at a
14 national level. This analysis models eligibility for
15 uninsured new mothers at the state level, taking into
16 account both income and immigration status in determining
17 their eligibility. It finds that of the 441,000 uninsured
18 new mothers, approximately 28 percent, or 123,000 women,
19 would become newly eligible for Medicaid or CHIP through an
20 extension of the postpartum period.

21 Thirty-seven percent of Black, non-Hispanic
22 uninsured new mothers; 36 percent of white, non-Hispanic

1 new mothers; and 24 percent of Hispanic uninsured new
2 mothers would become eligible under an extension of the
3 postpartum coverage period.
4 Most, about 83 percent, of uninsured new mothers
5 likely to become eligible following an extension live in
6 non-expansion states, and nearly two-thirds of these new
7 mothers live in five states: Florida, Georgia, Missouri,
8 North Carolina, and Texas.
9 Finally, to continuity. Although individuals
10 would likely experience change at the end of the 12-month
11 coverage period, just as they would at the end of this
12 current 60-day postpartum coverage period, extending the
13 time frame would avoid disruptions during a more critical
14 clinical period. This would allow for continuity in terms
15 of benefits, cost sharing, and provider relationships for
16 women who would otherwise be uninsured as well as for women
17 who would have maintained coverage but shifted to a new
18 source.
19 For example, in one study of coverage changes,
20 almost 20 percent of individuals had to change at least one
21 provider. For new mothers, it may be especially important
22 to maintain the connection to providers who oversaw their

1 prenatal care and delivery. These providers may have a
2 better understanding of the woman's health history and
3 ongoing care needs, and women may have established a
4 trusting relationship with the provider.

5 At the end of the postpartum period, women who
6 remain eligible for Medicaid may face minimal changes in
7 terms of out-of-pocket cost, although the benefits may
8 differ, depending upon the eligibility pathway.

9 For those ineligible for Medicaid following the
10 postpartum period, subsidized exchange coverage may be
11 available if their incomes are above 100 percent of FPL.
12 Exchange coverage would require premiums and cost sharing,
13 and the available benefits would differ. Some individuals
14 may be ineligible for any coverage source.

15 Moving on to the remaining issues, currently,
16 states are not permitted to provide continuous postpartum
17 coverage beyond 60 days. Creating a state option to extend
18 such coverage would allow states to do so without a waiver.
19 Under a state option, however, it is reasonable to assume
20 that not all states will choose to adopt it, leaving some
21 individuals without coverage after a 60-day postpartum
22 period.

1 Given the current coverage landscape, an option
2 to extend the postpartum coverage period may be more
3 attractive to states that have not adopted the Medicaid
4 expansion, as it would fill in an existing gap in coverage.
5 However, of the 11 states that we discussed in October that
6 are seeking or implementing such an extension, seven are
7 Medicaid expansion states.

8 Making the extension a requirement would be more
9 a directive approach. It would also ensure that all
10 eligible postpartum individuals receive the same coverage
11 period, regardless of where they live, an approach that is
12 consistent with current policy.

13 It is important to note that regardless of
14 whether the extension is mandatory or optional, states
15 would continue to have flexibility to establish the income
16 eligibility levels and as such the specifics of which
17 postpartum women would be covered would remain a state
18 decision.

19 Extending the postpartum period would have
20 financial implication for states and the federal
21 government. States would potentially assume increases in
22 spending if postpartum women would have otherwise received

1 a higher matching rate; for example, if the woman was
2 covered under the new adult group or had been fully
3 federally funded in the exchange.
4 In addition, the current budget challenges states
5 are facing due to COVID-19 and the accompanying economic
6 downturn may make an extension of the postpartum coverage
7 period more difficult for states to assume on their own.
8 As such, the Commission may wish to include
9 additional federal funding as an enticement for an optional
10 extension or to help offset the cost of a mandatory one.
11 However, even with a higher matching rate under an optional
12 extension, states may not choose to extend the postpartum
13 period if it is not consistent with their other priorities.
14 There also may be offsets to the cost in terms of
15 reductions in future expenditures and improved outcomes for
16 both the mother and the child. For example, New Jersey
17 noted in its waiver application to extend the postpartum
18 period, that 53 percent of pregnant women who have lost
19 coverage postpartum reenrolled at some point over the next
20 two years. If these women had not received care to manage
21 chronic diseases or health risks or family planning
22 services, there may be an increased risk in any future

1 pregnancy and higher cost for the program.

2 Finally, as was raised at the last meeting,

3 extending coverage for a longer postpartum period may have

4 implications for the child. For example, studies have

5 shown that perinatal mood and anxiety disorders can lead to

6 adverse effects for both the mother and the child.

7 During today's session, the goal is to assess the

8 views of the Commission as it relates to whether the

9 postpartum coverage extension should be mandatory or state

10 option and whether additional federal funding should be

11 provided. Based on the outcomes, staff will return with a

12 package of recommendations for a January vote.

13 Before we move on to the discussion, I do want to

14 remind the Commission that in September, the U.S. House of

15 Representatives passed H.R. 4996, which would give states

16 the option of extending the postpartum care period from 60

17 days to a full year. It is unclear whether or not there

18 will be Senate action on the matter before the end of the

19 year.

20 And with that, I'll turn it back to you.

21 CHAIR BELLA: Thank you, Martha. I appreciate

22 you taking us through that so quickly because I want to

1 make sure we have time to get to each Commissioner.

2 I'm going to make a couple opening comments, and
3 then I see Tricia. And I'm sure many of the rest of you
4 want to talk.

5 As Martha said, we need to really come out with
6 some direction today on mandatory versus optional and also
7 on the notion of federal funding and if there's a
8 difference of opinion over amount of federal funding.

9 In order to kick us off, I'm going to give you a
10 straw-person position and hope that others then can join in
11 and share your thoughts or where you have concerns.

12 Based on the decisions we have in front of us, I
13 would advocate that this is mandatory and that it is
14 federally funded, and I say this for three reasons, the
15 first being we need to stop talking about how reprehensible
16 our maternal morbidity and mortality rates are in this
17 country and begin to take action. And this is a huge
18 opportunity for us to take action to address that.

19 Secondly, Congress has precedent. There is
20 history of extending coverage to address poor birth
21 outcomes, poor infant outcomes, and to me, this seems very
22 consistent with past direction by Congress in this area.

1 And lastly and for me most importantly, this is
2 all about equity and disparities and access, and as we
3 continue to talk about how this is so important to our
4 work, this is an opportunity for us to make a meaningful
5 impact in that regard. I would argue it should be our
6 highest priority or one of our highest priorities as we
7 think about what we might recommend as an investment.
8 I don't take it lightly to recommend that we
9 would federally fund something, but if we want to make
10 improvements and we want to make sure that every birthing
11 individual in the country has access to that kind of health
12 care, we cannot leave this up to state option, yet we also
13 cannot pass on an unfunded mandate to states, especially
14 with everything else we have going on.
15 For those reasons, that's what I'm putting out.
16 I would encourage you all to be very clear in your
17 position, and then we'll try to see how far apart we are
18 and try to give Martha some direction by the end of this
19 session.
20 So Tricia and then Peter.
21 COMMISSIONER BROOKS: Thank you, Melanie.
22 It is so true that our nation's maternal and

1 infant mortality and morbidity indicators are really an
2 embarrassment for a country as advanced and wealthy as
3 ours. We already recognize how critical the first year of
4 life is by ensuring that all babies born to moms covered by
5 Medicaid or CHIP have uninterrupted coverage until their
6 first birthday.
7 So aligning 12 months of mandatory postpartum
8 coverage is really about improving the health and well-
9 being of infants as well as their moms, and as you noted,
10 this is a huge issue of health equity because people of
11 color are disproportionately impacted by poor maternal
12 outcomes.
13 If we're serious about addressing health
14 disparities and ensuring that infants get the healthiest
15 start possible, we should guarantee 12 months of
16 comprehensive postpartum coverage for all pregnancy people
17 enrolled in Medicaid and CHIP with enhanced federal
18 funding.
19 So I'm right in your court on this, Melanie.
20 Thank you.
21 CHAIR BELLA: I saw Peter and then Kisha.
22 COMMISSIONER SZILAGYI: Yes. Thank you. I'll be

1 very brief.

2 But I also agree that postpartum coverage
3 currently is truly inadequate. We should extend it to 12
4 months. There is extensive literature that shows that the
5 mother's health directly affects the child's health and not
6 just during the first six months after a pregnancy.

7 Just as an example, postpartum depression is
8 almost as common between 6 months and 12 months after
9 pregnancy as it is right after pregnancy to 6 months.
10 There's ample evidence that postpartum depression affects
11 the health of children, and that's just one example.

12 I strongly favor extending both the 12 months and
13 to have federal funding for this because I worry about not
14 only the inequity within the Black, white, and Latino,
15 racial and ethnic inequity, but the inequity across states.
16 To me, it's a little bit of the same type of argument that
17 we had when we discussed CHIP many, many years ago. It's
18 that for a child, why should it matter so much if you live
19 in one state versus another state in terms of Medicaid
20 coverage? In a sense, to me, postpartum coverage mirrors
21 coverage for children.

22 Thank you.

1 CHAIR BELLA: Thank you, Peter.
2 Kisha and then Toby and then Martha and then Tom.
3 COMMISSIONER DAVIS: I want to agree with
4 everything that has been said for many of the same reasons.
5 Really, when we think about maternal care, we're
6 thinking about child care and how we care for our children
7 and our community.
8 The last conversation, we were talking about how
9 the social determinants of health affect the medical
10 outcome, all of the poverty and transportation and
11 environment, and this is really an opportunity where
12 medical care is affecting future social determinants of
13 health for those women who may not have health insurance or
14 suffering worsening morbidity and mortality because they
15 don't have insurance. That is affecting the downstream
16 health determinants of their children and their
17 communities. So really when we talk about getting
18 upstream, there's no more upstream that you can get than
19 the benefits of a child having a mother who is healthy and
20 has access to health care programs to treat their
21 illnesses, and so really making sure that that is 12
22 months, that it is comprehensive, that it's consistent with

1 CHIP, but also making it mandatory.

2 While it's great to hear that of the states who
3 have sought waivers, four of them are not expansion states.
4 How do we make sure that if it is just optional? There are
5 states that had enhanced matching funds and did not take
6 advantage of Medicaid expansion?

7 And I want to make sure, as Peter was saying,
8 regardless of what state you are in, taking care of our
9 pregnant women and birthing persons is something that we
10 feel is important and I think is one of our highest
11 priorities.

12 CHAIR BELLA: Thank you, Kisha.

13 Toby, Martha, Tom.

14 COMMISSIONER DOUGLAS: Yeah. I have a few
15 questions. Can you hear me okay?

16 CHAIR BELLA: Yes.

17 COMMISSIONER DOUGLAS: Questions for Martha. So,
18 first, I just want to make sure we're saying that -- well,
19 first of all, states are at different income levels for
20 their pregnancies, anywhere from 133 over 300 percent of
21 FPL. So when we talk about this extension, we'd be
22 continuing that difference; is that correct?

1 MS. HEBERLEIN: Yeah. So what we're talking
2 about doing is just extending the postpartum period. So it
3 wouldn't change the eligibility threshold as it currently
4 is.
5 COMMISSIONER DOUGLAS: Okay. I have partly a
6 question and partly making sure everyone understands that
7 there is, therefore, not creating true equity across this.
8 So that's one question.
9 The other is, for those -- you mentioned about
10 the expansion state. Is it fair to say the reason those
11 expansion states went in for those waivers is because they
12 were trying to capture the groups, because they're higher
13 income, that they know most of those states are going up to
14 250, 300? Is that true?
15 MS. HEBERLEIN: Yeah. I think that's true. I'm
16 thinking Illinois is at 200. So I think that is definitely
17 a part of it, and it's also sort of the continuity issue
18 where you're keeping the woman in, but it is to bring in
19 some of the women who would be above the Medicaid
20 expansion.
21 COMMISSIONER DOUGLAS: So if the states that did
22 the Medicaid expansion, the five states or two-thirds, that

1 we would be solving a lot, and then it would be really an
2 issue of these states that have gone higher, above 200?
3 That would be where the true problem is?
4 MS. HEBERLEIN: Yeah. In expansion states, yes,
5 that would be true, and then it's also in non-expansion
6 states, some of them go higher up the income level for
7 pregnant women as well. So in some states, it would be
8 filling in a hole above 133, even if they were non-
9 expansion states.
10 COMMISSIONER DOUGLAS: Yeah. Well, I don't want
11 to make this more complicated, but I am, which is just a
12 question around the mandatory version optional, looking at
13 this through the lens of whether it's 200 percent of FPL or
14 it's mandatory up to 200, if states want to go above that,
15 that it's an option to go 12 months, so something to
16 consider just around this.
17 The reason also, back to the scoring from a CBO
18 standpoint, those five states, they could be expanding
19 right now, Medicaid expansion 90-10. We might be saying
20 mandatory, 100 percent. Clearly, there's not that plus, or
21 just we're actually impacting, as Darin mentioned the last
22 time, the states that did do the Medicaid expansion for

1 those pregnant moms that are going to flip over to this
2 coverage. Should we do it optional, not at 100 percent?
3 Maybe they would wash out.
4 CHAIR BELLA: So, Toby, can you be very explicit
5 on what you're supporting?
6 COMMISSIONER DOUGLAS: I am sorry. I am
7 supporting mandatory, up to 200 percent extension for 12
8 months, and then if a state wants to go above that income
9 level then it would be optional.
10 CHAIR BELLA: With federal support?
11 COMMISSIONER DOUGLAS: With their normal federal
12 support, their normal FMAP.
13 CHAIR BELLA: And what about for the 200 percent.
14 COMMISSIONER DOUGLAS: 100 percent FMAP. Up to
15 200 percent, 100 percent. Sorry, I am not being clear.
16 CHAIR BELLA: All right. Thank you. Martha,
17 Tom, Kit, Kathy.
18 COMMISSIONER CARTER: First I want to align
19 myself with the position that Melanie stated so well. I
20 don't need to reiterate it.
21 But Martha, I have a specific question, maybe
22 kind of related to what Toby was asking. In our October

1 decision, the third one is to reiterate our March 2014
2 recommendation requiring full Medicaid benefits for
3 pregnancy-related eligibility pathways. I am concerned
4 specifically about the COVID vaccine and whether that would
5 be included in our recommendation.
6 So we recommended full Medicaid benefits, and
7 that actually doesn't happen right now, right, because
8 pregnant women have various pathways that they would enter
9 Medicaid, and that would be continued. Correct? So they
10 wouldn't necessarily be eligible for dental or for a NEMT,
11 and for adult vaccines, including COVID. I'm really
12 muddying, and I apologize, but do we want to make a
13 specific statement in line with our equity conversations
14 about some of these other services that we think are really
15 important for continuity of care, for example, COVID
16 vaccine?
17 MS. HEBERLEIN: So the recommendation that was
18 made before was to align Medicaid. So states have the
19 option of covering pregnancy-related services for women
20 whose income is above the old AFDC welfare standard. Only
21 a handful of states limit that coverage to pregnancy-
22 related services. And so as we talked about last time,

1 this recommendation would say that in those states,
2 everybody needs to be provided the same benefit package.
3 They can't limit the benefit package to pregnancy-related
4 services.
5 As for the COVID vaccine, we didn't talk about
6 that, and I think there's also -- I would argue there's
7 also other things we could talk about in terms of which
8 benefits might be important to a pregnant and postpartum
9 woman, such as dental or behavioral health. So, to me, I
10 personally separate the issues. I think we can certainly
11 acknowledge that there are benefits that are of particular
12 importance to pregnant women that may not be part of the
13 regular Medicaid benefit package, but the recommendation
14 that was made before was to remove the option for states to
15 limit it to pregnancy-related-only services. Does that
16 help?
17 COMMISSIONER CARTER: Yes, I think it does, and I
18 would reiterate that former recommendation, but perhaps in
19 another discussion, consider what services are really
20 important for states to provide to pregnant and postpartum
21 women.
22 CHAIR BELLA: Thank you, Martha. Tom and then

1 Kit.

2 COMMISSIONER BARKER: Thanks. Thanks, Melanie.
3 Martha, thank you for that presentation. I thought it was
4 very good and very helpful.

5 So first I support 12 months. I think that is a
6 good recommendation.

7 Martha, I wanted to ask you, the legislation that
8 the House passed, that you mentioned in your presentation,
9 was that -- so I know you said that that was an optional
10 benefit, but for the states that accepted the option, was
11 it just at their normal FMAP?

12 MS. HEBERLEIN: Yes. It was at the normal FMAP.
13 An earlier version of the House legislation included a
14 time-limited FMAP bump, but the version that passed out of
15 the House did not.

16 COMMISSIONER BARKER: So this is where I'm sort
17 of hesitating on full federal funding. Are there other
18 examples in the Medicaid program where the federal
19 government pays 100 percent of the cost of the benefit? So
20 I know, obviously, with the expansion, it is at 90 percent.
21 Are there examples where the federal government fully funds
22 a benefit in Medicaid?

1 MS. HEBERLEIN: I'm trying to think. I know that
2 there is also -- Chuck has got his hand up so maybe he can
3 provide an example -- but like family planning services is
4 at 90 percent. There might be others that I'm not thinking
5 of, but I can look into that more.
6 VICE CHAIR MILLIGAN: Coverage for Native
7 Americans through IHS and Tribal 638 is at 100 percent
8 FMAP.
9 COMMISSIONER BARKER: Okay. I guess I'll reserve
10 judgment on whether I support full federal funding, just
11 because that seems to be quite a precedent, if we are going
12 to be taking that position.
13 CHAIR BELLA: So just to push you on that, do you
14 support federal funding and it's a question of whether it's
15 100 percent or a different amount?
16 COMMISSIONER BARKER: Yes, exactly. Oh, yeah,
17 yeah. I'm not suggesting it's just up to a state. To me,
18 the issue is, is it either the state's regular FMAP, an
19 enhanced match, like 90 percent, like it is for IT or the
20 expansion, or is it 100 percent?
21 CHAIR BELLA: Okay. Thank you. Kit and then
22 Kathy.

1 COMMISSIONER GORTON: Wrong button. So I won't
2 reiterate all the arguments. I will say for many years I
3 have been a proponent of federalism and state options and
4 state flexibility, and I still think that there are things
5 which states, left to their own devices, do better than a
6 centralized directive might get them to do.
7 That said, in the last year, thinking more deeply
8 about this whole question of institutional bias and
9 structural racism, and the session this morning gave me
10 some new words. I need to think about how to use them
11 properly. But I am persuaded that what the panel this
12 morning called the racialization of Medicaid is a real
13 thing. And I was heartened by her insistence that that is
14 not intentional, that there is not a motive behind is, but
15 that is just the way the system has evolved.
16 And so we need to address that, and so I am
17 persuaded that we should do this, with a recommendation
18 towards mandatory rather than optional, because that's how
19 we address it. And I would say, to Tom's point, that if
20 you think about what Chuck said, the example of where we
21 have 100 percent coverage, is in a place where there has
22 been systemic bias against the population being served,

1 which are the tribes on the reservations. So that might
2 not be enough of a precedent for a lawyer, but it is at
3 least enough of a precedent for me.

4 I would say that I believe that if we are going
5 to have a federal mandate then there ought to be federal
6 funding, because I think many times states don't take up
7 optional benefits because they can't come up with a state
8 share.

9 And so I would support a mandatory, full benefit
10 in Medicaid for 12 months, with full federal funding at 100
11 percent. I could live with 90 percent. I think it would
12 be unfair to the states to give them a mandate for 12
13 months of full benefit postpartum Medicaid and not give
14 them enhanced match.

15 CHAIR BELLA: Thank you, Kit. Kathy.

16 COMMISSIONER WENO: Martha already answered my
17 question so thank you. But I will align myself with Team
18 Melanie on this one.

19 CHAIR BELLA: Thank you, Kathy. Peter, did you
20 have your hand up again? And then there are a few of you
21 who haven't spoken who it would be really nice to hear
22 from. Fred, thank you for taking that prompt. You can go

1 after Peter.

2 COMMISSIONER SZILAGYI: Yeah, I actually had

3 forgotten. Thank you. I actually just wanted to amend

4 what I said before, that I could also support 90 percent.

5 I was actually going to suggest that, absolutely, full

6 funding, you know. I mean, I think the concept of enhanced

7 federal funding is really important, and I actually was not

8 as familiar with exactly what is at 90 percent. I didn't

9 realize about the IT, Tom, so I thought your point was

10 really good. But I would ideally have full funding but I

11 could still support something like 90 percent.

12 CHAIR BELLA: Thank you, Peter. Fred?

13 COMMISSIONER CERISE: Yeah, I was going to ask

14 Tom's question too, just because, you know, I do have

15 concerns over 100 percent, as Medicaid is a state-federal

16 program and there are a lot of other things that I think

17 are very important that states don't get to, that you could

18 make an argument for 100 percent federal. And I realize,

19 you know, on an important issue like this maybe you need to

20 start somewhere.

21 But my preference would be to look at the fact

22 that 83 percent of the eligibles are in non-expansion

1 states, and there is interest among non-expansion states in
2 this population, you know, there are various reasons why
3 they don't expand, but there's significant interest in this
4 population. A 90/10 option would draw in--I think would be
5 a significant inducement for those non-expansion states to
6 include this population. So that would be where I would
7 align.

8 CHAIR BELLA: Thank you, Fred. Chuck?

9 VICE CHAIR MILLIGAN: I take myself off mute.

10 I am in support of mandatory. I tend to be
11 closer to the 90 percent than the 100, partly for
12 operational reasons around women in older adult group, or
13 the expansion group, who become pregnant and state tracking
14 and reporting, different match rates, and people going in
15 and out of different match rates. I tend to think that
16 operationally that would have issues.

17 And, I mean, I did reference Native Americans,
18 and Kit, I take your point about it could be precedent,
19 from an equity and that kind of policy lens. I think the
20 Native American 100 percent FMAP is really a reflection of
21 a somewhat flawed attempt by the federal government to
22 fulfill its treaty obligations, which are quite unique in

1 terms of sovereignty.

2 But if the Commission as a whole is closer to 100
3 percent, I would not vote in opposition to that. Let me
4 just be clear about that.

5 The other thing where I think, Toby, the
6 discussion you led was extremely helpful, is I'm probably
7 more aligned to having the mandatory coverage equate to the
8 older adult group, the 133, 138. But again, to me, if the
9 Commission as a whole landed where Toby proposed, around
10 200, I would not be in opposition to that. But that would
11 not be my initial preference.

12 COMMISSIONER DOUGLAS: Can I just say on that,
13 and make sure Chuck understands, the reason I was using 200
14 is because they come in as a pregnant mom at 200. Once
15 they get into the child, their income, they are going to go
16 down with the two. That was the reason.

17 VICE CHAIR MILLIGAN: And, Toby, thank you for
18 the clarification. I could support whatever the kind of
19 broader --

20 COMMISSIONER DOUGLAS: I was trying to what
21 you're doing, track the Medicaid expansion. So whatever
22 that incoming level is that tracks when they switch groups.

1 VICE CHAIR MILLIGAN: And what I was tracking was
2 in states that maybe the Medicaid expansion adult is at the
3 138, 133. And so there's a women who might be in exchange
4 coverage at 150, moving in and out of Medicaid, like
5 continuity of care providers, all of those implications.
6 But again, I don't want to muck this up.
7 Melanie, you kind of wanted to get a sense of the will of
8 the Commission. I'm with mandatory, I'm with enhanced
9 FMAP. My preference is 90 but I won't oppose 100. My
10 preference is having the mandatory coverage mirror the
11 older adult group, but I won't oppose a different threshold
12 if the Commission as a whole lands in a different place.
13 CHAIR BELLA: Thank you.
14 MS. HEBERLEIN: Melanie, can I just jump in for a
15 second? I just wanted to add that the COVID testing group
16 is at 100 percent FMAP. Thanks, Joanne.
17 CHAIR BELLA: Stacey, are you wanting to speak?
18 I can't tell.
19 COMMISSIONER LAMPKIN: Yeah. I really appreciate
20 everybody's really thoughtful, passionate comments on this.
21 This one is really a thorny one for me. I've been kind of
22 wrestling with what I think is the best solution. And I

1 will vote for any recommendation because I think this is
2 important. I could go for the Melanie position; it
3 wouldn't be my preference, that Full Monty kind of
4 solution.
5 I think, for me, this is really -- my normal bias
6 is to think about the federalism and giving the states the
7 option and regular FMAP. So I'm sort of aligned with the
8 language in the existing House bill, I guess, mostly. If
9 we do make it mandatory then I think it needs to be 90
10 percent funded, but I guess to get there mentally I have to
11 think about this as just being a new part of the federal
12 floor for the program. And maybe it is important enough to
13 do that. I hear everything that all of you are saying.
14 So my preference is the optional, but I could
15 live with the mandatory if it has some extra money with it.
16 Maybe 90 is the best.
17 Oh, I really liked the income threshold that Toby
18 and Chuck were just talking about too.
19 CHAIR BELLA: Thank you, Stacey. Sheldon?
20 COMMISSIONER RETCHIN: Yeah. Am I on?
21 CHAIR BELLA: You are.
22 COMMISSIONER RETCHIN: Okay. So I support the

1 Melanie, Toby, Chuck position, and I don't know where that
2 is but I'm sort of like O Brother, Where Art Thou? I'm
3 with you guys.
4 So I don't see how -- I think we've already seen
5 what happens with a mandate at 90/10. States get twitchy
6 and they go to the Supreme Court and they win. So I'm in
7 favor of 100 percent federally funded, mandatory.
8 And then on the income level, I'm not sure where
9 I fall, but Chuck and Toby have raised an important point.
10 To me it would also involve the inequities across states,
11 with the different income level. So that's where I am.
12 CHAIR BELLA: Thank you, Sheldon.
13 COMMISSIONER GORDON: Yeah. So I'm like Stacey.
14 This is such a complicated issue and it's one that needs to
15 be addressed. There’s no debate of doing something here.
16 I'm struggling. If it's mandatory I do believe it would
17 need to be 100 percent, because that's where I struggle.
18 I hear all the issues that Tom and Chuck brought
19 up with regards to that and others about 100 percent
20 federally funded portion of the program, but that's the
21 only way I feel comfortable with the mandate aspect of it
22 in the program.

1 I do believe there has been pretty diverse
2 interest by states in doing this, and I think 90/10 funding
3 would only expand that interest in doing something for this
4 population, and we can debate whether or not, you know, if
5 that would be sufficient to bring everyone in, or if
6 there's still going to be differences from state to state,
7 and there likely could be for some period of time.
8 But I just struggle, as a state administrator, in
9 juggling all the different priorities, and there's many in
10 Medicaid that need to be addressed. And again, that's not
11 to undermine the importance of this particular one. But if
12 we are talking about a mandate, I think the only way I
13 could get behind it is if it was 100 percent federally
14 funded.
15 Optional, I think that 90/10 funding would make
16 it very much appealing to a broad swath of the country, and
17 I agree with Toby's and Chuck's income comment, at what
18 income level. But that's where I stand on this issue.
19 CHAIR BELLA: Thank you, Darin. Any other
20 comments? Leanna, I'm sorry. Leanna and then Bill and
21 then Brian.
22 COMMISSIONER GEORGE: Yes, I just want to say

1 that -- can you hear me?

2 CHAIR BELLA: We can hear you.

3 COMMISSIONER GEORGE: Okay, good. I'm also for

4 the mandatory 12-month postpartum coverage increased up to

5 -- or the level can be discussed a little bit more. I'm

6 leaning toward 200 percent. And the primary reason, of

7 course, is concerns about continuity of care, but also for

8 preventing lapses in coverage for moms who may have dropped

9 off the employer's insurance plans, who don't live in the

10 expansion states, and for moms who are caring for a child

11 who was born with sensitive health needs that prevents

12 employment while they're caring for that first year of life

13 of that child with those needs. So those are the big two

14 reasons I'm in support of this.

15 CHAIR BELLA: And where are you on the funding,

16 Leanna?

17 COMMISSIONER GEORGE: The funding? Enhanced --

18 I'm leaning more towards enhanced, but 100 percent would be

19 fine by me, too. Either way with that would be good.

20 CHAIR BELLA: Okay. Thank you. Bill and then

21 Brian.

22 COMMISSIONER SCANLON: Yeah, I have great

1 difficulty with this, and I actually lost you all because
2 we had a power outage here. But, Melanie, I agree with
3 your premises for why these recommendations would be
4 important. But I'd also worry that the same premises would
5 apply to other areas such as behavioral health, such as
6 long-term services and supports. And to think about this
7 in sort of isolation and make recommendations about this
8 without considering the bigger picture and asking for 100
9 percent federal funding of something to me is too big of a
10 leap without sort of that kind of broader consideration.
11 So I would be comfortable with encouraging the
12 Congress to have increased FMAP but not recommending an
13 absolute dollar -- an absolute sort of precise amount that
14 they should increase the FMAP, but warn them sort of about
15 the fact that this is such an important area that they may
16 want to consider this when they're considering sort of how
17 they're going to allocate all kinds of money for other
18 purposes as well.
19 Since the sense of the Commission is for
20 mandatory, I guess I'm also -- I'm willing -- like Chuck,
21 I'm not going to oppose sort of that in terms of the
22 Commission. But I also would sort of point out that

1 mandatory versus optional doesn't really necessarily buy
2 you much. There are all kinds of other policy parameters
3 within a benefit that determine actual access to services,
4 and so how it's implemented is going to matter a lot. And
5 one of the things to be thinking about is that if it's a
6 mandatory benefit, is this going to be revisited in terms
7 of whether the benefit is working the way we expect it?
8 CHAIR BELLA: Thank you, Bill. Glad your power's
9 back on.
10 COMMISSIONER SCANLON: I am, too.
11 CHAIR BELLA: Brian.
12 COMMISSIONER BURWELL: I'm just trying to clarify
13 the decision making here, because I see three different
14 things to decide. One is mandatory versus optional. And I
15 think the sense of most -- although I have heard support
16 for optional, most are mandatory.
17 Second is if it's mandatory, what the FMAP is,
18 between 90 or 100. And I'm not really sure what the sense
19 of the Commission is there. It seems to be fairly equally
20 divided.
21 And the third is income level up to which the
22 enhanced FMAP would apply. Now, I'm with Sheldon. I'm

1 kind of -- I'm not really sure what's on the table. And if
2 Toby or Chuck -- if Chuck could clarify what's on the
3 table, that would be helpful. That's it.
4 CHAIR BELLA: So, Brian, do you need that
5 clarification, or can you tell us where you are on
6 mandatory and funding?
7 COMMISSIONER BURWELL: I'm with mandatory at 90
8 percent.
9 CHAIR BELLA: Okay. I don't know that Chuck or
10 Toby were necessarily putting a position down. I think
11 they were raising the issue, but I'll let them clarify if
12 they're putting a stake in the ground.
13 VICE CHAIR MILLIGAN: Well, to Toby, why don't
14 you frame it up? I think you did a nice job illuminating
15 the issue, so I'll defer to you on framing it.
16 COMMISSIONER DOUGLAS: Sure. So what I was
17 trying to convey is right now states are all over from 133
18 up to 300 percent on the pregnancy coverage, which then
19 means the extension for 12 months would continue for that
20 population. We know that most of the impacts -- that two-
21 thirds of it is in the five states that haven't done the
22 Medicaid expansion. So if our goal is both to address the

1 large number that aren't getting the coverage for the 12
2 months plus at least for me trying to create some level of,
3 you know, equity across the states, using the 138 Medicaid
4 expansion, whatever that equates to under pregnancy only --
5 let's say it's 200 percent -- is where you would say that
6 is the mandatory 12-month extension. And then anything
7 above that would be an optional. It still would be allowed
8 to go for 12 months, but it would be optional at the normal
9 FMAP rate. And up to the equivalent of the Medicaid
10 expansion would be at the enhanced or 100 percent FMAP
11 rate, whatever the Commission chooses.
12 COMMISSIONER BURWELL: Okay.
13 COMMISSIONER DOUGLAS: Is that your position,
14 too, Chuck?
15 VICE CHAIR MILLIGAN: To me -- and I think Toby
16 and I are in the same neighborhood, probably, maybe the
17 same exact street, maybe the same address. To me it was to
18 ensure that a woman who would now potentially roll off of
19 pregnancy-related coverage would have coverage equal to
20 mandatory coverage, full benefits equal to the older adult
21 group. So at the enhanced matching rate, wherever we land.
22 And I agree with Toby to have kind of an optional, at-

1 normal FMAP above that, but to me it was to ensure that if
2 a women might come off coverage after a couple of months
3 now, that she be -- she receive a year guaranteed mandatory
4 coverage at an income level no lower than the older adult
5 group eligibility. That's where I'm at.
6 But, again, to me, if the will of the Commission
7 is in a different place on the eligibility threshold,
8 that's not going to predispose me to oppose it.
9 CHAIR BELLA: So let me try to summarize where I
10 think we are, and, Martha, like maybe tag-team this with
11 you a little bit.
12 So, first of all, I know this is not an easy
13 slam-dunk, right? It's complicated, and I feel like
14 everybody’s really engaged in very deliberate thought
15 around it, so thank you for that.
16 I am hearing that the majority of folks support
17 mandatory, and those that may not have that as their first
18 preference will not oppose that in a recommendation, so,
19 Martha, I'd like to say we have mandatory as the stake in
20 the ground. I feel like I heard the same thing around
21 federal funding, that even -- there are some folks that may
22 not love federal funding, but they could support federal

1 funding, and the majority of folks agreed that there should
2 be enhanced federal funding. So I would put that as a
3 stake in the ground.
4 And the questions that we need to answer next
5 month is the amount of funding, and to me that question is
6 whether it's 90 or 100. And then, Martha, I would ask that
7 you take this conversation back about the income level and
8 bring back to us either any additional illuminating
9 information that we should consider if we want to qualify
10 our recommendation, or anything else that you think might
11 be helpful to us. But I feel like that's information that
12 you can come back to us that we can digest in time, in kind
13 of real time, and it won't impact our ability to take a
14 vote on a recommendation next month.
15 Do you agree with that? Or do you have concerns
16 with that piece, more clarity that we could give you there?
17 MS. HEBERLEIN: No, I mean, I think I can -- what
18 I can do is like give you a chart with the income
19 thresholds, which is in your materials, but make it more
20 clear as to where states are above -- would be above 133
21 and where the mandatory/optional cut would be, assuming we
22 went with Toby's proposal. That's doable in the next month

1 for sure.

2 CHAIR BELLA: Okay. Are people comfortable with
3 that approach and are you comfortable with the stakes of
4 Martha bringing back our recommendation of mandatory with
5 federal funding and then our discussion next month is
6 around whether it's 90 or 100 and then looking again at the
7 additional data around whether we want to have a cutoff
8 above which it becomes optional? Is anyone uncomfortable -
9 -

10 COMMISSIONER DOUGLAS: I do want to -- well, I
11 just want to say if I and Chuck living on the same street
12 are really in a minority, then I don't want to make all
13 that work, and so I guess the question is: Is this
14 something more the Commission -- Melanie, did you --
15 because I don't want to create a lot of work for something
16 that is -- that's all I'll say.

17 CHAIR BELLA: Well, let's be highly scientific.
18 Can we take a show of hands on whether we would like to
19 include in the recommendation the Chuck/Toby
20 neighborhood/street approach?

21 [Show of hands.]

22 CHAIR BELLA: Is anybody counting? Can you keep

1 your hands up, please, so that we can -- and you can't half
2 -- folks that are trying to put your hand halfway up,
3 that's not fair.
4 Okay. I think it's worth Martha bringing that
5 back to us. There is enough interest, so yes, thank you,
6 Toby, to make sure there is not unnecessary work.
7 And, Anne, did you have a comment to make?
8 EXECUTIVE DIRECTOR SCHWARTZ: Well, I was just
9 going to say it's a modest amount of work. It's basically
10 taking the information that we have and displaying it for
11 you in a way that's compelling. And so it's not like we
12 have to go out and knock on doors or do a bunch of heavy-
13 duty data analysis. It's ultimately a normative decision,
14 but you can at least see the implications.
15 CHAIR BELLA: Okay. Are there -- I want to make
16 sure that if anybody has any additional comments, you have
17 an opportunity to make them now.
18 [No response.]
19 CHAIR BELLA: Martha, anything else from your
20 perspective?
21 MS. HEBERLEIN: No. Thank you. This was really
22 helpful to move it forward.

1 CHAIR BELLA: Okay. We are slated to take public
2 comment after the next session, so we'll go ahead and move
3 into the next session. Thank you, Martha.
4 Joanne is going to review the interim final rule
5 that came out, and, again, we'll take public comment on
6 both of these topics at the end of this session. Welcome,
7 Joanne.
8 ### **REVIEW OF INTERIM FINAL RULE AFFECTING MEDICAID**
9 **PROVISIONS OF THE FAMILIES FIRST CORONAVIRUS**
10 **RELIEF ACT**
11 * MS. JEE: Hello. Okay. So in this next
12 session, I will summarize the recently issued interim final
13 rule with comment. It implements provisions of the
14 Families First Coronavirus Response Act related to the
15 increase in federal Medicaid match.
16 Okay. I'm going to start with just a very high-
17 level overview of the interim final rule with comment.
18 Then I'll quickly review the key provisions of the Families
19 First Act, which this rule is addressing. Then we'll go
20 into some more detail about the continuous coverage
21 provisions and the COVID-19 vaccine coverage provisions in
22 the rule. And then, lastly, I'll present some potential

1 areas, Commissioners, that you may wish to think about
2 commenting on.
3 So the interim final rule with comment was
4 published in the Federal Register. The slide says the 2nd,
5 but it was actually on the 6th. I apologize for that. The
6 effective date, though, is November 2nd. Comments are due
7 on January 4, 2021, and like I said, it does address those
8 key provisions of the Families First Act that we've talked
9 about a few times at Commission meetings.
10 I just also want to note quickly here that the
11 interim final rule also addresses numerous other provisions
12 that are outside of Medicaid, and we will not be discussing
13 those.
14 So, Commissioners, you will recall that the
15 Families First Act provides states and territories a
16 temporary 6.2-percentage-point increase to the federal
17 medical assistance percentage, or FMAP. That is in effect
18 through the end of the quarter in which the PHE ends. To
19 qualify for the FMAP, states and territories must maintain
20 eligibility standards, methodologies, and procedures that
21 are no more restrictive than those in effect on January 1,
22 2020. States may not charge premiums that exceed those in

1 place on January 1st. States must cover without cost
2 sharing COVID-related testing services and treatment, and
3 this would include vaccines. And, lastly, states may not
4 terminate coverage of beneficiaries enrolled as of the
5 beginning of the PHE or who become enrolled during the PHE,
6 with some exceptions. And this is, of course, the
7 continuous coverage requirement, which is in effect through
8 the end of the month in which the PHE ends.
9 So turning to the continuous coverage provisions,
10 prior to the interim final rule with comment, CMS had
11 provided guidance to states primarily in the form of FAQs
12 on the maintenance of effort and continuous coverage
13 requirements. That prior interpretation was that states
14 must maintain beneficiary enrollment in the same amount,
15 duration, and scope of benefits that were in effect on or
16 after March 18, 2020.
17 So what this meant was that even if states
18 received information about a change in the beneficiary's
19 circumstance that would make him ineligible for Medicaid or
20 eligible for a different eligibility category, the state
21 could not disenroll that person or move him to another
22 eligibility group.

1 So, for example, states could not disenroll
2 individuals from full benefit Medicaid even if they turned
3 65 and became eligible for Medicare. This also meant that
4 states had to continue providing the EPSDT benefit to
5 individuals even if they turned 21 and were thus no longer
6 eligible for EPSDT.
7 The prior interpretation also meant that states
8 could not make changes to benefits such as reducing the
9 number of visits covered.
10 States expressed concern over this
11 interpretation. For example, in October we had officials
12 for Kentucky and California serve on a panel, and they
13 described what returning to routine renewal operations
14 would mean for their states, and they expressed concern
15 about the time and resources it would take to make their
16 way through the renewal backlog that accrued during the PHE
17 as a result of the continuous coverage requirement.
18 They also expressed concern about the
19 interpretation and its limiting effect on actions they
20 could take to address budgetary constraints and the fiscal
21 challenges that arise from the economic fallout of the
22 pandemic.

1 The interim final rule with comment provides
2 CMS's new interpretation of the continuous coverage
3 requirement, and that new interpretation is that states
4 must maintain Medicaid enrollment in one of three tiers of
5 coverage for validly enrolled beneficiaries through the end
6 of the month in which the PHE ends.
7 So we're going to break down that new
8 interpretation, and we'll start with the idea of validly
9 enrolled. So the interim final rule does refer to this
10 group of individuals. It's a new term, individuals are
11 validly enrolled if they've had an eligibility
12 determination, and in general beneficiaries are considered
13 to be validly enrolled unless that determination was
14 erroneous due to an agency error or beneficiary fraud for
15 which there was a conviction, or abuse. Individuals in a
16 presumptive eligibility period that have not had a full
17 determination are not considered validly enrolled.
18 The rule also introduces the concept of tiered
19 coverage. Tier 1 coverage is coverage that qualifies as
20 minimum essential coverage, or MEC. And as a reminder, MEC
21 is coverage that fulfills the individual mandate for
22 coverage under the ACA. This includes most Medicaid

1 coverage, CHIP, and Medicare. Coverage under a Medicare
2 Savings Program is also considered Tier 1 coverage because
3 individuals with MSP coverage also have Medicare, and as I
4 said, Medicare is considered MEC.
5 Tier 2 coverage is non-MEC coverage that includes
6 COVID-19 testing and treatment, including vaccines. An
7 example of Tier 2 coverage would be coverage for Medicaid
8 pregnancy-related services.
9 Tier 3 coverage is the least robust. It is non-
10 MEC coverage with limited benefits and no coverage for
11 COVID-19 testing or treatment. This includes, for example,
12 Medicaid coverage for family planning services or -- for
13 just family planning services or just tuberculosis-related
14 services.
15 The rule notes that beneficiaries in this tier
16 may be eligible under the optional COVID-19 testing group
17 as well, and that was established by the Families First
18 Coronavirus Response Act, and that they may also be
19 eligible under the COVID-19 claims reimbursement program,
20 which HRSA runs, to pay for vaccines and their
21 administration.
22 The interim final rule with comment also permits

1 states to transition beneficiaries to new eligibility
2 groups if they are so eligible and the new eligibility
3 group provides at least the same or a higher tier of
4 coverage.

5 For example, a beneficiary enrolled in Tier 1
6 coverage determined no longer eligible for that group but
7 eligible for another Tier 1 coverage group could be
8 transitioned to that new eligibility group. But if that
9 person is found eligible for a Tier 2 or a Tier 3 group,
10 which is a lesser level of coverage, the state may not
11 transition that individual to the new group but must
12 maintain that person's Tier 1-level coverage.

13 There is a special rule for those in Tier 3
14 coverage, and that is that individuals with Tier 3 coverage
15 can transition to Tier 1 or Tier 2, so to a higher level,
16 but if that individual is eligible for a different Tier 3
17 coverage group, the state must maintain that person's
18 original Tier 3 coverage. And that's because of the wide
19 variation in the Tier 3 coverage groups.

20 The rule and preamble are not explicit on whether
21 notice and appeals rules apply to the transitions between
22 coverage tiers. However, in order to make transitions,

1 states would need to conduct an eligibility determination,
2 in which we case we think that the federal rules would
3 apply for notice and appeals.
4 If a validly enrolled individual becomes
5 ineligible for Medicaid entirely, states must maintain that
6 same tier of coverage for that person, and that individual
7 may not be disenrolled.
8 Under the interim final rule, validly enrolled
9 individuals may be terminated from coverage under certain
10 circumstances. So states may disenroll a person if that
11 beneficiary requests termination, if the beneficiary is no
12 longer a resident of the state, if the beneficiary dies, or
13 if a PARIS match indicates that that beneficiary is
14 enrolled in Medicaid in two states and his or her residency
15 cannot be verified.
16 As a reminder, PARIS is the Public Assistance
17 Reporting Information System, and it's the system of data
18 matching that states use to find beneficiaries receiving
19 benefits in more than one state.
20 The interim final rule also requires that in
21 states that have opted to cover lawfully residing immigrant
22 children and pregnant women during the five-year waiting

1 period, that such coverage be limited to emergency only
2 services if those individuals no longer meet the definition
3 of lawfully residing.
4 States may also terminate coverage for
5 individuals who are not validly enrolled, and states doing
6 that would remain eligible for the 6.2 percentage point
7 increase.
8 The preamble notes that before terminating
9 coverage, states must first determine whether the
10 individual is eligible under other coverage groups, provide
11 notice and opportunity for a state hearing, and again,
12 these protections are stated in the preamble.
13 The rule also permits other programmatic changes.
14 These include allowing states to modify covered benefits,
15 such as eliminating optional benefits, modifying coverage
16 limits, and imposing utilization control measures. States
17 may establish or increase beneficiary cost sharing within
18 permissible limits, and states may increase beneficiary
19 liability under post-eligibility treatment of income, which
20 is commonly referred to as PETI. And PETI calculations
21 determine how much an individual in an institution must
22 contribute to the cost of their care.

1 The preamble states that before these actions are
2 taken, states must provide notice, that the actions may not
3 be retroactive, and that services must still be sufficient
4 in amount, duration, and scope to reasonably achieve their
5 purpose.
6 So now to switch gears to vaccine coverage, the
7 rule restates the requirement that during the public health
8 emergency, states must cover COVID-19 vaccines and their
9 administrations without cost sharing if they wish to remain
10 eligible for the 6.2 percentage point increase in FMAP.
11 States must make payments for administration of
12 the vaccine or for provider visits in which the vaccine is
13 administered. This does not apply for beneficiaries who
14 are eligible for only a narrow scope of benefits in
15 Medicaid, such as those with coverage for family planning
16 services only or TB-related services only.
17 The rule also clarifies that once the public
18 health emergency ends, typical Medicaid rules apply for the
19 coverage of the COVID-19 vaccine. This means that states
20 must cover ACIP-recommended vaccines and their
21 administration at no cost for certain populations. These
22 populations include children under 21, adults with coverage

1 under the alternative benefit plans, and adults in states
2 that have elected to receive a 1 percentage point increase
3 in FMAP for vaccine-related spending and for providing
4 those vaccines with no cost sharing.

5 Once the PHE ends, vaccine coverage would become
6 optional for certain other groups, such as individuals
7 enrolled on the basis of disability, parents and pregnant
8 women, and cost sharing would be allowed.

9 Commissioners, I just wanted to remind you here
10 that Chris and Amy described these existing mandatory and
11 optional coverage policies for vaccines during the
12 September meeting, and they also noted then that the
13 policies are statutory. So CMS could not alter these
14 policies or provide for more expansive vaccine coverage
15 through rulemaking.

16 All right. So, Commissioners, you may choose to
17 submit comments on this interim final rule with comment,
18 but you are not required to do so. However, if you would
19 like to, there are some potential areas for comments that
20 we would like to flag for you. A MACPAC letter could
21 comment on the need for early CMS guidance on returning to
22 routine operations post-PHE.

1 So I will note here that the rule focuses on
2 eligibility and enrollment with respect to the continuous
3 coverage requirement during the PHE, but states and MACPAC
4 have highlighted the need for this post-PHE guidance. And
5 so this might be an opportunity to just restate that.
6 A letter could comment on whether regulatory text
7 needs to be explicit about beneficiary protections in
8 places where it currently is not. A letter could address
9 whether the regulatory text needs to be explicit with
10 respect to notice and appeal rights for individuals
11 transitioning between coverage tiers, and you may wish to
12 weigh in on whether another eligibility determination
13 should be required for validly enrolled individuals losing
14 eligibility at the end of the PHE, which I guess kind of
15 relates back to that first bullet.
16 So just a few more topics you might want to
17 consider. They are appropriateness of the definition of
18 validly enrolled, the reasonableness of the tiered coverage
19 approach, and the approach for ensuring coverage for the
20 COVID-19 testing and treatment that would apply for
21 individuals in Tier 3 coverage, and the balance in the rule
22 between beneficiary protections and state flexibility.

1 That's all that I have for you, and I'll turn it
2 back for your discussion. I will just say that if you
3 decide to send a letter, staff will draft it based on your
4 conversation this afternoon.
5 Thank you.
6 CHAIR BELLA: Thank you, Joanne.
7 All right. I want to see if we have questions
8 for Joanne and then get the will of the group on a comment
9 letter and where we might want to comment.
10 I saw Brian, then Martha, then Peter.
11 COMMISSIONER BURWELL: Thanks, Joanne. That was
12 a great presentation.
13 I have a couple of questions about how the rule
14 affects vaccines for COVID vaccines. One is states are
15 required to cover the costs of administration. Does that
16 mean that anyone who administers vaccines has to be a
17 Medicaid-certified provider, which may limit access?
18 And the second is I'm concerned that with the
19 undersupply of vaccines that there may end up being a
20 private market for vaccinations. Is allowed for non-
21 Medicaid providers to provide -- administer vaccines at a
22 cost to the Medicaid population but not bill Medicaid?

1 MS. JEE: The providers would need to be Medicaid
2 providers.
3 COMMISSIONER BURWELL: Okay. So that limits it.
4 CHAIR BELLA: Did you have anything else, Brian?
5 COMMISSIONER BURWELL: No.
6 CHAIR BELLA: Okay. Martha and then Peter.
7 COMMISSIONER CARTER: Thank you, Joanne.
8 There's a lot here, and I'm in support of sending
9 a letter. The details, I think, we would need to work out
10 over time.
11 I have a few points that really struck me, and
12 other people probably heard others.
13 The first was that non-inclusion of presumptive
14 eligibility in validly enrolled. Tailing on our previous
15 conversations today, a lot of pregnant women enter Medicaid
16 under presumptive eligibility, and that's how people enter
17 Medicaid in early pregnancy when diagnosis and conditions
18 beginning to adapt lifestyle changes is really important.
19 So to eliminate presumptive eligibility for this group
20 would be a major step back in equitable care.
21 My second point is something I raised last time,
22 and it has to do with the notice and fair hearing

1 requirements. I think there definitely should be notice,
2 good notice for beneficiaries to respond, and again,
3 something that I said last time was that 10 days is just
4 not enough, especially as we're looking at potential of
5 people being evicted from their homes in the next couple of
6 months. People need adequate time to receive the notice
7 and to respond. So I take major exception to that.
8 I think the other concern is the non-provision of
9 COVID vaccines for the people who are in the limited
10 benefits package, and I think that's just, again, a major
11 public health issue.
12 And finally -- well, that's probably enough.
13 There's some questions about if that isn't reinstated and
14 the people who are in limited benefit packages have to get
15 their vaccine someplace else, and there isn't actually good
16 guidance out there about who can do that and how much they
17 get paid. And that's sort of a separate question, and
18 really the issue should be that everybody should be
19 eligible for vaccines through the end of the public -- I
20 mean past the end of the public health emergency if we want
21 to turn this thing around.
22 That's all I got for now.

1 CHAIR BELLA: Thank you.

2 Peter and then Darin.

3 COMMISSIONER SZILAGYI: I've got to thank you,

4 Joanne.

5 Boy, this is complicated. I had a question also

6 about the vaccines. Do you know, Joanne, how many

7 individuals would lose essentially coverage for vaccines

8 after the PHE? How big is that population? The reason why

9 I'm going there --

10 MS. JEE: I don't know, I'm sorry. Could

11 you say that again?

12 COMMISSIONER SZILAGYI: So how many individuals

13 would not be in the -- after the PHE, how many individuals

14 would not have complete coverage for vaccine plus

15 administration?

16 MS. JEE: So I would have to go back and look and

17 see if we have what the enrollment data are for those

18 particular groups for which coverage of vaccines would be

19 optional for states.

20 COMMISSIONER SZILAGYI: But I'm concerned that

21 states would -- oh, go ahead, Anne.

22 EXECUTIVE DIRECTOR SCHWARTZ: Well, what makes it

1 difficult is we could come up with some estimate of
2 enrollment of those groups, but we wouldn't be able to know
3 is how much of the Medicaid population would actually be
4 vaccinated during the public health emergency because a
5 they are members of priority groups or the public health
6 emergency keeps getting extended to the extent that more
7 and more people are vaccinated.
8 So what that residual group is? I'm sure there's
9 somebody out there who may have modeled it. But there's a
10 lot of unknowns there.
11 COMMISSIONER SZILAGYI: I know. And part of this
12 depends on exactly what you say, how long the PHE will be
13 extended.
14 EXECUTIVE DIRECTOR SCHWARTZ: Right.
15 COMMISSIONER SZILAGYI: What we do know from
16 modeling data is that we need -- don't hold me to this, but
17 around 70 percent of the U.S. population to get the vaccine
18 for herd immunity. If a large percentage of the U.S.
19 population is unwilling to get the vaccine, we won't
20 approach herd immunity. So if there's a significant amount
21 of individuals who would lose vaccine coverage after the
22 PHE, and it all depends on how long the PHE is extended. I

1 get that. Then I think this is kind of treading on very
2 dangerous public health waters.
3 So I would support if we have a letter, something
4 about extending the coverage for vaccines, but I know this
5 is all contingent on how long the PHE is, whether states
6 would be able to offer free vaccines to these individuals.
7 There definitely is a barrier to receiving vaccines if
8 there is -- both from the point of view of the providers
9 and from the point of view of patients.
10 EXECUTIVE DIRECTOR SCHWARTZ: If I can just hop
11 back in here, I hear what you're saying, Peter, but that's
12 a statutory issue, and so that's something we would need to
13 relay to Congress, not CMS, because the law makes this
14 available at no cost to all only during the public health
15 emergency.
16 COMMISSIONER SZILAGYI: Right.
17 EXECUTIVE DIRECTOR SCHWARTZ: So if you wanted to
18 make it broader, and you're making very good arguments for
19 why it should be, you would need a statutory change.
20 COMMISSIONER SZILAGYI: Thank you.
21 CHAIR BELLA: Thank you, Peter.
22 Darin, then Tricia, then Brian.

1 COMMISSIONER GORDON: Joanne, this is helpful. I
2 felt like I was tracking with it in the clarification, but
3 there's one part of the final rule that I'm not 100 percent
4 clear on. And you may need to get back to me and the
5 Commission on this.
6 But in the original interpretation -- and you
7 highlighted you couldn't make any changes to benefits or
8 cost sharing and the like as well as eligibility, and they
9 clarified a lot of your comments around eligibility part of
10 the clarification. But within the rule -- and I'm not
11 going to read this exactly, but I just want to read part of
12 what I found on there that I'm confused on.
13 It talks about taking somewhat of a blended
14 approach to balancing the stakeholder interest by the
15 pandemic and ensuring long-term program stability, and then
16 within that, it says this blended approach adopts the state
17 flexibility available through the enrollment
18 interpretation, allowing states to make programmatic
19 changes to benefits and cost sharing and to transition
20 individual beneficiaries between eligibility groups with
21 different benefit packages.
22 So when I read that, that makes it sound like

1 when it comes to benefits and cost sharing that they are
2 taking a bit of a different view on that than the original
3 interpretation that basically said you could make no
4 changes there either. Is that your understanding? And if
5 you need to go back and kind of look at that again and
6 revisit it and come back, that's fine. That's one part
7 that felt like it was a more significant change than the
8 original interpretation, but it's still not clear.
9 MS. JEE: So my understanding is that in the
10 original interpretation, there could be no such changes,
11 and I think that's what you understood as well, right?
12 Then what the reinterpretation allows for are
13 some changes to benefits. So if a state wanted to reduce
14 benefits, such as eliminating certain optional benefits, a
15 state could do that.
16 COMMISSIONER GORDON: Thank you for clarifying
17 that because it wasn't explicit, but it felt like that's
18 what the reclarification was hinting towards, so that's
19 helpful. Thank you.
20 CHAIR BELLA: Okay. Thanks, Darin. Tricia?
21 COMMISSIONER BROOKS: Yes. Thanks, Melanie, and
22 Joanne, that was helpful. I think the Commission could get

1 hugely bogged down in the minutiae of what was recommended.
2 I would recommend a different tack, and that is that we
3 call for full rescission of the 42 CFR 433.400, which are
4 the MOE requirements. And the reason for that is I think
5 Congress was very clear about not reducing coverage during
6 the pandemic in order to receive the 6.2 percentage point
7 increase in FMAP. Reducing coverage means no
8 disenrollment, no reduction in benefits, and no increase in
9 cost sharing.
10 Now I think some believe that the MOE was seen as
11 a short-term patch, because Congress had pushed Families
12 First out so quickly, and that Congress would come back and
13 revisit it. But they haven't done that, and there's no
14 indication that they are going to do that in the near
15 future, nor, as we know, is there any indication that the
16 pandemic is going to end.
17 So in the absence of congressional action, CMS
18 has taken it upon themselves to basically rewrite the
19 statute. They are reversing their own plain reading of the
20 language of the statute, that they provided guidance on in
21 April and updated through the summer, and now they are
22 foregoing the normal rulemaking process.

1 The reality is that rewriting a statute to smooth
2 out any rough edges -- and I believe that there are some
3 rough edges there -- but that responsibility and
4 prerogative lies with Congress and not with CMS.
5 So I think the whole section of 433.400 should be
6 rescinded.
7 CHAIR BELLA: Thank you, Tricia. Brian and then
8 Chuck.
9 COMMISSIONER BURWELL: I was just going to follow
10 up on Peter's question about how many people would lose
11 coverage for vaccinations after the PHE ends. I mean, my
12 understanding is that that would depend on what states do,
13 because they would then have the option to reduce
14 eligibility or coverage for optional groups on their own.
15 So I think it would depend upon state decisions, and that,
16 in turn, would depend upon the fiscal status of states at
17 that point in time, and how severe their budgetary
18 pressures were. That is my understanding.
19 MS. JEE: Right. I mean, so state behavior
20 certainly will play a part in this, and Chris just sent
21 some data, some information -- and Chris can jump in,
22 please, if you can. About 40 percent of Medicaid enrollees

1 have optional vaccine coverage, which would include the
2 duals. If you take out the duals it's about 25 percent.
3 So, Peter, I hope that gets at some of your
4 question.
5 CHAIR BELLA: Okay. Thank you. Chuck.
6 VICE CHAIR MILLIGAN: A couple of, I think, minor
7 points. One is if we do send a letter, and I am supportive
8 of sending a letter, I would not make comments around
9 reminding them of their obligation to do notice periods and
10 fair hearing rights. I would not include language around
11 their obligation to evaluate individuals' eligibility for
12 other coverage or kind of update eligibility. And I would
13 not want to put that in a letter because they have those
14 requirements already and I would not want to apply they
15 have the option not to do those things.
16 My second point is that if we send a letter I
17 think it would be useful to encourage the administration to
18 extend the PHE well in advance of where I think it is now
19 scheduled to end, which I believe is January 20th, which I
20 believe is Inauguration Day. And I would urge them to not
21 wait until two or three days ahead of that, which has been
22 kind of the cadence they have been on through the summer

1 and fall, is only extending the PHE right at the deadline.
2 There's going to be a lot happening in the few days before
3 inauguration, so I would urge that we request that they act
4 early this time, and I assume the PHE will be ongoing.
5 If there's any Commissioner interest in where
6 Tricia took her comments about repeal and all that, I would
7 have additional comments, but I will, in the interest of
8 time, withhold those until and if we kind of talk about
9 that more significant potential letter.
10 CHAIR BELLA: Okay. Let me just see. Everyone
11 who has spoken so far is generally in favor of commenting.
12 Is there anyone who would have a problem with the
13 Commission sending a letter?
14 [No response.]
15 CHAIR BELLA: Okay. I agree with Chuck. I think
16 it's always important for us to be reinforcing the need for
17 early guidance and all those kinds of things. I would say,
18 Chuck, last time they did give more notice on the PHE, at
19 least way better than the first time, but I agree with you
20 that we can be making that theme.
21 I worry about making a laundry list of things, as
22 opposed to kind of sticking to core, big things, and

1 looking for those opportunities. But Joanne, you have a
2 list of things. Let's talk about what Tricia put on the
3 table, the rescinding. Is there an appetite -- where are
4 folks on that? Are there others who support including
5 that, and then if so, then we should debate that. Martha.
6 COMMISSIONER CARTER: I don't think I've got
7 enough information, I'm sorry, to make a reasonable
8 judgment on that one.
9 CHAIR BELLA: Tricia, I am struggling a little
10 bit with the agency feeling that they are always asked to
11 clarify things, and then when they've overstepped their
12 bounds then what's appropriate for us to call attention to,
13 and where we think we might be able to get action. That is
14 where my head is on that.
15 COMMISSIONER BROOKS: Yeah. I think that this is
16 not that they clarify. I think they reversed their
17 original interpretation, came up with guardrails that the
18 interpretation could go from here to here, and we're going
19 to take the blended approach. And, you know, there are
20 things in there that, for example, if a state has adopted
21 ICHIA, the coverage for lawfully residing immigrant
22 children and pregnant women, when they have a potential

1 change the state is required to move them into emergency
2 services only. They would not be in the other tiers of
3 coverage. So if a lawfully residing child turns 19, that
4 child can lose coverage under the rule as it is proposed.
5 So I think the point is that they have gone so
6 far on so many aspects of this that it's really hard to
7 piecemeal it, to go provision by provision and say, oh, we
8 are okay with this, maybe not for that, this needs a little
9 tweak. That's far more complicated than the time we have
10 to do this. And I do think there is a significant issue on
11 whether they had -- you know, overturning this really does
12 overstep their bounds. While I agree that we probably are
13 going to be that strong in our language in a letter, but I
14 think there is too much at stake here that it can't be
15 repaired, and we don't know what's going to happen when the
16 new administration comes in. States already should be
17 implementing this because it is already in effect, and then
18 it's going to get potentially changed again. It just seems
19 like we should pause and wait and let the new
20 administration deal with this.
21 CHAIR BELLA: Chuck, did you want to make a
22 comment?

1 VICE CHAIR MILLIGAN: I disagree with a couple of
2 comments Tricia made. I think on a lot of the facts she is
3 correct. I think CMS issued a lot of FAQs and guidance
4 through the summer and fall. I think it is fully within
5 its right to identify where its guidance might have been
6 mistaken or reinterpreted, and I don't perceive that as
7 walking things back.
8 And let me be more specific about this. I have
9 always understood the MOE requirements to be about
10 maintaining eligibility and coverage, not about maintaining
11 appointment time, benefit package, around now optional
12 benefits become mandatory benefits as elements of the MOE,
13 whereas I've always understood coverage and eligibility to
14 be elements of the MOE. And I do have concerns around
15 boxing states in, about maintaining every particular tool
16 to manage through the budget crisis around Medicaid where
17 everything is perceived to be off limits from being
18 touched, during a PHE, in which state general fund and
19 state revenue is getting hammered.
20 And so I've always understood the MOE to be more
21 of an eligibility-related MOE, similar to previous
22 recessions, and not every single aspect -- cost sharing,

1 benefits, all of the rest of it -- is defined as
2 maintaining coverage.
3 So I just think if we start getting into trying
4 to write a letter that parses out, at that level of detail,
5 what we want to recommend in a letter, I think that is a
6 pretty broad undertaking. So that's my high-level concern.
7 CHAIR BELLA: Thank you, Chuck.
8 COMMISSIONER BROOKS: Yeah, just a quickie in
9 response to that. The reality is that the statutory
10 language was different than prior recessions, where there
11 were MOEs attached. And the statutory language specifically
12 says that they will continue to be eligible for “such
13 benefits” as they were receiving on March 18th, or if they
14 subsequently enrolled. And I don't think it referred to
15 the cost sharing but the original interpretation suggested
16 that if you increase cost sharing then you are providing
17 fewer benefits. That was CMS's language, not mine. But
18 clearly the statute says to continue receiving the benefits
19 that they had.
20 So it is very different, and I think it took
21 everybody by surprise, Chuck.
22 VICE CHAIR MILLIGAN: Melanie, I worry about

1 having a lengthy discussion here. I think the language
2 "such benefits" is open to interpretation, Tricia, "such
3 benefits" meaning what is provided to this eligibility
4 group, or does it mean "such benefits" as existed at that
5 point in time. And I think that it is within
6 administrative law to interpret what that means.
7 And so all to say I just think that that is a
8 much bigger undertaking if we try to parse out some of
9 those elements, but I will leave it there, Melanie. I will
10 leave it there.
11 CHAIR BELLA: Joanne, I hate to give this to you
12 but I'm going to dump some of this back on you. We are
13 going to comment, and I am going to ask that at least a
14 subset of us review that comment. I think the folks that
15 obliviously are interested are Tricia, Chuck, Martha,
16 Darin, and Peter. If others would like to comment we can
17 send it to the whole group. I'm just trying to be
18 cognizant. Tom, you would like to comment? We'll just
19 send it to the whole group. That's fine. But I might ask
20 that a first version goes through this particularly Tricia
21 and Chuck, and Peter on the vaccine piece, Joanne. And
22 we're going to have to sort our way through. I mean, I

1 think we've had a healthy discussion here that gives us
2 latitude in how we choose to comment on this, and we can
3 work on that offline to find the right balance that makes
4 everyone comfortable.
5 It is worth remembering that this is final, and
6 so our comments are making a point but they have limited
7 influence, probably, at this point, given that it's final.
8 So that's also just something. It's not a reason not to do
9 it. It's not a reason to not be on record and be
10 consistent about the things that we care about. But is
11 that doable for you, Joanne?
12 MS. JEE: Yes.
13 CHAIR BELLA: Okay.
14 CHAIR BELLA: I am now going to ask, are there
15 folks in the public who would like to comment on either of
16 these last two sessions, so that would be postpartum
17 coverage or the commenting on the IFR? And if you would
18 like to comment, please hit the little hand thing and we
19 will unmute you.
20 [Pause.]
21 CHAIR BELLA: Okay. It looks like we have a
22 comment. If you can introduce yourself and your

1 organization before you speak that would be appreciated.

2 Let's start with Colin.

3 MS. HUGHES: Colin, you are self-muted. Just

4 click the icon to unmute yourself.

5 CHAIR BELLA: Okay. How about while Colin is

6 unmuting we go to Emily.

7 ### **PUBLIC COMMENT**

8 * MS. ECKERT: I think I'm off mute. Can you hear

9 me okay?

10 CHAIR BELLA: You are, yes. Thank you.

11 MS. ECKERT: Excellent. Thanks. Hi, everyone.

12 This is Emily Eckert, policy manager with the American

13 College of Obstetricians and Gynecologists, or ACOG. As

14 you can probably guess, my comment is related to the

15 postpartum coverage discussion.

16 I just want to thank the Commission once again

17 for your continued prioritization of this issue. I think

18 today's discussion was particularly fruitful and

19 insightful, and I was so pleased that every single

20 Commissioner took the time to make a comment and clearly

21 state your positions on the policy.

22 I just want to reiterate, again, that ACOG,

1 America's obstetricians, are putting their whole weight
2 behind this policy. Our obvious preference is for a
3 minimum of 12 months of coverage for women in the
4 postpartum period that is 100 percent federally funded,
5 comprehensive, balances out with coverage under CHIP,
6 everything you all have been discussing.
7 And, you know, that is sort of closer to where we
8 started in Congress, two-plus years ago, but here we are at
9 the end of the 116th Congress and the bill that passed out
10 of the House and is now being considered in the Senate has
11 drifted quite far from where we started. And so the House-
12 passed version, as you know, is a state plan option. There
13 is no increased FMAP. But ACOG continues to put our full
14 support behind H.R. 4996, you know, because we see it as
15 sort of an incremental step.
16 And so I just want to say that while all of that
17 is happening now, we really look forward to the final
18 recommendations from this Commission in the March report to
19 Congress. We think those will go a long way in improving
20 upon whatever we are hopefully able to get before the end
21 of the year.
22 So thank you so much again for the fruitful and

1 thoughtful discussion. ACOG is always here as a resource
2 for you all, and I wish you all safe and happy holidays.
3 Thank you so much.
4 CHAIR BELLA: Thank you. Looks like we have a
5 comment from Rachel.
6 MS. ROSALES: Hi, everyone. My name is Rachel
7 Rosales. Can you hear me?
8 CHAIR BELLA: Yes.
9 MS. ROSALES: So I work with Colin. His audio
10 actually went out so I'm just speaking on both of our
11 behalves. We both work at Community Catalyst, and we have
12 recently written a blog about this particular interim final
13 rule. And while we understand the concerns with state
14 flexibilities, we are concerned about the reversal of CMS's
15 previous guidance causes confusion for program
16 administrators and enrollees. Furthermore, we are
17 concerned that people covered by Medicaid could suddenly
18 lose access to critical services, like dental care and
19 prescription drugs, in the midst of a pandemic, putting
20 them at higher risk for complications associated with both
21 COVID-19 and existing chronic conditions like diabetes.
22 In the interim final rule, CMS acknowledges that

1 loss of benefits under the guidance could leave people
2 without the care necessary to manage complex health
3 conditions.
4 We also encourage the Commissioners to consider
5 the administrative burden these changes pose for Medicaid
6 agencies in determining valid eligibility while they
7 balance an influx of new enrollees. And we encourage also
8 the letter that would urge CMS to rescind their most recent
9 interim final rule.
10 And thank you for letting me speak on our behalf.
11 CHAIR BELLA: Thank you, Rachel. It looks like
12 we have a comment from Nataki.
13 MS. MacMURRAY: Yes. Good afternoon again. So I
14 had question going back to the discussion around pregnant
15 and postpartum benefits. I'm not sure exactly where my
16 issue of behavioral health for women who especially, for
17 instance, have substance use disorders around opioid use
18 and their children being exposed prenatally, how that would
19 be termed within this concept of pregnancy-related
20 services. Would substance use disorder treatment for women
21 and the additional services needed for the infants be
22 considered pregnancy-related services or would that be

1 outside of the scope? So how would that impact the
2 discussion around what services are extended to them under
3 this continuous service, the additional 12 months that you
4 are considering now?
5 CHAIR BELLA: Anne, I'll ask you to respond to
6 that, and perhaps we can also follow up offline in more
7 detail.
8 EXECUTIVE DIRECTOR SCHWARTZ: Yes. The issue
9 around pregnancy-related services: The Commission's
10 recommendation would be to ensure that pregnant women have
11 as broad a benefit package as others in the program, not
12 just services related to their coverage. I think you are
13 referring to additional services that pregnant women with
14 substance use disorder might need. So that recommendation
15 doesn't affect that.
16 I also want to note, for your reference, that we
17 did an entire chapter on the ability of states to provide
18 such additional services and the authorities under which
19 they can do that in our June 2020 report. So you might
20 want to find that on our website.
21 MS. MacMURRAY: Thank you very much. It looks
22 like I have some extra reading to do.

1 CHAIR BELLA: Just in time for the holidays.
2 More reading.
3 Okay. And then we have a comment from David.
4 MR. LINN: Thank you. David Linn with the
5 American Dental Association. Just a comment and follow-up
6 to what Community Catalyst mentioned on optional benefits.
7 The intended effect, according to the rule, was
8 cost savings and the possibility of allowing states
9 flexibility to eliminate optional benefits, but there are
10 studies showing in past economic downturns the elimination
11 of optional benefits, specifically dental, has resulted in
12 the opposite of that, and increased associated costs,
13 mainly due to increase in emergency department use.
14 CHAIR BELLA: All right. Thank you for that
15 comment. Do we have another comment?
16 MS. HUGHES: The attendee is self-muted.
17 MS. TUTSON: Oh, hi. This is Vacheria Tutson.
18 I'm with the National Association for Community Health
19 Centers. I just wanted to highlight that NACHC is really
20 concerned about CMS's interpretation to not include
21 beneficiaries with limited coverage, just because they
22 instruct health providers to treat that person as if they

1 are uninsured and direct them to the HRSA program for
2 reimbursement for uninsured patients. And we are just
3 concerned that there are so many Americans that do not have
4 health insurance, especially given the pandemic, that
5 Medicaid should use their discretion to cover all
6 beneficiaries.
7 So we really appreciate the Commissioners
8 bringing that up earlier, and that is something that NACHC
9 has heavily considered, and we will be addressing in our
10 comments, that CMS should use their discretion to cover as
11 many beneficiaries as possible so that we can keep the
12 resources for the uninsured population and make sure that
13 they are able to get vaccinated, but also that providers
14 can keep their doors open by being reimbursed as much as
15 possible.
16 So I just wanted to share our perspective, and
17 thank you.
18 CHAIR BELLA: Thank you very much.
19 It looks like we don't have any more comments. I
20 want to thank the folks who did comment. We always
21 appreciate that.
22 We are going to take a very short break. We are

1 going to take a 10-minute break, so if I could ask everyone
2 to be back at 2:50 Eastern time. We will get a quick
3 update on highlights from 2020 MACStats and then go into
4 our last two sessions. So please try to be back in 10
5 minutes so we can keep moving. Thank you.
6 * [Recess.]
7 CHAIR BELLA: Okay. We've got two more pop up.
8 I'm ready to go. So, thanks, everyone, for getting back
9 promptly, and, Jerry, please take it away with your update.
10 **### HIGHLIGHTS FROM THE 2020 EDITION OF MACSTATS**
11 * MR. MI: Great, thanks. Good afternoon.
12 MACStats is scheduled for release next Wednesday, December
13 16th. For members of the public, we'll have MACStats both
14 compiled as a resource and separated into individual tables
15 on our website. Most of the tables have both Excel and
16 .pdf versions available for your convenience.
17 So MACStats is a regularly updated end-of-year
18 publication that compiles a broad range of Medicaid and
19 CHIP statistics from multiple data sources, including
20 Census, enrollment, survey, and national and state level
21 administrative data. Listed on this slide are the six
22 sections of MACStats.

1 This is the first time MACPAC is using data from
2 the Transformed Medicaid Statistical Information System, or
3 T-MSIS, which captures substantially more data and
4 information than what was previously available under the
5 Medicaid Statistical Information System, or MSIS. We feel
6 very comfortable with the high-level analyses for MACStats,
7 but are still working on assessing the quality of the data
8 for more granular analyses. Due to data quality improving
9 over time, we skipped from 2013 to 2018.
10 The 2020 edition of MACStats includes eight
11 republished exhibits on beneficiary characteristics,
12 health, service use, and access to care that use 2018
13 National Health Interview Survey, or NHIS, data. This is
14 due to a delay in the release of NHIS results after a
15 redesign in 2019. We plan to publish updated tables on our
16 website in early 2021 as we complete our analyses on the
17 2019 NHIS data.
18 Key statistics of this year's MACStats show
19 similar results to last year's. These key statistics focus
20 on Medicaid and CHIP enrollment and spending compared to
21 other payers, Medicaid's share of state budgets, and more.
22 I will discuss some of these findings in more detail in the

1 upcoming slides.

2 So getting into the trends of the data, over the

3 last seven years, Medicaid and CHIP enrollment has

4 increased by about 32 percent. Most of this change

5 happened in the first initial years after the bulk of ACA

6 expansion. From July 2015 to July 2017, Medicaid and CHIP

7 enrollment had a steady increase at about 1 percent

8 annually. These data are not shown in this table.

9 In the following two years, from July 2017 to

10 July 2019, there was a decline in enrollment of a little

11 over 1 percent annually. From July 2019 to July 2020,

12 there was a 5.6 percent increase in enrollment. This is in

13 large part due to the economic downturn from the

14 coronavirus pandemic and the maintenance-of-effort

15 requirements to qualify for the 6.2 percent FMAP increase

16 during the public health emergency.

17 Furthermore, this graph shows growth trends in

18 Medicaid enrollment and spending. Overall, spending and

19 enrollment have had complementary trends, both rising and

20 falling compared to policy changes and economic conditions,

21 such as economic recessions and expansion.

22 In this graph, spending for health programs are

1 compared with spending for other components of the federal
2 budget for fiscal years 1965 through 2019. Medicaid and
3 CHIP's share of federal outlays has remained stable. In
4 2019, CHIP was 0.4 percent of the total federal outlays,
5 showing no difference from the previous year. Medicaid's
6 share decreased slightly from 2018 to 9.2 percent of total
7 federal outlays, which is still less than Medicare's share
8 at about 14 percent.

9 In fiscal year 2018, we see that the use of
10 managed care continues to increase. Enrollment in managed
11 care has increased since 2013. Over half of enrollees who
12 are eligible on the basis of disability and over one-third
13 of enrollees age 65 and older were enrolled in
14 comprehensive managed care. LTSS users accounted for only
15 5.5 percent of Medicaid enrollees, but almost one-third of
16 all Medicaid spending. That is, $182.7 billion was spent
17 for services for these 4.7 million enrollees. The new
18 adult group accounted for over 20 percent of enrollees and
19 17 percent of spending in fiscal year 2018.

20 In fiscal year 2019, drug rebates reduced gross
21 drug spending by about 56 percent. DSH, upper payment
22 limit, and other types of supplemental payments accounted

1 for over half of fee-for-service payments to hospitals.

2 Total spending per full-year equivalent enrollee

3 across all service categories ranged from $3,138 for

4 children to $20,300 for the disabled eligibility group.

5 Total spending per full-year equivalent enrollee were

6 highest for the disabled and aged populations, which were

7 about three times the other eligibility groups. The

8 service category with the largest dollar amount spent per

9 full-year equivalent enrollee in fiscal year 2018 was

10 managed care for a beneficiary within the disabled

11 eligibility group. Medicaid spent $7,855 per person in

12 this particular service category.

13 There were also no substantial changes in

14 eligibility criteria within the past year. In 2018, 41

15 percent of Medicaid enrollees had annual incomes less than

16 100 percent of the federal poverty level, and about 60

17 percent had incomes below 138 percent of the federal

18 poverty level. Our exhibit shows that as of April 2020, 35

19 states and D.C. -- two more states than last year -- are

20 now covering the new adult group. Three additional states

21 have approved Medicaid expansion but are not reflected in

22 our exhibit.

1 MACStats also reports on beneficiary health,
2 service use, and access to care using survey data from the
3 NHIS and the Medical Expenditure Panel Survey, MEPS. In
4 2018, children and adults with Medicaid or CHIP coverage
5 were less likely to be in excellent or very good health
6 than those who are privately covered.
7 Individuals with Medicaid or CHIP coverage were
8 also less likely to have visited a doctor or dentist than
9 those with private coverage, but more likely than though
10 who were uninsured.
11 And this concludes my presentation. Thank you.
12 CHAIR BELLA: Thank you, Jerry. We appreciate
13 you taking us through that. Questions, comments? Darin.
14 COMMISSIONER GORDON: Yeah, thank you for walking
15 us through that. On the slide that showed the spending by
16 different categories, you had LTSS and you had managed
17 care. Is MLTSS in the managed care bucket or is it in the
18 LTSS -- this slide, is it in the LTSS bucket? Or do you
19 need to get back to us?
20 MR. PARK: Oh, I can jump in here. Anything that
21 would -- like capitation payment paid to a managed care
22 plan would be in the managed care bucket. You know, some

1 of the shift you're probably noticing from prior years
2 reflects a movement from fee-for-service LTSS into managed
3 LTSS.
4 COMMISSIONER GORDON: Yeah, that's what I would
5 expect. I just want to make sure I was reading the data
6 correctly.
7 CHAIR BELLA: Thanks, Darin. I think I saw
8 movement, either Tricia or Stacey. Is that right? Or are
9 my eyes playing tricks on me? No? Okay. Better safe than
10 sorry, right? Right, Darin? You say I never call on you.
11 Okay. Anybody else have questions for Jerry?
12 Brian. Brian, you're on mute. And then Chuck.
13 COMMISSIONER BURWELL: One of the challenges we
14 have had with Medicaid data is to know what services are
15 being provided under the rubric of managed care, so those
16 are in MACStats. To the extent that we are able to get
17 encounter data from managed care plans, are those services
18 displayed under type of service statistics or under managed
19 care? Or in general, comment on the degree to which we are
20 losing the ability to report information under Medicaid due
21 to the shift to managed care by type of service.
22 MR. PARK: I can --

1 CHAIR BELLA: Was that a question, Brian? Are
2 you making a statement?
3 COMMISSIONER BURWELL: That's a question. To
4 what degree has that continued to be a data response?
5 MR. PARK: Sure. Per the MACStats exhibit, we
6 kind of report things from the state perspective in terms
7 of expenditures. So we would report the capitation
8 payments made to managed care plans but not necessarily
9 what the managed care plans actually spent providing
10 services. You know, we focus on the data we needed for
11 MACStats first, but we're in the process of evaluating the
12 rest of the data in terms of the completeness of encounter
13 data, to what extent the plans are reporting paid amounts
14 to the states. So we may -- you know, we're still in the
15 process of that, and hopefully in the future we'll be able
16 to focus a little bit more on exactly what the managed care
17 plans are spending in terms of providing services.
18 COMMISSIONER BURWELL: Thank you, Chris.
19 CHAIR BELLA: Chuck and --
20 COMMISSIONER GORDON: Chris, just a
21 clarification. Chris, you're saying that -- gathering that
22 from T-MSIS data, that's where you're doing some of that?

1 MR. PARK: Yes, for T-MSIS, you know, some of the
2 requirements are that the managed care plans report the
3 payments to the states and the states report that to T-
4 MSIS. For the publicly available file, I think they are
5 going to blank out the managed care payments because that's
6 considered proprietary. But because we have access to the
7 full T-MSIS data set, we should be able to do some analysis
8 on what managed care plans are paying providers.
9 COMMISSIONER GORDON: Thank you. Thanks for the
10 clarification.
11 COMMISSIONER BURWELL: So I just want to follow
12 up, because one important impact of that is knowing to what
13 degree MLTSS plans -- and you can see that there's a lot of
14 MLTSS being provided now -- are successful in rebalancing
15 services from institutional care to home and community-
16 based care, and we won't be able to know that until we're
17 able to break up what the MLTSS plans are actually spending
18 their money on.
19 CHAIR BELLA: Thank you, Brian. Chuck and then
20 Tricia, and then we're going to wrap this up.
21 VICE CHAIR MILLIGAN: Jerry, nice job. I wanted
22 to -- you haven't been in front of us frequently, and I

1 just wanted to compliment the work and the presentation.

2 My main comment is subliminal and potentially

3 subliminal to MedPAC. I do think it would be nice to get

4 back on a cadence where this kind of data is produced in

5 the dual-eligible data book. It seems like that hasn't

6 been produced for a while, and I think it's an important

7 contribution, and I would -- I just wanted to put in a plug

8 while we're talking about MACStats that the dual-eligible

9 data book is from my point of view overdue for being

10 refreshed, and to the extent MedPAC folks might be

11 listening in, I would urge that we work together as

12 Commissions to get that data book produced.

13 So thank you.

14 CHAIR BELLA: I think there's uniform interest in

15 that. It's been a T-MSIS issue. Is that right?

16 MR. MI: Yes, and currently, staff -- we're

17 currently working with Kirstin and have occasionally

18 chatted with MedPAC about updating the data book. And so

19 currently the plan is to release an updated subset of

20 numbers from MACPAC's perspective only and then potentially

21 update it within the next cycle.

22 VICE CHAIR MILLIGAN: But I think the T-MSIS data

1 is getting to the point where it is usable for that. So if
2 I'm mistaken about that, I apologize. But I'm very eager
3 to see it when it's ready to be produced. I guess that's
4 the main point.

5 EXECUTIVE DIRECTOR SCHWARTZ: I think our plan
6 right now is to be able to produce something with MedPAC
7 over the summer because that's the time frame that works
8 best for them. But we will have a few numbers that we'll
9 be able to put into our duals work in our upcoming reports
10 prior to being able to release a duals data book later.

11 VICE CHAIR MILLIGAN: Thank you.

12 CHAIR BELLA: Tricia and then Toby, and then we
13 are going to need to wrap on this session. Tricia, yes.

14 COMMISSIONER BROOKS: Thank you. I answered my
15 first question. The totals by category are at the bottom.
16 Two quickies.

17 One, is this -- will it be in the MACStats on a
18 50-state basis? And can you speak to the residual problems
19 that maybe some of the states are having in terms of the
20 validity of the data?

21 MR. PARK: So this particular graph where it
22 shows spending by eligibility group and service category is

1 not available on a 50-state basis in the data book. But we
2 do have a 50-state table on overall spending per enrollee
3 for these different eligibility groups.
4 You know, there certainly are some data reporting
5 challenges that at a high level we were comfortable with
6 reporting because our methodology grosses up spending to
7 match the CMS-64, so if a state was underreporting managed
8 care payments, you know, we kind of factor that up to kind
9 of account for what we think is their actual level for
10 managed care. So, you know, in terms of this high level
11 where we adjust it at 64, we felt comfortable with that,
12 but for a more granular analysis where we may not be able
13 to do that kind of factoring up, there may be cases where
14 we would have to leave out a state or two, depending on how
15 their data look.
16 CHAIR BELLA: Toby?
17 COMMISSIONER DOUGLAS: Yeah, if we can just go
18 back to Slide 11. You know, just thinking back to our
19 health equity discussion and really just want to press on -
20 - as we think about all the interventions and social needs,
21 and just fundamentally when you look at this data, this is
22 -- I don't want us to lose sight of what can the Commission

1 be doing to continue to make sure that we don't just see
2 this level of disparity in access to services. So I just
3 want to keep the focus too on that as we think about
4 housing and social needs just at the basic level of what
5 Medicaid -- what we're supposed to be doing where we're
6 falling short compared to other payers.
7 CHAIR BELLA: Thank you, Toby, for reminding us
8 to pay attention to that as well. Thank you, Jerry, very
9 much. Thank you, Chris, for answering some questions. We
10 will look forward to this coming out.
11 And we are going to transition now. Moira is
12 going to join us alongside Chris, and we're going to go
13 into countercyclical. As you all know, we're going to be
14 making a recommendation here, so we will turn it over to
15 these guys to go through the slides, and then we'll have a
16 very focused discussion around the recommendation and areas
17 that are sort of within bounds for that. So we'll turn it
18 to you two. Thank you.
19 **### A COUNTERCYCLICAL MEDICAID FINANCING ADJUSTMENT:**
20 **MOVING TOWARDS RECOMMENDATIONS**
21 * MS. FORBES: Thank you. So Chris and I are here
22 today to talk about countercyclical financing again,

1 following up on a few earlier presentations. We had first
2 started talking about the design features of a
3 countercyclical financing mechanism about a year ago when
4 we described how these mechanisms work in Medicaid and
5 introduced the GAO prototype. Then the pandemic hit, so in
6 April we focused more on the policy choices and technical
7 considerations that would need to be considered in
8 designing an automatic mechanism. And over the summer we
9 published an issue brief about the fiscal relief provided
10 to states under the Families First Coronavirus Response
11 Act, or FFCRA.

12 In September, we provided more detail on the GAO
13 prototype, estimated the effects of this model if it had
14 been implemented this year, and compared these results to
15 the 6.2 percentage point FMAP increase provided to states
16 under the FFCRA.

17 Commissioners identified some specific objectives
18 for a permanent mechanism and asked us to come back with
19 options for recommendations, which we have today.

20 So I'll recap how a Medicaid automatic
21 countercyclical financing mechanism works and specifically
22 what's in the GAO model. And then we'll show how the GAO

1 approach compares to prior congressional actions. This
2 comparison can help inform the options for recommendations,
3 and we can answer any technical questions you have before
4 turning it over for your discussion.

5 As we've discussed before, Medicaid is a public
6 assistance program, and demand for assistance is
7 countercyclical to economic growth in that enrollment and
8 spending increase when there's a downturn in the economic
9 cycle. The program is designed to automatically offset
10 these cyclical changes in economic activity without
11 additional governmental intervention, but financing these
12 additional program costs is complicated by the requirement
13 for states to contribute a fixed percentage of program
14 expenditures because states can face steep revenue declines
15 in a downturn, but they can't run deficits or take on debt
16 for program expenses, and the extent to which states are
17 affected by a recession or have the ability to finance
18 these additional demands on Medicaid can vary.

19 While the federal government can run deficits and
20 contribute additional share, it can only do so through
21 congressional action. One option is for a permanent
22 countercyclical FMAP adjustment formula that would go in

1 statute, which could help do away with the need for one-off
2 congressional interventions whenever there's an economic
3 downturn. We've discussed what a permanent model should
4 look like in a couple of previous meetings, and
5 Commissioners have identified several objectives, including
6 that it should be automatic, with objective timely
7 indicators to trigger changes in federal assistance; it
8 should have a threshold that is sensitive enough to signal
9 the beginning or end of an economic downturn quickly, but
10 not be so sensitive that small fluctuations trigger
11 frequent adjustments; and be able to target any additional
12 financing for states based on state-level factors.
13 As part of the 2009 stimulus bill, Congress asked
14 the GAO to provide recommendations for modifying the FMAP
15 formula to make it more responsive to state Medicaid
16 program needs during future economic downturns, and the GAO
17 developed a prototype formula for temporarily increased
18 FMAP which they published in 2010. We have discussed this
19 a couple of times. We went back and compared the GAO model
20 very specifically to the key objectives identified by
21 Commissioners and also to the actual interventions made by
22 Congress during the past-year recessions.

1 In looking at the features of the GAO model, it's
2 automatic, obviously, per design. Specifically, the FMAP
3 increase is triggered based on changes in state-level
4 economic conditions in more than half the states. It's
5 designed to be sensitive to economic changes, but not too
6 sensitive. It uses three-month averages and year-over-year
7 comparisons in order to balance using timely data with some
8 evidence of trends.
9 And it's targeted by varying the FMAP increase
10 based wholly on state-level factors.
11 The GAO developed their formula in 2010, but they
12 went back and looked at data back to 1990 to see how their
13 model would have fared during the 1990, 2001, and 2008
14 recessions. Would it have been triggered? For how long?
15 How much of an increase would it have given the states and
16 so on?
17 The GAO prototype was designed for typical
18 recessions which generally begin with a gradual economic
19 slowdown, which is not what happened this year. And also
20 because their paper came out 10 years ago, we had to look
21 at the data to see if it would have been triggered this
22 year, which is what Chris presented in September. So we

1 can look at what the GAO looked at for the previous
2 recessions and then our own work for this year.
3 So applying the GAO model to the real world, we
4 see that it would have been triggered during the 2001 and
5 2008 and current recessions. We also see that it would not
6 have been triggered at any other time.
7 Congress authorized temporary Medicaid FMAP
8 increases corresponding to those three recessions. So the
9 GAO model would have provided assistance during the same
10 periods; however, not exactly the same time frames or the
11 same amounts, as shown in the next slide.
12 So the paper in your materials provides more
13 detail, but here's a summary comparison of the three
14 congressional FMAP increases to what the GAO model would
15 have provided in terms of timing and targeting.
16 As you can see, for the regular recessions in
17 2001 and 2008, the GAO model would have started providing
18 additional FMAP to states much sooner than Congress,
19 although this year it took time for the downward trend to
20 trigger a start. So also factoring in the retroactive FMAP
21 to January 1, states would have gotten the FMAP increase
22 six months later of this year than the GAO -- if they had

1 been following the GAO model.

2 The formula-driven increases also ended at
3 different times. The GAO formula-driven increases would
4 have ended at different times than the temporary FMAPs
5 authorized by Congress. Those had specific lengths, and
6 this year, of course, it's tied to the public health
7 emergency.

8 Then because the GAO model doesn't have a base
9 FMAP increase, only state-level increases, we can't compare
10 the amount of the increase in the prior recessions,
11 although we know that the GAO model does a better job
12 targeting fiscal relief to states because that's how it's
13 designed.

14 But on this slide, you can see, because we did
15 the calculations ourselves for the current recession, the
16 amount each state would get varies a lot based on state-
17 level economic indicators. So this shows two quarters,
18 July through September and then October through December.

19 As you can see, two states, the light blue, would
20 have gotten 2 percentage points the last quarter this year,
21 and ten states would have gotten 6 or more percentage
22 points. Most states would get between 2 and 8 percentage

1 points added to the base FMAP. And we're just applying the
2 GAO formula. We're not saying anything here about state
3 need or whether this is sufficient or not to enrollment.
4 We're just applying the formula to see how it would work
5 with this year's data.
6 But the bottom line is that the GAO model results
7 in variation by state and also, based on the two quarters
8 we looked at, seems to give states a percentage point bump
9 similar to the temporary bumps, roughly, that Congress has
10 provided before.
11 One thing we do want to note here is that the
12 largest FMAP increase we calculated using this -- you have
13 to look back two years, so using 2018 through 2020 data --
14 is 10.6 percentage points. There is no mathematical
15 maximum in the GAO model. So we don't know if a state
16 could have an enhanced FMAP over 100 percent. We didn't
17 calculate one, but we don't know if that's theoretically
18 possible.
19 Also, while spending isn't part of this slide, if
20 we had done something to calculate spending, we would have
21 excluded the adult expansion population from a comparison
22 of 2020 approaches. The GAO model doesn't say anything

1 about whether any services or populations should be
2 included or excluded. The GAO model just addresses how you
3 calculate the FMAP increase, presumably on the -- which
4 would then be added to the regular FMAP.
5 Because the adult expansion population already
6 receives a 90 percent match, the FFCRA FMAP increase
7 doesn't apply to the Medicaid expansion population or other
8 services that already receive a higher matching point.
9 So based on this comparison and looking at the
10 GAO model, we've identified a number of takeaways for the
11 Commission to think about.
12 First, thinking about that table from a few
13 slides ago and thinking about congressional action versus
14 an automatic mechanism: of course, Congress did act during
15 each of the last and current three nationwide recessions to
16 provide additional federal funds to states in the form of
17 enhanced FMAP. However, the gradual nature of the economic
18 downturns made it difficult for Congress to be proactive in
19 identifying state need and taking action early, although it
20 was easier this time--2020--because the pandemic and
21 shutdown was so clear.
22 It was also hard for Congress to anticipate how

1 long to leave an FMAP increase in place. In 2003 and 2009,
2 they just made the FMAP increase in effect for 27 months,
3 which could have been too short or too long in terms of
4 what states actually needed, but they sort of had to pick
5 something. It wasn't tied to an indicator.

6 It's also hard to create a formula to target
7 assistance to states. They didn't target at all in 2003,
8 and then in 2008, they came up with a formula. We were
9 well into the recession at that point. They gave all the
10 states a 6.2 percentage point increase to start with and
11 then targeted on top of that. There was also a lot of
12 congressional negotiations as there will be when you're
13 talking about giving out money to the states. So it's
14 challenging.

15 One thing Congress has done that the GAO model
16 does not is include -- they've included additional policy
17 requirements. While not shown on that slide comparing the
18 different models or different approaches, in 2009 and 2020,
19 Congress included maintenance of effort provisions that
20 require states to maintain existing eligibility standards
21 in order to receive enhanced federal funding. These
22 provisions were introduced following the 2003 FMAP increase

1 in which many states took the federal money but then
2 introduced premiums and caps in CHIP, scaled back outreach
3 administrative simplifications, and otherwise sought to
4 reduce enrollment in order to limit state spending. So a
5 number of states used the federal money as a substitute
6 instead of a supplement. Since then, additional FMAP has
7 been tied to maintaining eligibility standards.
8 In terms of the GAO prototype, when we applied
9 the data, we could see that it does adjust the amount of
10 federal relief to state-level conditions. We only used a
11 couple of quarters of data. So we don't know what will
12 happen over the longer term, but clearly, there's targeting
13 among the states.
14 Comparing the GAO model to congressional actions
15 and prior sessions, we can see that an automatic trigger
16 would have kicked in both times, months before Congress
17 passed the stimulus bill.
18 We can also see that it kicked in for the 2001
19 and 2008 recessions, but it didn't trigger an FMAP bump at
20 any other time. We've had a couple of major weather
21 disasters that affected large parts of the country. There
22 was Hurricane Katrina, there was Hurricane Sandy--it didn't

1 kick in. The threshold that half the states have to have a
2 sustained downturn does seem to be a pretty high threshold
3 for triggering this.
4 Finally, because you're considering making a
5 recommendation, we wanted to get an estimate of the fiscal
6 effects. To estimate the cost of a legislative proposal,
7 the CBO, Congressional Budget Office, compares projections
8 of proposed spending against current law. A projection for
9 a policy like this is tricky because there is a large
10 uncertainty. CBO can assume that a recession might occur
11 sometime in the next 10 years, but it doesn't know when or
12 how long it will be, or for purposes of this model
13 specifically, what the changes might be in unemployment and
14 wages and salaries by state and by quarter so they can
15 figure out when an FMAP increase would be triggered and how
16 much it would be by state and when it would end.
17 So to estimate the cost of things like that, CBO
18 uses probabilistic methods. They run multiple scenarios
19 with recessions of different timing and size and duration,
20 and they average them to create an estimated cost or
21 expected value. So it took a while to come back with some
22 numbers.

1 We have a preliminary estimate from CBO that
2 assuming this policy would go into effect in FY2023, so
3 starting October 1, 2022, it would cost about $30 to 40
4 billion over the 10-year budget cycle, that's between now
5 and 2030. That's their preliminary estimate. So that's
6 the estimate for policy change, a permanent countercyclical
7 financing mechanism in statute.
8 Of course, there probably will be a recession in
9 the next 10 years. It's a cyclical economy. If there is
10 no mechanism in statute, Congress could always enact
11 another one-off stimulus with an FMAP increase, which would
12 become part of the program cost at that time.
13 The 2009 stimulus ended up with total Medicaid
14 outlays of $32 billion in 2009 and $40 billion in 2010 and
15 actually some outlays after that.
16 So the question is maybe not whether or not the
17 money is going to be spent, since Congress has shown during
18 the last three recessions that it will spend the money.
19 It's just that this proposes a statutory change. The cost
20 will become part of the 10-year program cost estimate, and
21 a portion of the cost based on what the expected value of a
22 recession happening in the near term would be part of the

1 annual estimate. That's a very small part. It would be
2 like $250 to 750 million would become part of the one-year
3 estimate.
4 So that's what we know about the GAO model and
5 how it compares to the alternative, which is Congress
6 continuing to just respond to each recession as it happens.
7 It appears that the GAO model does a good job meeting the
8 three objectives that the Commission identified, which are
9 that it be automatic, sensitive to major economic changes,
10 and targeted to state-level factors. Therefore, the
11 Commission could recommend that Congress should adopt an
12 automatic Medicaid countercyclical model using the GAO
13 prototype as the basis.
14 The Commission could also recommend that Congress
15 adopt the GAO prototype with additional policy
16 modifications, such as a maintenance of effort provision to
17 ensure that states do not cut eligibility, a cap or ceiling
18 on additional FMAP to create upper bound on federal match,
19 or limits on additional FMAP to apply it only to
20 expenditures eligible for regular FMAP and to exclude
21 services and populations that already have higher FMAPs--or
22 there could be other policy modifications.

1 We are happy to answer technical questions before
2 you discuss these potential recommendations and decide if
3 you have a preferred approach, and then, if you want, we
4 can draft specific recommendation language to be voted on
5 at the next public meeting.
6 CHAIR BELLA: Thank you, Moira. Thank you,
7 Chris.
8 I would like to start with technical questions
9 before we get into recommendations. Does anyone have any?
10 Fred and then Chuck.
11 COMMISSIONER CERISE: Does the budget planning --
12 is there any practical impact? Does this help to be more
13 realistic in Congress' budget planning since you're
14 building in these costs year to year in your projections
15 compared to coming up as an emergency at some point in
16 time, or is that not really a consideration? You're
17 accruing for the expenses that are going to happen at some
18 point.
19 MS. FORBES: I don't have a good sense of that.
20 I mean, it would certainly increase the baseline
21 for Medicaid to make it part of the statute. Some amount
22 of that would show up in the annual each year, and that

1 amount would increase the longer we go without a recession.

2 CHAIR BELLA: Chuck and then Bill.

3 VICE CHAIR MILLIGAN: Yeah. And I think Bill is

4 probably going to have insight into the question I'm about

5 to ask.

6 I'm wondering whether GAO's approach was ever

7 scored by CBO, and it's my understanding that when CBO does

8 score something like this, they're scoring it against kind

9 of the baseline statute in which case this could look like

10 -- I mean, they're going to -- they would have to make

11 estimates about recessions and length of recessions and

12 depth of recessions and all that.

13 My basic question is, do we have a sense of how

14 the GAO model would be scored by CBO, and was it in the

15 past? Because I don't think it will be scored against

16 what's going on currently with the 6.2. I just would like

17 to understand that piece a little bit better at a technical

18 level.

19 MS. FORBES: So they didn't score it before

20 because it they only score things that are introduced as

21 legislation.

22 What they have given us is the same sort of broad

1 estimate that they usually do, sort of like the bucket-
2 level estimate. But it is akin to how they would score it
3 if it were introduced, which is that they haven't --
4 they've scored it against the current baseline, not with
5 the FFCRA bump in there. That's why it starts in fiscal
6 year 2023, when we're back to normal FMAPs.
7 CHAIR BELLA: Thank you. Bill?
8 COMMISSIONER SCANLON: I didn't have an answer.
9 I actually had a question, and the question was, do we know
10 whether or not that Congress would have to have pay-fors if
11 they were to enact this now? The amount of the pay-fors
12 would depend on what CBO score is, and I think your
13 characterization of how CBO approached it is exactly what I
14 would have expected, that it's going to be against the
15 baseline that's going to be post COVID.
16 CHAIR BELLA: Anne, did you raise your hand?
17 Yep. Go ahead.
18 EXECUTIVE DIRECTOR SCHWARTZ: I think if they
19 enact it now, they would have to have pay-fors. The issue
20 really to think about is that during an emergency
21 situation, they often dispense with pay-fors. Congress
22 doesn't have to pay for it if they're doing an emergency

1 because everyone's hair is on fire. The costs are probably
2 the same in the long run of whether you did the policy now
3 or later. So that's maybe a somewhat cynical answer to
4 that.

5 COMMISSIONER SCANLON: I thought that might be
6 the case, but at the same time, $30 to 40 billion seems
7 like a small amount over a 10-year baseline.

8 CHAIR BELLA: Okay. I don't see any more hands
9 for technical questions.

10 Sheldon, you do? You have a technical question?

11 COMMISSIONER RETCHIN: Yeah. Well, you can be
12 the judge, but I guess the question I had was on CBO
13 scoring. I'm not an economist, but I've seen -- and I saw
14 it back when the GAO originally did its -- it was asked to
15 come up with a countercyclical formula, that there was some
16 thought that, yes, economic recessions can cause a swell in
17 Medicaid enrollments, but also blunting the -- that giving
18 an earlier increase in FMAP might actually blunt the length
19 of time of a recession. Is that anywhere in the scoring,
20 do you know, from when the GAO did that?

21 MS. FORBES: We talked to them about their model,
22 and it sounded like there were a lot of elements. They

1 were doing a lot around the estimating all these pieces
2 around what would trigger the model and then applying it to
3 a separate way they have to estimate the effect of
4 recessions on Medicaid enrollment and spending. So it
5 sounds to me like whatever they normally have to estimate
6 that, they were applying here, but I don't know all the ins
7 and outs of how they project costs over the 10 years.
8 COMMISSIONER SCANLON: If I could add, as an
9 economist, I would say that they probably factor in a
10 stimulus effect from the additional public spending, but I
11 wouldn't expect it to be very large.
12 CHAIR BELLA: Okay. Thank you, everyone.
13 Moira and Chris, a lot of work has gone into
14 this. We've looked at a lot of different factors. It
15 makes sense to me that we're using the GAO as the basis for
16 our recommendation as opposed to taking something new or
17 something, trying to come up with it ourselves. So I
18 appreciate that you've brought back to us two very concrete
19 recommendations.
20 What I'd like to remind the Commissioners is this
21 is meant to be forward thinking. We are not solving for
22 COVID right now. So please try to keep that in mind.

1 If we have concerns, if we want to talk about
2 additional state funding or support right now, we can do
3 that tomorrow when we talk about messaging that we might
4 want to send to the new Congress or the new administration.
5 So for right now, I'd like us to stay focused on
6 looking forward.
7 It seemed that we had consensus last time that we
8 wanted to make a recommendation. I would ask if anyone
9 does not want to make a recommendation, please speak up,
10 otherwise please share your thoughts on whether you support
11 Option 1 or Option 2. And let's kind of get that out on
12 the table and see if we can get a sense of where we are
13 relatively quickly and then see what we need to discuss.
14 So is there anyone who is not comfortable making
15 a recommendation? This is called day of putting people on
16 the spot. I'm sorry, but we're just trying to get the
17 business done, right?
18 [No response.]
19 CHAIR BELLA: All right. Then can people get
20 their comments on Option 1 or Option 2? Just a reminder,
21 Option 1 is GAO as it is. Option 2 has modifications or
22 refinements such as an MOE that we've seen in prior

1 congressional support.

2 Tom?

3 COMMISSIONER BARKER: Thank you, Melanie.

4 Just to be clear, I do support making a

5 recommendation, and I sort of lead towards Option 2.

6 Moira, could you just slip to the Option 2 slide

7 real quick?

8 MS. FORBES: Yeah. I don't know if maybe --

9 COMMISSIONER BARKER: Well, that's all right. I

10 just want to say I do think that the idea of having an MOE

11 requirement is important, and so I think at the very least,

12 that's why I support Option 2.

13 But there was something else on that slide that I

14 saw that I also thought was important. So that would be my

15 position.

16 CHAIR BELLA: All right. So Option 2 has MOE, a

17 ceiling, or a cap on FMAP, and FMAP applied to expenditures

18 eligible for regular FMAP.

19 COMMISSIONER BARKER: I think it's that third

20 bullet point that I thought was important also.

21 CHAIR BELLA: Okay.

22 Sheldon?

1 COMMISSIONER RETCHIN: I agree with Tom. I
2 support Option 2 for the same reasons.
3 CHAIR BELLA: I'm looking for other hands. Bill?
4 Chuck?
5 COMMISSIONER SCANLON: Yeah, I agree as well. I
6 think this is a long-term issue that would finally be
7 addressed and that Option 2 has the right quid pro quos in
8 it.
9 CHAIR BELLA: Okay. Thank you. Chuck?
10 VICE CHAIR MILLIGAN: I'm supportive of Option 2
11 as well, and, to me, one of the benefits of it, and partly
12 reflecting MOE I think is going to be important in some of
13 the other elements on this slide.
14 But the other part of it is I think the current
15 FFCRA approach is flawed because there's going to be a long
16 tail to the state distress coming out of when the PHE
17 itself ends, in terms of just getting the economy back in
18 shape and people employed and back with employer-sponsored
19 insurance. And I think the degree of predictability in
20 this kind of recommendation, in terms of state budgeting
21 and state expectations -- I mean, I guess what I'm adding
22 is some things to kind of go into whatever narrative might

1 support this recommendation in a publication down the road.

2 You know, many states are going into their

3 legislation sessions in a couple of weeks, having no

4 knowledge whatsoever of the cliff that may or may not come,

5 and when it may or may not come, in terms of the 6.2

6 percent, and this element not only would add some more

7 predictability to all of that but it would be, I think, a

8 better recognition that the tail of digging out from

9 economic recessions lasts beyond some of the acute factors

10 that prompted it in the first place.

11 CHAIR BELLA: Thank you, Chuck. Darin, can I

12 turn to you, and then Peter, then Tricia.

13 COMMISSIONER GORDON: Yeah. I support Option 2.

14 I think we have got to be clear on the MOE component, and I

15 align more with Chuck. I think that our definition is one

16 that is more consistent with what we've seen in an MOE in

17 years past, and I lean in that direction. Also the third

18 bullet point, I think, makes sense.

19 I am less interested in scoring a cap or a

20 ceiling on the additional FMAP, for only one reason, which

21 is it would be arbitrary and capricious to pick what that

22 cap would be. If that formula is driven on downturns and

1 other economic factors, I think putting an artificial cap
2 in place -- I would question what the basis for doing that
3 would be. So the second bullet, I don't know how we would
4 get there, and therefore wouldn't support that particular
5 component.

6 CHAIR BELLA: Thank you, Darin. Peter and then
7 Tricia?

8 COMMISSIONER SZILAGYI: Yeah. I also support
9 Option 2, and I must admit, for me I understand the MOE
10 conceptually. I'm having a little harder time kind of
11 following the size of the population, for example, for the
12 third bullet, similar to what Darin just much more
13 eloquently talked about for the second bullet. So I do
14 understand the first one, I think, at least conceptually,
15 and that seems like an important addition to the GAO model.

16 CHAIR BELLA: Moira, do you want to say anything
17 about the third bullet?

18 MS. FORBES: Sure. So the third bullet would
19 exclude the adult expansion population, because they get 90
20 percent. Services, it would exclude things like family
21 planning services, services for Title IV, for foster care
22 and adoptees, Indian Health Services. All those things

1 that get 100 percent match wouldn't get an enhanced match.
2 So those are the ones I can think of off the top of my
3 head, the biggest ones.
4 And to Darin's point, what we joke about -- I
5 mean, one cap you could include is 100 percent.
6 COMMISSIONER GORDON: That's a fair cap. And I
7 think one of the questions, to follow up on Peter's point
8 and your clarification, the additional FMAP being applied
9 to the regular FMAP, I think we need to be clear, and my
10 assumption would be that we say that, yeah, a maintenance
11 of effort would apply to, is it the entire population or
12 only to the populations covered by the regular match rate?
13 I'm assuming, and my understanding is that it would apply
14 to the entire population, not just the population for which
15 the additional match was available. But I think we're
16 going to have to be clear on that point.
17 CHAIR BELLA: That is a good clarification.
18 Tricia and then Bill.
19 COMMISSIONER BROOKS: I totally agree with that
20 clarification, Darin.
21 My question is CHIP. This was the first boost
22 that allowed the formula for Medicaid that flows into CHIP

1 to mean that there was a 4.34 percentage point bump in
2 CHIP. It had not been in prior MOE box. And so I think we
3 need to be clear about whether CHIP should be in or out,
4 simply because when we say regular FMAP versus higher FMAP,
5 CHIP is always referred to as enhanced FMAP, and I'm not
6 quite sure where it falls. So the question is, do we need
7 to address that?

8 MS. FORBES: So we didn't talk about CHIP and we
9 also didn't talk about the territories, and a lot of times
10 those have been excluded because they have -- anything with
11 capped funding, if you increase the FMAP for those it just
12 means that you draw down the funding faster. And if this
13 is an automatic formula and Congress isn't intervening,
14 then there is no opportunity to raise that cap, raise the
15 total amount of funding. So I get a little -- I guess,
16 those are some of the aspects of that.

17 CHAIR BELLA: Okay. So that would be something
18 we would need to be clear about, though, in our
19 recommendation. Okay. Thank you, Tricia. Bill?

20 COMMISSIONER SCANLON: Yeah. Moira touched on
21 sort of what I was going to say. It's about the second
22 point, about a cap or a ceiling, that there are two

1 different approaches to that. One would be that there is a
2 cap on the additional percentage point increases in the
3 FMAP, like you couldn't add more than 10 percentage point.
4 Or the other one is that the total FMAP, when you are done
5 adding, can't be greater than a certain amount. And
6 greater than 100 obviously would seem to be problematic.
7 Maybe you don't want it higher than, sort of for the
8 optional population, greater than 90.
9 CHAIR BELLA: Or we're just silent on a cap,
10 right? That's another option.
11 COMMISSIONER SCANLON: Right. You could be
12 silent. Right.
13 CHAIR BELLA: Okay. Fred. Fred, you're on mute.
14 COMMISSIONER CERISE: Sorry about that. Yeah,
15 I'm with the group. I prefer Option 2 as well. One
16 technical point, since you're on caps, is how you would --
17 I don't know if you want to comment on how you would handle
18 DSH. That's caused some confusion in the past as well, in
19 terms of, you know, you just decrease the state share or
20 does the cap float? But I don't know if you want to be
21 clear on that. You know what I'm talking about? It's a
22 similar issue of caps.

1 MS. FORBES: Yeah. There's language in existing
2 situations - how Congress has handled some of these things,
3 and I think that we thought that we would -- if we want to
4 put that level of detail in we could do that.
5 CHAIR BELLA: Does anyone want to make a case for
6 retaining Option 1, or can we focus our attention on Option
7 2?
8 Okay. We're going to focus on Option 2. Other
9 comments from folks on Option 2? It sounds like there's
10 agreement on the MOE and we need to clarify, be very clear
11 about the MOE and what in and out. It does not sound like
12 there's agreement on a cap, and it does sound like there's
13 acknowledgement that bullet point three makes sense.
14 Stacey, did you have a comment?
15 COMMISSIONER LAMPKIN: No, but I agree with
16 everything you just said. I'm just perfectly in line with
17 everything that you said.
18 CHAIR BELLA: Okay. Chuck, I saw your hand.
19 VICE CHAIR MILLIGAN: Yeah, and my comments have
20 less to do with the recommendation itself. I think we
21 could say there should be a cap without specifying the cap.
22 I mean, I do think that that's a choice to say, you know,

1 we shouldn't have distorted effects like going above 100, I
2 mean, without picking a number.
3 I just -- again, part of my comment, Moira, as we
4 write up a chapter about this, and thinking about how we
5 frame it, even for purposes of January, Congress would
6 still -- let's say they adopted this recommendation. They
7 would still have the opportunity to help target enhanced
8 funding in a state like New Orleans during Katrina that is
9 uniquely affected, that isn't -- you know, it is not a
10 broad enough scale impact that it would trigger all of
11 this. But I think we should note that we are not
12 precluding, of course, Congress doing more adjustments
13 along the way that are targeted, because they will.
14 The second thing is I think it's going to be
15 important to talk about, or refer back to some of the
16 analysis, Moira, you and Chris have already shared with us,
17 around the pandemic, because you noted that the enhanced
18 funding took effect in January, and yet the GAO method
19 wouldn't have taken effect until July. But there wasn't
20 kind of the same state distress, economically, in the first
21 two quarters of this year, because there was a lag in terms
22 of the impact on employment and the impact on the economy.

1 So I think it would be good to contextualize that
2 there would not have been, even based on our own analysis,
3 a lot of significant strain on state budgets in the first
4 two quarters of this calendar year.
5 So I just think it's going to be important how we
6 frame this, not just the recommendation, and I wanted to
7 add those comments while we were on this topic.
8 CHAIR BELLA: Chuck, you have now self-appointed
9 yourself as the first editor of the chapter, so thank you
10 for that.
11 VICE CHAIR MILLIGAN: Thank God Moira is such a
12 good writer. I won't have to worry about it.
13 VICE CHAIR MILLIGAN: Darin, can I put you on the
14 spot and put a proposal on the table relative to the cap?
15 It makes me nervous, Chuck, to put a cap in there and not
16 put an amount in there. That makes me nervous.
17 COMMISSIONER GORDON: Yeah, no, I totally agree.
18 I think that Moira's obvious point that, you know, 100
19 percent might be the place to stay, and I think that feels
20 right to me. We've never exceeded 100 percent, and I think
21 saying, you know, a cap of 100 percent would be a
22 reasonable thing to propose, as part of the recommendation.

1 MS. FORBES: And if you don't want to put it in
2 the recommendation we can always -- there can also be
3 discussion. I mean, there is always discussion too. So
4 some of these things, if you don't want to put it in a
5 recommendation we can always put it in the narrative, that
6 I'm sure Congress, you know, pays super close attention to.
7 So we can also do that.
8 CHAIR BELLA: All right.
9 COMMISSIONER GORDON: I'm worried if we don't put
10 something -- I mean, if we say there should be a cap and we
11 don't put anything, that's where it will slip into scoring,
12 you know, driving the decision, or some other arbitrary and
13 capricious matter could be the driving force. So if we're
14 going to say something about a cap that there should be a
15 cap, I would support saying that the enhanced match could
16 be no greater than 100 percent, total match can be no
17 greater than 100 percent.
18 CHAIR BELLA: Okay. Why don't we use that as our
19 starting point, and then, Bill, we can have a discussion
20 about whether 100 is too high and what it needs to be, and
21 then we can see what makes it through in our final
22 recommendation.

1 So it sounds like Option 2 with those three
2 examples, and if there are others that you think of you can
3 bring them back to us in January. But otherwise, does
4 anyone have any final comments, any Commissioners?
5 CHAIR BELLA: Why don't we just go ahead and see
6 if there is any public comment right now, so we can close
7 out on this. Would anyone from the public like to comment
8 on this session? If you do, please raise your hand.
9 **### PUBLIC COMMENT**
10 * [No response.]
11 CHAIR BELLA: It is kind of funny to be this
12 excited about a countercyclical proposal, but I'm pretty
13 excited that after all these years we're going to advance
14 some work in this area. So thank you for all the time that
15 you have put into this. Do you guys have what you need to
16 come back to us for the vote?
17 MS. FORBES: Yep. Thank you.
18 CHAIR BELLA: All right.
19 VICE CHAIR MILLIGAN: Yeah, and Melanie, I just
20 want to give you, in particular, a compliment here. We
21 started taking this work, as Moira said, a year ago, when
22 people thought this was super theoretical and what could

1 possibly go wrong with the economy, and look what happened.
2 And I think getting ahead of it and taking this issue up, I
3 just want to acknowledge your leadership on this point, in
4 particular, because we went to this topic before there was
5 a crisis, when it may have seemed like not a great use of
6 MACPAC time and energy, and it turned out to be an
7 incredibly use of our time and energy.

8 CHAIR BELLA: Thank you, Chuck, and thank you,
9 Moira and Chris.

10 CHAIR BELLA: We are in the very home stretch,
11 everybody. Thank you for staying so engaged. Chuck is
12 actually going to finish us out and then also start us off
13 tomorrow. So Chuck, I will turn it to you.

14 VICE CHAIR MILLIGAN: Thank you. So let me just
15 really briefly set the stage for this. We've been, as a
16 Commission, taking on the issue of integration between
17 physical health and behavioral health in several different
18 areas over the course of recent months, and there is more
19 work to come, so today's presentation and discussion is not
20 going to be the be-all-and-end-all, and I don't want
21 anybody in the public who might be attending thinking that
22 this one particular topic is the sole focus of our effort

1 in this area. It is a building block that is part of a
2 more comprehensive approach that we are taking to thinking
3 about integrated care between behavioral health and
4 physical health.
5 So having said that background I will now turn it
6 over to Erin and Aaron to help us go through the materials.
7 It's all yours.
8 ### **INTEGRATING CLINICAL CARE THROUGH GREATER USE OF**
9 **ELECTRONIC HEALTH RECORDS BY BEHAVIORAL HEALTH**
10 **PROVIDERS**
11 * MS. McMULLEN: Thanks, Chuck. So the Commission
12 has repeatedly commented on the need to improve the
13 integration of clinical care for patients with both
14 behavioral and physical health conditions. So at today's
15 meeting, like Chuck said, we are going to continue that
16 discussion on this issue but we are focusing more narrowly
17 on how increased use of certified electronic health record
18 technology can improve integration. As we will discuss
19 shortly, EHR use among behavioral health providers is
20 relatively low, and presents a barrier to care
21 coordination.
22 Next slide, please.

1 So first we're going to briefly discuss prior
2 MACPAC work on substance use disorder confidentiality
3 regulations under 42 CFR Part 2, or just known as Part 2
4 for short. Then we'll summarize barriers to clinical
5 integration, highlighting the financial and legal barriers
6 behavioral health providers encounter when receiving and
7 sharing patient data within the health care system.
8 Then I'll hand it over to Aaron to discuss prior
9 federal efforts to strengthen EHR adoption under the Health
10 Information Technology for Economic and Clinical Health
11 Act, or HITECH Act, of 2009. He will also present findings
12 from an internal analysis of federal survey data that
13 demonstrates behavioral health treatment facilities lag
14 significantly behind physical health providers in the
15 sharing of standardized patient information. We will
16 conclude by discussing existing Medicaid authority to
17 support EHR adoption and next steps.
18 I just wanted to note that the Medicaid program
19 is uniquely poised to address low rates of the EHR use
20 among behavioral health providers. Medicaid is the largest
21 payer for mental health services in the U.S., and it is
22 assuming a larger role in the payment of substance use

1 disorder treatment services. Based on Commissioner
2 interest, this is an area where the Commission could make
3 recommendations in the June report to Congress, if it so
4 chooses.
5 Next slide.
6 So before we discuss barriers to EHR adoption we
7 just wanted to remind Commissioners and the public of our
8 prior work on Part 2. As you know, Part 2 is the federal
9 rule governing the confidentiality of patient records
10 related to substance use disorder treatment. If a provider
11 wants to disclose or redisclose Part 2 protected
12 information for treatment purposes, additional patient
13 consent is required.
14 In our June 2018 report to Congress, MACPAC
15 discussed how Part 2 affects care delivery for Medicaid and
16 CHIP beneficiaries who have substance use disorders. We
17 explored options to promote information sharing, and we had
18 two recommendations to address these concerns. Generally,
19 the chapter noted confusion among providers and payers
20 about how to comply with Part 2, and how this confusion
21 hindered care coordination for individuals with substance
22 use disorders.

1 When it comes to sharing Part 2 protected
2 information electronically, EHRs must segment Part 2
3 information from other health records that are only
4 subjected to HIPAA. This segmentation requirement is
5 further complicated by the fact that Part 2 also allows for
6 granular consent. For example, a patient could choose to
7 share only a portion of their substance use treatment
8 record, as opposed to all or none of their substance use
9 treatment history.
10 Therefore, in order to share Part 2 protected
11 information, an EHR system must be able to comply with
12 segmentation and granular consent requirements. In
13 practice, we have heard that this is often challenging for
14 providers.
15 Since publication of the June 2018 report, the
16 Commission responded to further Part 2 rulemaking that
17 occurred in the fall of 2019. In a comment letter to
18 Secretary Azar, the Commission noted that proposed
19 regulatory changes to Part 2 were modest, and did not
20 address broad concerns MACPAC raised in its prior work.
21 This proposed rule was finalized earlier this year and
22 makes some modest changes to facilitate better care

1 coordination for individuals with substance use.

2 More recently the Coronavirus Aid, Relief, and
3 Economic Security Act permanently aligns 42 CFR Part 2 and
4 HIPAA, although the specifics of that alignment will occur
5 through future rulemaking.

6 Next slide.

7 So the barriers to clinical integration as they
8 relate to EHR adoption are numerous and discussed in
9 greater detail in your meeting materials. I'm not going to
10 discuss the issues related to Part 2 that are noted on this
11 slide because I've just mentioned them previously, but I am
12 going to touch on a few other challenges providers face.

13 In part, slow adoption of EHRs can be attributed
14 to the fact that behavioral health providers often have
15 limited working capital to invest in technology. Aaron
16 will get into this in greater details, but many behavioral
17 health facilities and providers were left out of large-
18 scale efforts to modernize and digitize health care under
19 the HITECH Act. Until recently, federal guidance also
20 advised opioid treatment programs not to share Part 2
21 protected information with prescription drug monitoring
22 programs. It was SAMHSA's view that it was not feasible

1 for PDMPs to protect substance use disorder information for
2 redisclosures that are prohibited by Part 2.
3 Due to these issues as well as challenges
4 associated with Part 2, there has been limited investment
5 in high-quality behavioral health EHR systems. Many EHRs
6 and health information exchanges simply omit substance use
7 disorder information, and in some instances, substance use
8 treatment providers are excluded from HIE participation.
9 With that, I'll turn it over to Aaron.
10 * MR. PERVIN: Thank you, Erin.
11 As a consequence of the 2008 recession, providers
12 delayed in investing in EHRs because of the expensive
13 implementation costs. As a partial response to this,
14 Congress passed the HITECH Act as part of the 2009 stimulus
15 package, which created what is now known as the Promoting
16 Interoperability Program. The program promoted the
17 meaningful use of EHRs through a fully federally funded
18 incentive payment. To receive incentive payments,
19 providers had to adopt certified EHR technology and submit
20 data to the states that showed meaningful use of EHRs.
21 To help states administer the program, HITECH
22 provided a 90 percent federal match for all administrative

1 expenses. After the passage of HITECH, EHR adoption
2 increased substantially.
3 This chart shows the rate of adoption among non-
4 federal acute-care hospitals, which are broadly consistent
5 with the hospitals that were eligible for HITECH incentive
6 payments. Payments began in 2011, and according to survey
7 data collected by the American Hospital Association,
8 adoption and meaningful use of basic EHR systems increased
9 from 10 percent in 2008 to over 80 percent by 2013.
10 Likewise, by 2015, almost 100 percent of
11 hospitals had in their possession EHR technology certified
12 by HHS. Robust adoption of certified EHR technology is
13 important to interoperable efforts. Certified EHRs are
14 required for HITECH incentive payments. They ensure that
15 the records adhere to HIPAA requirements, and they ensure
16 that EHRs have a standardized language which enables
17 greater patient data sharing.
18 One of the drawbacks of HITECH is that it was
19 fairly limited in scope. The intent of HITECH was to focus
20 on physicians, who are the primary clinical decisionmakers,
21 and hospitals, which are the facilities with the highest
22 share of medical spending. Providers that were eligible

1 for incentive payments included all medical doctors,
2 psychiatrists, dentists, nurse-midwives, nurse
3 practitioners, and certain physician assistants. Eligible
4 hospitals were primarily acute-care centers. Consequently,
5 many providers that disproportionately serve the Medicaid
6 population were left out of the HITECH framework.
7 In 2015, for example, 20 percent of ineligible
8 hospitals such as long-term care, psychiatric, and
9 rehabilitation hospitals, had adopted a basic EHR system
10 compared to over 80 percent of eligible hospitals.
11 This chart gives you a sense of the different
12 types of providers that were ineligible for Medicaid EHR
13 incentive payments under HITECH. They include a large
14 variety of providers that are critical for the Medicaid
15 population, including long-term and post-acute care
16 providers, many behavioral health providers, and safety net
17 facilities such as federally qualified health centers and
18 rural health clinics.
19 One caveat on this is FQHCs and rural health
20 clinics. They are both facilities that could theoretically
21 receive incentive payments if they were led by an eligible
22 physician.

1 As part of this work, we quantified the extent to
2 which certain behavioral health facilities have adopted
3 EHRs using two SAMHSA surveys that asked mental health and
4 SUD treatment facilities about using electronic means for
5 basic clinical functions. Similar to EHR analyses for
6 hospitals, we looked at the extent to which non-federally
7 owned behavioral health facilities use and adopt EHRs and
8 compared them to federally owned facilities. We do this
9 because federally owned facilities, such as those owned by
10 the Veterans Administration and the Department of Defense,
11 have benefitted from federal efforts from federal efforts
12 to digitize health records. It is important to note that
13 these surveys do not ask about certified EHR technology,
14 indicating that the need for federal intervention could be
15 even greater than the surveys would suggest.
16 Overall, we find that behavioral health
17 facilities use electronic means for basic clinical
18 functions at a lower rate compared to HITECH-eligible
19 hospitals. Furthermore, non-federally owned behavioral
20 health facilities use EHRs and electronically share patient
21 data at lower rates compared to federally owned facilities.
22 As an example, federally owned BH facilities are

1 over two times as likely to electronically store patient
2 health records and over ten times as likely to share this
3 information electronically with other providers compared to
4 non-federally owned facilities.

5 This chart looks at mental health and SUD
6 treatment centers that have access to federal support for
7 basic EHR adoption and compares them to facilities that do
8 not have access to these resources. As you can see, the
9 differences between federally owned and non-federally owned
10 facilities are quite large.

11 Among non-federally owned mental health
12 facilities, only 6 percent use electronic means to
13 accomplish basic clinical tasks such as client assessments
14 or creating treatment plans compared to 58 percent of
15 federally owned mental health facilities.

16 Among non-federally owned substance use treatment
17 facilities, only 29 percent have access to a basic
18 electronic system compared to 87 percent among federally
19 owned facilities.

20 It's a similar story with sharing patient
21 information. Facilities without access to federal
22 resources, electronically share patient information at much

1 lower rates compared to facilities with access to federal
2 IT resources. This chart shows that 89 percent of
3 federally owned mental health facilities electronically
4 share data compared to 9 percent of non-federally owned
5 facilities. Meanwhile, 56 percent of federally owned
6 substance use treatment facilities electronically share
7 patient data compared to 3 percent of non-federally owned
8 substance use treatment facilities.
9 This highlights an important point about
10 interoperable systems. Low rates of certified EHR adoption
11 also lowers the incentive for other facilities to adopt
12 interoperable EHR systems. This is because that facility
13 may have a low number of partner facilities that can
14 receive their patient data. This can lead to low patient
15 information sharing across the entire health system, not
16 just within the behavioral health space.
17 There are a few existing authorities that can be
18 used to support EHRs within behavioral health centers.
19 We're not going to spend a lot of time discussing these two
20 authorities, but we did want to bring them to your
21 attention. It is our understanding that neither of these
22 options are viable mechanisms to fund EHR adoption across

1 the behavioral health community writ large.

2 The first authority states can use is they can
3 apply to use HITECH administrative funds to pay facilities
4 to share data with other providers. However, payments
5 cannot be used to incentivize certified EHR adoption or
6 supplement existing certified EHR technology.

7 Secondly, the SUPPORT Act authorized the
8 Innovation Center to administer demonstrations that target
9 EHR incentive payments to behavioral health providers and
10 facilities. However, no funding was allocated under the
11 SUPPORT Act, and none of CMMI's current models use this
12 authority to date.

13 Given that Medicaid is the largest payer of
14 mental health services and is a growing payer of substance
15 use disorder treatment, we think that Medicaid is in a
16 unique position to promote interoperability as a means of
17 strengthening clinical integration. As next steps for this
18 project, we wanted to gauge Commissioner interest in doing
19 more work on interoperability, EHRs, and behavioral health
20 providers. Furthermore, staff could develop policy options
21 which build on the success of HITECH by expanding EHR
22 incentive payments to behavioral health providers.

1 Thank you, and both of the Erin/Aaron(s) look
2 forward to your questions and feedback.
3 VICE CHAIR MILLIGAN: Thank you very much, both
4 of you. Would anybody like to start us off? Kisha and
5 then Kit.
6 COMMISSIONER DAVIS: Hi. Thanks, both
7 Erin/Aaron(s). This was a really great report.
8 A couple things that actually have come up for
9 me, you know, we've talked about the interaction between
10 Part 2 and HIPAA before, and, again, I just want to say how
11 much Part 2 adds an additional barrier. And I often wonder
12 if it's actually protecting patients and their data or just
13 getting in the way of being able to have an interoperable
14 system.
15 A couple of examples. One, you know, substance
16 use facilities are not sharing their data. I could
17 potentially have a patient that is being seen and treated
18 and on methadone, and I have no insight into that. And I
19 check the PDMP or am not able to get data unless that
20 patient discloses it. They could come to me for pain,
21 could potentially get prescribed an opioid, and that is,
22 you know, just -- could potentially be lethal for that

1 patient. And so it is really important for the health care
2 team to be integrated and really to be able to have full
3 insights into the care that patients are getting.
4 The other is around the ability to risk-code, and
5 when we think about value-based care, how the risk-coding
6 factors into the complexity of the patient. And so when we
7 are -- what I'm looking at, you know, my patients, you
8 know, complicated diabetes and heart failure and COPD, if I
9 am not able to see their substance use disorder, that
10 carries risk weight and that, you know, factors into
11 discussions around, you know, services and benefits, and
12 it's really important when you're thinking about value-
13 based contracting to have full insights into that.
14 So, you know, in terms of whether the Commission
15 should explore this area more, absolutely, and what I would
16 love to see from staff, you know, in addition to kind of
17 continuing this conversation around HIPAA and Part 2, would
18 be what are the types of incentives that would get us to
19 more expansion of EHR use among providers. Is it -- you
20 know, what's the level of funding that's needed? What's
21 the level of integration, and encouraging that with any EHR
22 expansion or funding that comes for that, also requirements

1 around interoperability?

2 VICE CHAIR MILLIGAN: Thank you, Kisha. Kit and

3 then Martha and --

4 COMMISSIONER GORTON: I have to laugh that --

5 VICE CHAIR MILLIGAN: Sorry?

6 COMMISSIONER GORTON: I have to laugh that Aaron

7 was bold enough to ask whether the Commission wanted more

8 work done. When does the Commission ever not want more

9 work done? So you just check yes or no.

10 I would -- I don't disagree with what Kisha said,

11 but there's another perspective that I think as we go

12 forward with more work we have to keep in mind. When we

13 did the Part 2 work -- was it two years ago, Erin, three

14 years ago? -- we heard about misuses of the information.

15 And as we talked earlier today about a situation with the

16 lines between social services, human services, and health

17 care services are blurring, we need to take into account --

18 we talked a lot about housing. Substance use gets you

19 disqualified from subsidized housing. Substance use gets

20 you evicted. And so there's the balance there. Substance

21 use gets your children taken away from you if you're in the

22 child welfare system. So there's a tension there that I

1 think we need to be sensitive to.

2 I agree within the medical silo we can't achieve

3 full integration, but as the medical silo expands to

4 include these other things, I think we do need to think

5 about protections that eliminate these other things. It

6 does us no good to extend somebody's postpartum treatment

7 if their substance use becomes known to law enforcement and

8 they're in violation of their parole and they get sent back

9 to jail. So it is a complicated issue, and as we blur the

10 lines, I think we need to pay attention to that.

11 I would underscore, though, Kisha's point, which

12 I think is spot-on, that this is a black hold in risk

13 adjustment. It's a black hole, and it's one of those

14 places when we're talking about information that we don't

15 know, what you don't know can hurt you, particularly if you

16 don't know what you don't know. And so the bias that we

17 were talking about earlier, right? So there's a

18 rationalization of this as well, and so we need to think

19 about how we can collect data in ways that don't harm or

20 disadvantage Medicaid beneficiaries in ways which would not

21 harm and disadvantage people who are not on Medicaid

22 because they have the wherewithal to protect their privacy

1 more stringently.

2 VICE CHAIR MILLIGAN: Thanks, Kit. Martha.

3 COMMISSIONER CARTER: Thank you. I've had a
4 little background conversation with the Erin/Aaron(s) on
5 this, but I also want to highlight the role of community
6 health centers in providing integrated behavioral health
7 care, because that's not really a category that you've
8 looked into, and I think it's an important addition. You
9 talk about private practices, and you talk about federally
10 owned facilities. But the health centers are a unique type
11 of provider, and in 2019, 98 percent of health centers used
12 an EHR for all providers at all sites, and 95 percent of
13 health centers provide behavioral health services. So --
14 here comes a technical term -- "a lot" of health centers
15 are using an integrated behavioral health record or they're
16 using an EHR for their behavioral health services.

17 Now, how integrated that is, I think it's almost
18 a chicken-and-egg thing, because unless there's a
19 requirement that the vendors develop an integrated product,
20 it's not going to happen. And you can't integrate unless
21 your system will do it. I know several years ago when we
22 were trying to design into a leading EHR the ability to

1 track substance use disorder services, it just wasn't
2 there. We couldn't do it. And we wound up with work-
3 arounds and scanned-in paper files. And so I think it's
4 really important that we do this work and that we highlight
5 the limits of the capabilities right now in really
6 integrating the data collection.
7 And one final point is that this all has
8 important implications for quality metrics. As states are
9 increasingly requiring quality measures and some of them
10 are going to be at least around depression screening, we've
11 got to be able to measure that accurately, and really you
12 need the EHR to do that. And I don't know if there are
13 other ways that -- you know, the coming requirements for a
14 state to report quality metrics really puts some pressure
15 to implement EHRs in behavioral health, but I think that
16 would be another place to look into.
17 VICE CHAIR MILLIGAN: Thank you. Tom, did I see
18 that you wanted to jump in?
19 COMMISSIONER BARKER: Sorry, Chuck. No, I might
20 have just been moving my hand. Sorry about that.
21 VICE CHAIR MILLIGAN: Okay. I would be a
22 terrible auctioneer.

1 COMMISSIONER BARKER: Same here.
2 VICE CHAIR MILLIGAN: Is there anybody else?
3 Fred.
4 COMMISSIONER CERISE: Thanks. I would just lend
5 my support to it. I think it's a good topic, perhaps even
6 talking to some of the providers out there about their
7 experience. You know, I'm aware of at least -- you know,
8 our local mental health authority tried to develop their
9 own as a work-around, and it was not successful. You know,
10 there's frustration out there. Even large providers, you
11 know, community mental health centers that have difficulty
12 finding the right tool, they're not big enough to get
13 people like Epic to work with them, and so they're sort of
14 searching to hook on. We, you know, talk to groups that
15 want to connect through our systems, and so I think it
16 would be good to get some of the perspective of those out
17 there that are trying to do this. But I do think it's just
18 something we haven't shined a light on, but it's out there,
19 and it's amazing the disparity between, you know, physical
20 health and mental health providers and their access to
21 this. So I think it's a good topic to probe deeper into.
22 [Pause.]

1 CHAIR BELLA: Chuck, if you're talking, we can't
2 hear you.
3 VICE CHAIR MILLIGAN: Yep. So was there anybody
4 else?
5 [No response.]
6 VICE CHAIR MILLIGAN: I had a question and a
7 couple of comments.
8 Erin McMullen, I assume we haven't heard anything
9 further about rulemaking regarding the CARES Act changes to
10 confidentiality in Part 2. Is that correct?
11 MS. McMULLEN: Your assumption is correct. We
12 are still waiting to see a proposed rule that would do the
13 alignment that was required by the CARES Act in regulation.
14 VICE CHAIR MILLIGAN: So aligning more to HIPAA?
15 Aligning more to HHS and the Office for Civil Rights as
16 kind of the administrative entity. Okay.
17 I had a couple of comments, but I think they fit
18 in the area where a lot of the discussion has been. I
19 think as we advance the work here, it would be helpful in a
20 descriptive sense to articulate the ways in which an EHR is
21 utilized for risk stratification in terms of identifying
22 high-risk, high-need members for enhanced care coordination

1 or enhanced interventions and the gap that's created
2 because of where we are right now with some of the
3 behavioral health-related information.
4 I think it would be good to capture descriptively
5 how EHRs are used to measure and track quality and quality
6 improvement, per Martha's comment and other comments in
7 similar veins, because I think if we want to get to the
8 point of thinking about incentives or HITECH or what was
9 made available to other provider types, I think it would be
10 helpful to lay the foundation first around how these tools
11 are utilized for outcomes in care. And I think building up
12 that foundational piece would be good.
13 The other, I guess, comment I have -- and maybe
14 it's a question. Do we have a sense from the vendors that
15 are kind of the leading EHR vendors of whether there would
16 be in the IT roadmap sense a development process that would
17 be a barrier, or is this something that they could
18 accommodate integrating information more broadly if it was
19 provided to them and the incentives were aligned? I'm
20 trying to figure out if the way in which the data in these
21 systems is segmented or people have read access or use
22 access, whether there's any IT development element of this

1 that would be relevant or not. Do we know?

2 MR. PERVIN: Erin, do you want to talk about the

3 Part 2 segmentation issues, and I can talk about some of

4 the resources that are required?

5 VICE CHAIR MILLIGAN: Where I'm going is, if that

6 is part of the problem statement here, I want to make sure

7 that we don't miss it, and if it isn't, I want to make sure

8 that we articulate that it's not a problem to integrate

9 data because systems might have been built to segment data.

10 MS. McMULLEN: So maybe just a little bit more on

11 what the CARES Act did around Part 2 and HIPAA. Currently,

12 under Part 2, in order to disclose any information, you

13 have to get additional patient consent.

14 One of the things that the CARES Act did was,

15 assuming the person gives us consent initially, there

16 wouldn't need to be that additional consent for subsequent

17 redisclosure. So that kind of addresses -- it's our

18 understanding from talking to a few different folks that

19 work in this space that that's kind of one barrier that the

20 CARES Act addressed.

21 Another thing -- and I think this is something

22 that we are going to have to watch as it plays out when a

1 proposed rule does come out -- one of the things that we
2 highlighted through our previous work had to do with the
3 fact that Part 2 allows for granular consent. The EHR
4 systems, I think it was incredibly difficult for providers
5 to try to figure out how to account for that granularity.
6 It's actually one of the things that you all highlighted
7 and commented on when you made recommendations on this. So
8 I think those are things that we'll have to watch for as we
9 continue to do work in this area.
10 Then, Aaron, I don't know if you wanted to touch
11 on some of the things that I didn't address.
12 MR. PERVIN: Sure. So under HITECH, because of a
13 lot of the funding that was provided through HITECH,
14 vendors were able to use that expanded market to create
15 additional modules for different specialty groups. So we
16 talked to a few stakeholders, and what we've heard is that
17 there's kind of a market issue, that the market isn't
18 demanding a lot of behavioral health-specific modules.
19 Because of that, provider satisfaction with behavioral
20 health modules tend to be pretty poor.
21 So there's some sense that the market just isn't
22 there right now, and the demand isn't there for a very

1 strong and consumer-focused module, which would help
2 behavioral health facilities.
3 VICE CHAIR MILLIGAN: And so the more you can
4 help us understand those implications as this work
5 progresses, I think that would be good.
6 Just kind of a little bit of a roadmap, I'll ask
7 and see if Commissioners have any final thoughts. Then
8 I'll turn it to public comment.
9 Tom, you're trying to trick me again, aren't you?
10 COMMISSIONER BARKER: Chuck, no. This time, I
11 really do have a comment, which is to say that I actually
12 believe that that reg might have just been issued in the
13 past 15 minutes. OCR just issued the HIPAA privacy reg
14 that I believe deals with Part 2, but every time I try to
15 open it on my computer, my computer crashes. So I cannot
16 say for sure, but maybe tomorrow we can give a brief update
17 in the morning just to let people know if I'm correct that
18 it has been issued.
19 VICE CHAIR MILLIGAN: Tom, if you are correct,
20 maybe we can spend the first couple of minutes, because we
21 do come back to behavioral health in children and
22 adolescent issues first thing tomorrow.

1 EXECUTIVE DIRECTOR SCHWARTZ: As long as all
2 we're going to say is it either did or didn't happen, not
3 what the implications of it are.
4 COMMISSIONER BARKER: Well, yes. Anne, I wasn't
5 suggesting that we would do -- one thing I have seen is
6 that it's 354 pages. I just can't go beyond that first
7 page. So I wasn't suggesting we do a summary. Just to let
8 people know that it's out.
9 VICE CHAIR MILLIGAN: If it was 45 minutes ago,
10 maybe, but not 15 minutes ago.
11 [Laughter.]
12 VICE CHAIR MILLIGAN: Okay. Is there anybody in
13 the public who wants to comment on this particular issue or
14 sessions? If you do, if you could raise your hand, and
15 we'll see if there's somebody who wants to comment on this.
16 **### PUBLIC COMMENT**
17 * [No response.]
18 VICE CHAIR MILLIGAN: Seeing none, let me just go
19 back, then, to Erin and Aaron and see if you have what you
20 need form us to kind of work on the next steps. Do you
21 feel like you've got what you need?
22 [No response.]

1 VICE CHAIR MILLIGAN: Okay, great. So that will
2 wrap up this session.
3 Melanie, I'll kind of give it back to you to
4 close out the day for us.
5 CHAIR BELLA: Thank you, Chuck. I think you'd
6 make a good emcee and possibly a good auctioneer with more
7 practice.
8 Thank you, everybody, for staying engaged. We
9 made a lot of progress today. We have a jam-packed day
10 tomorrow as well starting with access to behavioral health
11 for children and adolescents, as Chuck indicated. We'll
12 start with some Commission discussion, and then we'll turn
13 to a panel. And then we'll just keep running the rest of
14 the day until about this time tomorrow.
15 Again, appreciate your preparation, appreciate
16 your engagement, appreciate Anne and the staff and Jim and
17 everybody for making this continue to be relatively
18 painless, even though we don't get to physically be
19 together.
20 Tomorrow we'll reconvene for the public meeting
21 at 10:30 and look forward to seeing everybody then. Hope
22 you all have a nice evening.

1 * [Whereupon, at 4:19 p.m., the meeting recessed,
2 to reconvene at 10:30 a.m., Friday, December 11, 2020.]
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PUBLIC MEETING

Via GoToWebinar

Friday, December 11, 2020
10:31 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
CHARLES MILLIGAN, JD, MPH, Vice Chair
THOMAS BARKER, JD
TRICIA BROOKS, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
STACEY LAMPKIN, FSA, MAAA, MPA
SHELDON RETCHIN, MD, MSPH
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 [10:31 a.m.]

3 CHAIR BELLA: Welcome, everyone, to Day 2 of
4 MACPAC's December meeting. Thank you all for joining us.
5 We have an exciting topic this morning, including a panel,
6 and Chuck is actually going to lead us through that, so I
7 will turn it over to you, Chuck.

8 VICE CHAIR MILLIGAN: Thanks, Melanie. We are
9 going to begin this morning with an ongoing discussion
10 about access to behavioral health services. In a previous
11 meeting, we had discussions around access for adults. This
12 morning we are going to hear first from our staff who have
13 done some work on this area, to present some background
14 information, and we look forward to that, Erin and Melinda.
15 After that we will have a panel discussion, and then a
16 Commission discussion following that panel.

17 So without further ado I will turn it over to
18 Erin and Melinda to set the context and provide the
19 background information that will drive this morning's
20 discussion.

21 **### ACCESS TO BEHAVIORAL HEALTH SERVICES FOR CHILDREN**
22 **AND ADOLESCENTS**

1 * MS. ROACH: Great. Thanks, Chuck.
2 As Chuck mentioned, today's discussion of
3 children's behavioral health is divided into three parts.
4 First, we will present our analysis of access to behavioral
5 health services for youth in Medicaid and CHIP. Then we
6 will hear from a panel of experts who will provide
7 additional insights and address actions states are taking
8 to improve care for youth with behavioral health needs.
9 Following the panel, Commissioners will have additional
10 time to reflect on findings from the presentations and
11 offer thoughts on MACPAC's ongoing work in this area.
12 Based on Commissioner feedback, this information may be
13 incorporated into a chapter for the June report.
14 As we will explore today, the needs of youth with
15 behavioral health conditions often go unmet. This is
16 despite Medicaid's early and periodic screening,
17 diagnostic, and treatment or EPSDT benefit, which requires
18 states to cover all medically necessary services for
19 enrollees under age 21, and the SUPPORT Act provision
20 mandating behavioral health coverage in CHIP.
21 Next slide.
22 To further the Commission's understanding of

1 these issues and where gaps exist, we will start by
2 discussing the prevalence of certain behavioral health
3 conditions among adolescents and the rates at which they
4 receive treatment, comparing those in Medicaid or CHIP to
5 those with other sources of coverage. Then Erin will
6 discuss the availability of specialty mental health and SUD
7 treatment facilities as well as office-based providers and
8 school-based health centers serving children with
9 behavioral health needs.
10 Next slide.
11 For this analysis, we contracted with the State
12 Health Access Data Assistance Center at the University of
13 Minnesota to analyze the National Survey on Drug Use and
14 Health, a federal survey that is conducted annually in all
15 50 states and the District of Columbia. It provides
16 information on self-reported alcohol and drug use, mental
17 health, and other health-related issues among non-
18 institutionalized individuals, age 12 and older, in the
19 United States.
20 Our first slide here looks at mental health
21 characteristics among youth, and as you can see, in 2018,
22 roughly 1 in 5 adolescents reported ever experiencing a

1 major depressive episode or MDE, and nearly 1 in 10 had
2 experienced an MDE with severe role impairment in the past
3 year. These rates were fairly consistent across coverage
4 groups.

5 Our analysis also examined the prevalence of
6 suicidal thoughts and behaviors among non-institutionalized
7 adolescents. In 2018, roughly 12 percent of youth had
8 thoughts of suicide, and nearly 4 percent had attempted
9 suicide in the past year.

10 Next slide.

11 While the prevalence of past-year substance use
12 was similar across coverage groups, rates at which
13 adolescents use alcohol and certain drugs varied when
14 comparing adolescents in Medicaid to those with private
15 insurance. In 2018, Medicaid beneficiaries were less
16 likely than those with private insurance to have ever used
17 alcohol, or to have used alcohol in the past year.
18 Conversely, adolescents in Medicaid reported higher rates
19 of marijuana use, and were more likely to have used a pain
20 reliever not directed by a doctor. Due to the small sample
21 size we were not able to estimate the prevalence of other
22 types of illicit drug use, including use of heroin,

1 cocaine, and methamphetamines.

2 Next slide.

3 Our analysis also examined the prevalence of MDE
4 and substance use across demographic groups. In 2018, the
5 percentage of youth with MDE didn't vary significantly
6 based on race and ethnicity. When looking across coverage
7 groups we found that Black and Hispanic youth in Medicaid
8 were less likely to report a past-year MDE when compared to
9 their privately insured peers. We also found that females
10 were generally about twice as likely as males to have a
11 past-year MDE. In 2018, the prevalence of past-year
12 substance use didn't vary significantly by sex, race, and
13 ethnicity, nor were there notable differences across
14 coverage groups. Here again, our analysis was limited due
15 to the small sample size. We are working on additional
16 analyses of behavioral health conditions and treatment
17 rates across racial and ethnic groups in Medicaid, and look
18 forward to sharing our findings with the Commissioners.

19 Next slide.

20 In 2018, nearly 1 in 4 adolescents received some
21 form of specialty or non-specialty mental health services.
22 Youth in Medicaid received treatment at similar rates as

1 their peers with private coverage, but were more likely to
2 receive non-specialty mental health services, for example,
3 from a pediatrician or school counselor, when compared to
4 their privately insured peers, who more often received care
5 from a private therapist, psychiatrist, or social worker.
6 Medicaid beneficiaries were also more likely to stay
7 overnight in a hospital or residential facility.
8 Rates of treatment among adolescents with mental
9 health conditions suggest there was a significant number
10 who needed but did not receive services. Among Medicaid
11 beneficiaries, only 54 percent of youth with MDE and 60
12 percent of youth with MDE with severe role impairment
13 received some form of mental health treatment in the past
14 year.
15 Next slide.
16 Among all non-institutionalized adolescents
17 receiving specialty mental health services, the majority
18 did so because they felt depressed. Other common reasons
19 included because they thought about or had attempted
20 suicide, felt afraid or tense, or had problems at home or
21 with family.
22 Next slide please.

1 Schools played an important role in identifying
2 youth with behavioral health needs and connecting them with
3 treatment and other services. In 2018, all youth in
4 Medicaid were more likely to receive mental health services
5 from education sources when compared to you with private
6 coverage. They were also more likely to receive specialty
7 treatment in a school or attend a school program for
8 emotional problems. Compared to all youth without
9 insurance, adolescents in Medicaid were three times more
10 likely to speak with a school social worker, psychologist,
11 or counselor for emotional problems. Perhaps
12 unsurprisingly, youth with MDE and MDE with severe role
13 impairment were more likely to receive school-based
14 services, and this was generally true regardless of an
15 adolescent's coverage status.
16 Next slide.
17 Nearly half of all youth in Medicaid who received
18 school-based mental health services did so because they
19 were depressed. Other common reasons included feeling
20 afraid or tense, having problems at school, and having
21 thought about or attempted suicide.
22 Next slide.

1 Across all coverage categories, adolescents with
2 past-year substance use had high rates of unmet need. In
3 2018, about 94 percent of adolescents with SUD reported
4 that they needed but did not receive alcohol or drug
5 treatment in the past year. Less than 15 percent of youth
6 in Medicaid with SUD ever received alcohol or drug
7 treatment, and roughly 1 in 10 received treatment for
8 alcohol or drug use in the past 12 months.
9 With that I will turn it over to Erin to discuss
10 the availability of behavioral health providers serving
11 children.
12 * MS. McMULLEN: Thanks, Melinda. Children and
13 youth with behavioral health conditions need access to a
14 range of treatment services that vary in intensity. These
15 services could be delivered in a variety of settings,
16 including office-based settings, school-based health
17 centers, or SBHCs, and specialty behavioral health
18 treatment facilities that serve youth with more severe
19 needs.
20 On the next several slides we will discuss the
21 availability of behavioral health screening and treatment
22 in these three settings. We will also discuss provider

1 participation in Medicaid, as well as what types of
2 services are offered by these providers. Where possible,
3 we will describe availability of these providers at the
4 state level. Due to data limitations, I just wanted to
5 point out that today we are not going to discuss the role
6 of foster care settings and juvenile detention centers as
7 they relate to the diagnosis and treatment of youths with
8 behavioral health conditions. These settings do play a
9 really important role, however. We are currently exploring
10 additional data analyses to examine the role of these
11 settings, and hope to come back to you in the future with
12 some more information on that.
13 So many different types of providers, including
14 social workers, psychologists, psychiatrists, and
15 professional counselors, deliver office-based behavioral
16 health services to children and adolescents, but no single
17 data set captures all of these providers. So as such, you
18 will see in your meeting materials that we highlight select
19 findings related to physician availability. In particular,
20 we note that there is a severe shortage of child and
21 adolescent psychiatrists in the United States. According
22 to the American Academy of Child and Adolescent Psychiatry,

1 there are such shortages in all 50 states, the District of
2 Columbia, and Puerto Rico.
3 Your meeting materials also note that access to
4 office-based treatment for youth with opioid use disorder
5 is also limited. The U.S. Food and Drug Administration has
6 approved buprenorphine for opioid-dependent adolescents age
7 16 and older. However, most pediatricians have limited
8 training in addiction medicine, and the number of these
9 physicians currently prescribing buprenorphine to youth
10 enrolled in Medicaid is unknown. A 2017 study did find
11 that pediatricians account for only 1 percent of all
12 physicians that are certified to prescribe buprenorphine
13 for the treatment of opioid use disorder.
14 School-based health centers do offer one approach
15 to improve access to behavioral health care for low-income
16 and minority youth. However, a very small percentage of
17 U.S. public schools have either an onsite school-based
18 health center or have access to one. In 2016 to 2017,
19 approximately 2,500 school-based health centers were in
20 operation, providing access to 6.3 million students in over
21 10,600 schools.
22 School-based health centers provide a variety of

1 health services that extend beyond the first aid treatment
2 provided by a school nurse. These services might include
3 preventative care, like immunizations, and diagnostic care,
4 such as routine screenings. Over the last 10 years, there
5 has been a significant increase in the number of school-
6 based health centers in the U.S. that has largely been
7 driven by increased FQHC sponsorship. In 2016 to 2017,
8 more than half of school-based health centers were
9 sponsored by FQHCs. Generally, the rate of growth of these
10 centers in rural and suburban settings has outpaced growth
11 of school-based health centers in urban environments.
12 The next few slides focus on the availability of
13 specialty behavioral health treatment facilities. Here we
14 depict the availability of specialty mental health
15 treatment facilities at the state level. This map shows
16 the percentage of facilities that offer tailored services
17 for youth with serious emotional disturbance, or SED, and
18 participate in Medicaid. Nationally, we see that about
19 one-third of these facilities offer such programming and
20 participate in Medicaid. However, as you can see on the
21 map, this varies greatly by state, ranging from 17 percent
22 in Puerto Rico to 60 percent in Alaska.

1 This slide takes a little bit more of a granular
2 look at the percentage of specialty mental health treatment
3 facilities offering tailored programming for youth with SED
4 and participating in Medicaid based on level of care.
5 Approximately 28 percent of these facilities offer tailored
6 programming for adolescents with SED, and provided
7 outpatient treatment services. Of these facilities, the
8 majority reported that they accepted Medicaid.
9 In addition, roughly 1 in 5 facilities offered
10 tailored programming for adolescents with SED and report
11 offering on- or off-site crisis services. However, more
12 intensive services like partial hospitalization,
13 residential treatment for children, and in-patient care are
14 much less likely to be available to Medicaid beneficiaries
15 with SED.
16 The next two slides depict information about
17 substance use treatment facilities. This map depicts the
18 percentage of substance use treatment facilities offering
19 tailored programming for youth and reporting participation
20 in Medicaid. In 2018, nearly 1 in 5 specialty substance
21 use treatment facilities offered tailored programming for
22 adolescents and accepted Medicaid, but Medicaid

1 participation among those facilities varied quite greatly
2 at the state level. As you can see here, it was a low of 7
3 percent in Puerto Rico, up to 46 percent in Idaho.
4 Again, this slide just provides a look at the
5 availability of these services based on level of care. As
6 you can see, youth with substance use disorder have limited
7 access to specialty treatment across all levels of care. A
8 small proportion of facilities offer tailored programming
9 as well as intensive outpatient treatment, partial
10 hospitalization, short-term residential treatment, long-
11 term residential treatment, and then in-patient hospital
12 care. In some states there are no facilities offering
13 certain levels of care as well as tailored programming for
14 adolescents with substance use disorder.
15 So that concludes our presentation. Melinda and
16 I are happy to answer any questions you might have about
17 the findings presented today. Thanks.
18 VICE CHAIR MILLIGAN: Thank you very much both of
19 you. Commissioners, what I would like to do in the 15
20 minutes we have before the panel is really focus our
21 questions on better understanding the data, better
22 understanding kind of the research and the foundation here.

1 We can have a fuller discussion around policy directions or
2 kind of further work after the panel, and Erin and Melinda
3 will be available to help us then as well.
4 So if we can focus on just making sure that we
5 understand what was presented and if we have any questions
6 about what was presented, if we could just focus there
7 before the panel starts.
8 Is there anybody who wants to start? Kit, and
9 then I think I saw Sheldon after that, and then Peter.
10 COMMISSIONER GORTON: Thanks, Melinda and Erin,
11 for laying this out and setting this foundation. It is
12 very helpful.
13 You talked about digging deeper into issues with
14 children in substitute care and youth involved in juvenile
15 detention and law enforcement. I wonder, are you planning
16 and/or is it possible to look at some other key
17 subpopulations? It is my impression, and I think there is
18 data to support this, that youth who identify as LGBTQ+
19 have substantially higher rates of morbidity, and I don't
20 know what their access is, if it is different or if we can
21 tell, and whether they use that access. They often have
22 trust issues with respect to health care providers.

1 And then the other group is children who are
2 homeless. So again, I think I have read published stuff
3 that says that there is a higher rate of mental health
4 disorders in those.
5 And then sort of aligned with our interest in
6 people of color, I would be interested in children and
7 youth who don't use English as their first language. And
8 some of the stuff I have read, some of you know I have
9 started work as a substitute teacher in the public schools,
10 and some of the stuff I have read is in the educational
11 literature. And so it might be -- you have to look outside
12 of health care in order to identify some of those data.
13 But again, given the blurring boundary with school-based
14 clinics and other things there may be Department of
15 Education information or other things in the education
16 literature that talk about mental health issues in English
17 language learners.
18 So those are just -- I don't expect you can deal
19 with them today, and I don't know whether you will ever be
20 able to, but if you can think about whether those can be
21 addressed I would appreciate that.
22 MS. McMULLEN: Yeah, sure. I will just mention

1 that the National Survey on Drug Use and Health, which is
2 what we used to present the data here today, and what we
3 used to present data on adults in September, does include
4 some variables that we can maybe spend some time thinking
5 about additional analyses. I will just say we encountered
6 this issue when we tried to do work around pregnant women
7 with substance use in Medicaid. The analyses tend to take
8 a little bit longer because we wind up having to merge
9 years to get a representative sample that is specific to
10 Medicaid. So we can definitely take those three
11 populations into account as we kind of plan moving forward.
12 VICE CHAIR MILLIGAN: Thank you.
13 Sheldon and then Peter.
14 COMMISSIONER RETCHIN: Yeah, thanks. Am I --
15 CHAIR BELLA: Yes.
16 COMMISSIONER RETCHIN: Am I on? Yeah.
17 Erin and Melinda, this is a tremendous work on
18 the background paper. I must say this is the most
19 troubling set of data that I've seen since I've been on
20 MACPAC. I found it very disturbing, and the unmet needs of
21 the population, we can come back to that later. But I was
22 very disturbed by this.

1 I do want to ask if you -- a couple of questions,
2 I guess, the same thing. One is the adequacy of the
3 workforce. Did you find data on the number of child
4 psychiatrists that are out there who participate the
5 proportion you participate in Medicaid, and did you find or
6 were you able or do you anticipate being able to look at
7 the network adequacy of MCOs?
8 Thanks.
9 MS. McMULLEN: So I think that the material in
10 your background paper had a very high level of just notes
11 that there is a shortage of child and adolescent
12 psychiatrists, and that's observed nationally.
13 The data that we presented in September around
14 Medicaid participation of psychiatrists didn't get into --
15 COMMISSIONER RETCHIN: Yeah.
16 MS. McMULLEN: Yeah, subspecialties. So we would
17 have to see if there is such information out there. We can
18 probably, hopefully, get back to you on it.
19 Melinda, I don't know if there's anything else
20 that I'm leaving out.
21 MS. ROACH: I don't think so.
22 COMMISSIONER RETCHIN: On the MCOs and the

1 network adequacy?

2 MS. McMULLEN: Yeah. So that is, I guess,

3 anecdotally, we heard that it's difficult for managed care

4 organizations to find child and adolescent psychiatrists

5 and psychiatrists generally, in seeking adequacy

6 requirements.

7 In terms of data, I don't have any that I can

8 point to today, but it's something that we can maybe try to

9 look into. But I don't want to overpromise.

10 VICE CHAIR MILLIGAN: Thank you.

11 I have Peter and then Fred and then Stacey.

12 COMMISSIONER SZILAGYI: Yeah. Thank you, Melinda

13 and Erin. This is really fabulous.

14 As Sheldon said, both disturbing and incredibly

15 important, if you ask pediatricians what is the number one

16 unmet need for their patients, it is really behavioral

17 health and mental health services for our patients, and

18 that's not actually just for patients who are on Medicaid

19 or CHIP. It's for all children in general.

20 I had a couple of suggestions, and I do apologize

21 because I have not reviewed very recently the recent work

22 that we have published on this, but just a couple

1 suggestions for the background paper.

2 If there are more recent data, if there are any

3 recent data on mental health problems during COVID or due

4 to COVID, that would be really helpful to point out,

5 especially if we have anything at the national level,

6 because what we're hearing is that depression and anxiety

7 is skyrocketing among adolescents. And we know that this

8 is just sort of overwhelming pediatric offices as well as

9 mental health services, the limited mental health services

10 we have.

11 So I don't know what we have kind of at the

12 national level. There's been lots of reports, published

13 papers, so that's one point.

14 The second point is -- and maybe -- I don't know

15 whether that would be best in this chapter, but one of the

16 other major problems from the behavioral health is actually

17 adverse childhood experiences, which by itself is not a

18 psychiatric diagnosis, but it's extremely common in

19 children and adolescents. It's clearly related to

20 significant morbidity in children. It's unbelievably

21 related to morbidity and mortality in adults. So not only

22 is it common, but it often manifests itself looking like

1 mental health problems because it is a mental health
2 problem, but it isn't always ADHD or depression.
3 It's actually trauma, and the treatment is -- the
4 ideal treatment is trauma-focused care, which is very
5 different than regular mental health care. So to the
6 extent that we can sort of at least mention that, I think
7 that's a really important issue.
8 In terms of access, many of us in pediatrics end
9 up referring patients to psychologists because there aren't
10 any psychiatrists around. So if we have data on access to
11 psychologists in addition to psychiatrists, I think that
12 would be helpful.
13 Often what ends up happening is a joint
14 management with pediatricians or family physicians and
15 psychologists, maybe with a psychiatrist involved.
16 Then finally, in terms of the school-based health
17 centers, just my rough calculation is there's about 25
18 million 11- to 17-year-olds in the United States. School-
19 based health centers have access to -- or provide access to
20 maybe 6 million of them. If we could narrow down on for
21 the Medicaid population -- because school-based health
22 centers are much more likely in low-income areas. So it

1 would be great if we could get some sort of percentage for
2 what percentage of Medicaid beneficiaries have access to
3 school-based health centers. I think that would be really
4 helpful. They are part of the solution, but they can't be
5 the entire solution, because they're just not there in an
6 awful lot of these schools.
7 I have some other thoughts, but I'll let some
8 other Commissioners comment. Thanks.
9 VICE CHAIR MILLIGAN: Thanks, Peter.
10 Fred and then Stacey.
11 COMMISSIONER CERISE: Thank you.
12 Peter, you made me think of one question I'll
13 probably save for the panel, but that's when you talk about
14 causes. I want to see what people think about the
15 contribution of social media to this as well.
16 But what I was going to ask you is, you know, as
17 bad as the numbers are, they're even worse for the
18 uninsured, and when you look at the school-based health
19 center numbers, where they are half, a third of the access
20 of Medicaid, I'm wondering if you have any insight into
21 that, because my understanding of school-based health
22 centers, it's sort of all comers. There's not

1 distinguishing among payers there. Is that a factor of
2 school centers enrolling kids into Medicaid, so those
3 numbers tend to bump up, or is there something else going
4 on there?

5 MS. McMULLEN: So after we finalized our meeting
6 materials, Melinda and I were able to get in touch with the
7 School-Based Health Center Association. They implement a
8 survey every year that gets at some of the data we
9 presented today, and they have additional information that
10 gets more granular. Maybe we can kind of try to pull out
11 some of that information that you're looking for as we move
12 into drafting a chapter on this topic, but we just were
13 able to connect with them last week. So I think we have
14 some work to do in that space.

15 COMMISSIONER CERISE: Thanks.

16 VICE CHAIR MILLIGAN: I have Stacey and then
17 Brian.

18 COMMISSIONER LAMPKIN: Thank you.

19 My question, I don't know if it's for Erin and
20 Melinda or maybe other Commissioners, Sheldon, but the
21 shortage of child psychiatrists and other critical
22 providers across all payers, what can be done about that?

1 What kind of initiatives are in place? Can anything be
2 done through graduate medical education initiatives or any
3 kind of incentives like that to kind of -- the supply of
4 critical providers in this space?
5 MS. McMULLEN: Melinda, I don't know if you have
6 anything to add, but I think our panel is probably pretty
7 well poised to see about that.
8 VICE CHAIR MILLIGAN: Yeah. Stacey, we can maybe
9 come back to that in the discussion about solutioning, if
10 you don't mind holding for when the panel's part of that
11 conversation then.
12 I have Brian, and then I had one question. I
13 think we'll go to the panel after that.
14 Brian?
15 COMMISSIONER BURWELL: I'm going to pass. My
16 question was answered.
17 VICE CHAIR MILLIGAN: Okay, thanks.
18 Erin, I have one question related to Slide 12,
19 and it kind of picks up on the comment that Peter made
20 about psychologists. It's really where you identified the
21 severe shortage of psychiatrists, the second bullet there.
22 One of the things, I think, would be helpful to

1 tease out in the data, if we can, is scope of practice,
2 honestly, and why -- I know that in New Mexico,
3 psychologists got prescribing authority, and it's under
4 physician supervision. To me, part of this issue is what
5 distinguishes from a scope of practice or other
6 perspective, how we should understand provider shortages
7 and provider shortage types, which is to say there are
8 significant and severe shortages, but I think understanding
9 the relative roles each provider type plays in the
10 continuum, I think, will be helpful going forward.
11 It looks like Martha is jumping in.
12 Erin, is my comment clear? Can I just maybe --
13 [No response.]
14 VICE CHAIR MILLIGAN: Okay. Martha, you get the
15 last word, and then we'll go to the panel.
16 COMMISSIONER CARTER: Real quick, this is one of
17 those issues that overlaps others that we've worked on, and
18 I haven't heard anybody bring up the overlap with
19 telehealth. And I think that's really significant
20 innovation to address the shortages and also preserving
21 telephonic care. You know, it's the whole question about
22 whether it's audiovisual or just audio and making sure that

1 there's good access to telehealth services to spread the
2 availability of our very limited rural health staffing.
3 VICE CHAIR MILLIGAN: Okay. Thank you, Melinda
4 and Erin, for setting the stage so well.
5 I'm not sure who's driving in terms of the panel,
6 but, Melinda, it's all yours. And I understand all three
7 of our panel members are with us. Please lead us through
8 the rest of the way.
9 **### PANEL: ACCESS TO BEHAVIORAL HEALTH SERVICES FOR**
10 **CHILDREN AND ADOLESCENTS**
11 * MS. ROACH: Great. Wonderful. I am going to
12 introduce our panelists to continue this conversation and
13 provide further insights regarding access to behavioral
14 health services for youth. Their full bios are in
15 Commissioners' meeting materials, so I will give brief
16 introductions.
17 Our first panelist is John O'Brien, a former CMS
18 official and national expert on behavioral health, who
19 advises states as a senior consultant with the Technical
20 Assistance Collaborative. John will set the stage by
21 discussing some of the challenges facing children and their
22 families seeking behavioral health services and the role of

1 EPSDT in addressing access.

2 We're also joined by two state officials to

3 discuss how they're improving the system of care for youth

4 with behavioral health needs. Dan Tsai is assistant

5 secretary for MassHealth and Medicaid director for the

6 Commonwealth of Massachusetts. He'll be followed by

7 Kristine Herman, chief of the Bureau of Behavioral Health

8 for the Illinois Department of Healthcare and Family

9 Services. We're really grateful that they've agreed to be

10 part of this conversation.

11 So thank you to our panelists, and with that, I

12 will turn it over to you, John.

13 * MR. O'BRIEN: Terrific. Thanks, Melinda, and

14 good morning and thank you, Commissioners, for considering

15 this very important topic and allowing me some air time to

16 discuss my impressions and some recommendations regarding

17 children's behavioral health services through the Medicaid

18 lens. It's good to see some of you again as well.

19 As you saw in the previous presentation, a

20 significant number and percent of children that are

21 enrolled in the Medicaid program have a behavioral health

22 condition as recognized by either receiving a behavioral

1 health service or prescribed and receiving a psychotropic
2 medication.
3 What the data does not reflect, although it was
4 discussed later in the presentation, is the challenges that
5 children and families that participate in the Medicaid
6 program confront when seeking behavioral health services.
7 Obviously, a major issue that families face is
8 related to stigma, and many families are uncomfortable
9 talking about their children's mental health or substance
10 use disorder, and frankly, there's little payers can do to
11 change people's minds and hearts on that issue.
12 There's plenty of campaigns that are out there
13 that are attempting to make it okay to talk about their
14 children's behavior health issues, but I just want to raise
15 that as an ongoing and major barrier for families seeking
16 treatment for their children.
17 Second -- and we talked a little bit about this
18 in the presentation and some of your questions -- the gaps
19 and barriers to mental health services. A study several
20 years ago found in a review of Medicaid state plans, which
21 included state plan amendments, waivers, et cetera, had
22 about 84 percent of Medicaid state plans identifying or

1 having identified gaps in service coverage for behavioral
2 health services, meaning there were certain critical
3 behavioral health services that were not included on the
4 books in these states.

5 Even when that coverage on paper exists, there
6 was a shortage of providers, as you've been talking about,
7 that contribute to the lack of access to schedule and
8 locate nearby behavioral health services. Some of this is
9 directly related to the shortage of licensed providers and
10 how you think about using licensed providers. If you look
11 at HRSA data, for years, they've been reporting that most
12 of the counties in the United States are workforce shortage
13 areas for behavioral health or behavioral health workforce
14 deserts.

15 One of the more alarming trends -- and maybe
16 we're just getting better at reporting this information --
17 is the increased rate of custody relinquishment among
18 parents that have not been able to access behavioral health
19 services.

20 Over the past two decades, between 25 and 35
21 percent of families through various research methods were
22 either advised to relinquish custody or suggested to refuse

1 to bring their children home from a hospital or residential
2 setting, encouraged by social service staff or therapists
3 or friends, to be able to relinquish custody in order for
4 those kids to get services.
5 Finally, I'd be remiss in my remarks if I didn't
6 discuss the increasing trend for many children being
7 admitted and staying longer in residential or inpatient
8 psychiatric, including out-of-state placements in these
9 facilities.
10 For instance, in Ohio, their out-of-state
11 placement rates have doubled over the past 4 years. Almost
12 all states have a cadre of kids that are in these
13 placements for months and sometimes years, and a
14 significant reason is that their local communities did not
15 have the community services in place to support families
16 for these children to remain at home.
17 But we certainly have some ability to be able to
18 address some of these issues through the Medicaid program
19 and in particular through EPSDT.
20 As many of you know, 50-plus years ago, Congress
21 introduced the Medicaid benefit for children and
22 adolescents known as Early and Periodic Screening,

1 Diagnosis, and Treatment. The goal of the benefit is to
2 ensure that children under the age of 21 who are enrolled
3 in Medicaid receive age-appropriate screening, preventative
4 services, and treatment services that are medically
5 necessary to correct or ameliorate any identified
6 conditions. Many of you that are former Medicaid program
7 officials are well aware of the EPSDT requirements.
8 But if you look at this mandate and you break
9 them down into component parts, this is what we find.
10 Related to screening, there was some discussion earlier
11 around screening. States with their managed care coverage
12 fall short on their mandate regarding behavioral health
13 screening, either because they don't emphasize that
14 expectation for primary care physicians to do screening, or
15 frankly, they haven't designed a way to be able to capture
16 the information.
17 At a network level, you will hear that PCPs
18 aren't aware of the referral options or probably had some
19 not-so-good experience with behavioral health provider
20 network mostly due to lack of follow-through.
21 Around diagnostic services and, in particular,
22 behavioral health assessments, this is an area where we

1 have a dearth in activity. First, there are good
2 assessment tools that are out there. State practice acts
3 have been including or addressing and offering some wiggle
4 room about who can do these assessments, and we spend in
5 the Medicaid program a fair amount of money on assessments,
6 actually a little lopsided.
7 Some of that is due to the various assessments
8 that are out there that I think clinicians are feeling like
9 it makes sense for children to be able to be assessed, and
10 sometimes it's state policies that sometimes require 90-day
11 assessments to be able to continue to receive services,
12 both outpatient and higher-end services.
13 Then last but not least, the third component of
14 EPSDT being treatment, and as I'll talk a little bit about,
15 states have variable approach on how and what they cover
16 for children's behavioral health services through the EPSDT
17 program. While children with low to moderate behavioral
18 health needs generally need access and get access to
19 routine outpatient services such as counseling and
20 medications, the variation regarding coverage in behavioral
21 health services is mainly for children, youth, and young
22 adults with significant mental health conditions.

1 Let me just add another footnote on screening and
2 treatment, and it really is some of the states' efforts or
3 lack thereof around screening and treatment that are the
4 focus of litigation in a number of states regarding EPSDT.
5 There are, to my knowledge, about 10 states that have
6 active lawsuits that are specific to violations within
7 EPSDT because they are alleging that the state is not
8 providing the medically necessary behavioral health
9 services for kids that have behavioral health needs.
10 Some of this litigation also focuses on whether
11 the state is meeting the reasonable standards for access,
12 but also, some of the EPSDT lawsuits are coupled with ADA
13 violations and Olmstead violations as well, and we can talk
14 a little bit about that if you want to in our discussion.
15 CMS has intended to take some of the guesswork
16 out of what constitutes good coverage. As some of you
17 know, about seven years ago, they released an informational
18 bulletin that I believe is in your packet that really did
19 suggest or recommend coverage for kids, especially kids
20 with high behavioral health needs, and I won't go through
21 that bulletin. But the four legs of the stool of coverage
22 really are intensive care coordination using a wraparound

1 approach, and it's basically a team-based collaborative
2 care process for developing and implementing individualized
3 plans of care for children or youth with complex mental
4 health needs in their families.
5 The second service being intensive home-based
6 services, and these are services that really are provided
7 both at home and community settings that improve youth and
8 family functioning and really to prevent out-of-home
9 placement, whether it be into residential services through
10 the child welfare system or inpatient or PRTF settings.
11 The third service is parents and youth support
12 services, sometimes known as peer services, and those are
13 critical to be able to develop and link both formal and
14 informal supports to the kids and families. These peer
15 supporters really serve as a mentor or facilitator for
16 resolving issues and sometimes teaching skills necessary to
17 improve families' coping abilities.
18 Then last but not least -- and there's been lots
19 of discussion and activity about this over the last year --
20 mobile crisis response and stabilization services, and not
21 just for high-end kids but for all kids in general that can
22 be used in diffusing and deescalating critical mental

1 health situations and also preventing out-of-home
2 placements or facilitating more rapid reentry when a kid is
3 leaving an out-of-home placement.
4 Some states are using their mobile crisis
5 response initially when kids are placed in foster care
6 settings to be able to address the trauma but also to
7 facilitate moving that child back home.
8 So what are some of the opportunities that I see
9 for state and federal policymakers that could improve
10 access? Let me be clear. I think over the last 10 years,
11 CMS has done a really good job providing tools to states to
12 assist them with meeting the expectations under EPSDT
13 regarding behavioral health services. They've been very
14 clear about what Medicaid's role could be for developing
15 community-based services and even allowing flexibilities to
16 address IMDs, both on the mental health and substance use
17 disorder side.
18 On the CMMI side, you've got programs such as
19 InCK, the Integrated Care for Kids model, as another
20 strategy that was deployed to allow states to get some
21 traction in this area.
22 I think one of the biggest issues is to the

1 extent to which states understand and use the tools that
2 are available to them, and honestly, I think they could
3 benefit from some focused attention, similar to what CMS
4 has done to support states to develop their SUD systems and
5 to integrate mental health and primary care.

6 A technical assistance effort could be extended
7 to states regarding kids with behavioral health needs. It
8 wouldn't duplicate efforts with other federal agencies.
9 When I was at CMS, we chose not to go into this direction
10 because SAMHSA was doing a fair amount, but more recently,
11 SAMHSA and other agencies have decreased their focus on
12 working with states for kids with behavioral health needs.

13 Also, I think good messaging regarding the use of
14 PRTF. While I'm not advocating that we need more PRTF
15 beds, I do think that some additional guidance and
16 expectations of states regarding the use of these beds
17 would be helpful. It's been about 8 years since the PRTF
18 initiative was ended, and some states that were
19 participating in the initiative have lapsed back into pre-
20 demonstration behavior with longer length of stay and
21 little direction to these providers on what good practice
22 should look like in these facilities.

1 Also, as some of you know, there's a larger push
2 due to Family First Prevention Services Act to improve the
3 quality of residential facilities and reduced lengths of
4 stay in these facilities. Many states are getting pressure
5 from their child welfare providers to consider these
6 facilities, many of which are IMDs, PRTFs, which frankly is
7 not a good direction. I would suggest that some guidance
8 might be helpful that could be based, for instance, on what
9 New Hampshire has most recently released as part of their
10 procurement process to message what they expect from their
11 PRTF beds that builds on a couple initiatives, including
12 Building Bridges, that really was very effective in
13 producing shorter lengths of stay.
14 And then, finally, I think it's time to review
15 some of the outcomes for children in behavioral health.
16 The current set of core measures for children is limited
17 and has focused on, you know, follow-up for kids that have
18 been prescribed medications, for instance, for ADHD,
19 follow-up after hospitalizations for mental illness, again,
20 which is very important, and then just monitoring children
21 and adolescents on antipsychotics, which, again, I think
22 states have actually done some good work in that area.

1 I encourage CMS to consider moving measures
2 forward on at least two areas. One is around initiation
3 and engagement for kids seeking mental health treatment.
4 We've got some on the SUD side that, frankly, I think
5 should be considered as measures on the mental health side.
6 And while I know this is not necessarily claim-based,
7 better functioning regarding school performance, many
8 states collect and have this information for the Medicaid
9 populations. They have some standardized assessments that
10 they are using in their data warehouses that could be used
11 to feed the measures, for instance, most states are being
12 able to collect it through the Child and Adolescent Needs
13 and Strengths tool.
14 So those are my thoughts and recommendations,
15 and, again, thank you for your time this morning.
16 VICE CHAIR MILLIGAN: Thank you. I think we are
17 going to turn, Dan, to you next and then Kristine.
18 * MR. TSAI: Hi. Good morning. Thanks for the
19 time on this. I'd like to applaud the Commission for
20 actually tackling this topic. I don't think kids and
21 behavioral health get enough discussion and attention, and
22 on this particular topic around behavioral health services

1 for children and youth and adolescents, I think this is
2 probably one of the top two most pressing issues from a
3 kid's standpoint in any respect, and in particular for
4 Medicaid. So I will talk a little bit about some of the
5 intensive wrap services we have in Massachusetts, some
6 thoughts on that.
7 I did want to start by noting behavioral health
8 across the board, not just in Massachusetts but any part of
9 this country, there are things that work well and there are
10 some major gaps I think we all know from a parity
11 standpoint, speed of access standpoint. Every one of those
12 issues, what the behavioral health system has is acutely
13 exacerbated when it comes to kids. So everything from ED
14 boarding to availability of actual crisis supports and
15 diversionary supports when kids are in some sort of crisis,
16 developmental specialists or folks that have enough
17 experience in things like ASD/IDD to help deal with the
18 unique needs of kids with behavioral health conditions,
19 support for families and ways to engage parents around
20 that, and some of the basic access pieces around child
21 psychiatry -- that came up as a topic -- and specialized
22 even inpatient psych beds and things of that sort. So

1 every one of those things cumulatively adds up to a system
2 where, when we talk -- we recently did a bunch of family
3 stakeholder listening here in Massachusetts, parents and
4 families feel unsure of what services are available. Even
5 when they know they need something, getting access in a
6 timely way sometimes is highly confusing and a mystery of
7 acronyms and how to access things, and when kids are in
8 crisis, folks feeling like there are little alternatives
9 other than taking a kid to the ED.
10 So in Massachusetts, we have a set of high-touch
11 wrap services that I'll talk about. The punch line is
12 those are highly effective. John, they're pretty much in
13 line with exactly the set of things that you referenced.
14 But you need both. You both need those high-touch
15 services, and you need to address the underlying issues and
16 gaps in the ambulatory behavioral health system and in the
17 way primary care thinks about behavioral health.
18 So on the wrap side, we have a ten-year history
19 of this in the commonwealth leading back to some court
20 action and discussions as well. Essentially, what the
21 genesis of this was the need to create a statewide
22 treatment system for kids, particularly on Medicaid, to get

1 access to behavioral health services for all the reasons
2 we've discussed. What the Commonwealth has here in
3 Massachusetts is essentially it's called CBHI, Children's
4 Behavioral Health Initiative program, that has a set of
5 high-touch services, intensive care coordination, in-home
6 therapy in a range of different settings, family partners
7 to come alongside the parents, therapeutic mentors for
8 kids, and mobile crisis intervention.
9 There are a dedicated set of over 25 providers,
10 25 providers in the Commonwealth, many of whom serve folks
11 in behavioral health across the age continuum, but some
12 were specialized for kids, who offer that set of services.
13 There are universal screening and diagnosis requirements
14 for every pediatric practice in the Commonwealth to do some
15 level of screening for kids and to make folks aware of this
16 sort of benefit and essentially both kids with SED as well
17 as some other behavioral health needs are receiving a range
18 of these wrap services. We have about 35,000 kids in the
19 Commonwealth receiving some level of service for the range
20 I mentioned, and it's about quarter of a billion dollars a
21 year just on those services for kids here. So it's over a
22 $7,000 PMPY just on behavioral health services for that.

1 The short answer is it works relative to a whole
2 range of things that we're seeing. I think one of the
3 things we've seen, though, is the expansion of folks
4 utilizing those services from kind of the top of the
5 pyramid, kids with SED are very complex or moderate to
6 complex behavioral conditions, to an increasing set of
7 families and even just accessing the services that are more
8 at the middle of the pyramid from a behavioral health
9 complexity standpoint, in part for the reasons I mentioned
10 where the underlying base behavioral health -- you know,
11 the way in which behavioral health services are available
12 and accessed and straight behavioral health, you know,
13 specialty providers, more in primary care. Where folks see
14 challenges on that, they're kind of going to this intensive
15 wrap program where you've got a dedicated set of providers
16 and you've got very clear navigation. You've got family
17 partners and things of that sort.
18 So it's an effective model. It doesn't
19 substitute the need to address from a Medicaid standpoint
20 for any state in the country and not just -- beyond
21 Medicaid as well, some of those underlying gaps in
22 behavioral health treatment and access in primary care and

1 in specialty behavioral health settings.

2 So, you know, one of the questions around what
3 states and from a federal standpoint could do, certainly
4 contemplating wrap services of the sort, very aligned with
5 some of the previous CMS guidance on this as well, and both
6 financial and other payment flexibility for states who want
7 to and recognize the need to start thinking about the
8 underlying system for behavioral health a little bit
9 differently in terms of expectations for behavioral health
10 integration or the type of crisis and access services that
11 are actually available to folks in the core system from a
12 parity standpoint, not just relying on a very specialized,
13 highly intensive set of wrap services around that.

14 So there's a lot more I could talk about on this.
15 It's a really, really critical topic. It requires real
16 focus, and it's probably one of the top issues I could
17 possibly think about relative to not just, you know,
18 behavioral health issues but for kids overall and what we
19 collectively should be thinking about.

20 So I'll pause there, and I'll look forward to
21 whatever discussion and questions folks have.

22 VICE CHAIR MILLIGAN: Thank you. Kristine.

1 * MS. HERMAN: Yeah, hi. Kristine Herman. I am
2 the chief of the Bureau of Behavioral Health at Illinois'
3 Medicaid state agency. We're known as the Department of
4 Healthcare and Family Services. And this entire discussion
5 has been, while painful because we know there are so many
6 gaps, so welcome. I eat, sleep, and breathe this
7 particular issue on a daily basis for kids in Illinois, and
8 we're actually about ten years behind where Dan is. So
9 I'll kind of give you a look at a state that is working
10 towards development of these types of services that we know
11 are super critical for these kids.
12 So I'm going to begin. I'll offer you a little
13 bit of context for the Medicaid landscape in Illinois. We
14 cover approximately 3.1 million individuals, making
15 Medicaid our largest insurer. And of those 3.1 million,
16 approximately 2 million are children under the age of 21.
17 Around 80 percent of our covered individuals are enrolled
18 in one of our five managed care plans, and then we do have
19 an additional plan that was recently launched that's
20 specifically designed for children who are in the custody
21 of our child welfare system. And these plans cover all of
22 our Medicaid-eligible physical and mental health and

1 substance use disorder services.

2 We have a very large and diverse population
3 across the state, mostly clustered around the Chicago area,
4 and then in the Metro East area of St. Louis, and then in
5 between those two major metropolitan areas, we have smaller
6 cities, and then we have some very rural counties. So this
7 type of racial and ethnic and geographical diversity
8 creates some challenges for our members and limits their
9 access to services, and that's especially true for our kids
10 with behavioral health needs.

11 So I'll give you a brief history of the drivers
12 that have pushed us towards developing this continuum of
13 behavioral health services for particularly kids. About
14 three years ago, we completed a full review of our Medicaid
15 population, including individuals with behavioral health
16 diagnoses and services received and the total cost of those
17 services.

18 So what we found is that approximately 25 percent
19 of the overall Medicaid populations, so roughly 800,000
20 individuals, had a behavioral health diagnosis and/or had
21 received behavioral health services. And then these
22 individuals' total health care expenditures accounted for

1 approximately 56 percent or $5.5 billion of our overall
2 Medicaid service spending.
3 In addition, at that time Illinois was spending
4 around $150 million annually on psychiatric
5 hospitalizations for children under the age of 21. That's
6 a significant portion of the national spending on
7 psychiatric hospitalizations for children under the age of
8 21. And while we had a statewide mobile crisis response
9 system, it wasn't equipped to provide the home and
10 community-based services that Dan and John talked about to
11 really help deflect these kids from hospitalizations and
12 keep them stable in their homes.
13 So this was really underlined by an EPSDT class
14 action lawsuit and then a subsequent consent decree in
15 2018, as John mentioned. We are one of those states that
16 is currently under a consent decree. And it stipulated
17 that Illinois must develop a children's behavioral health
18 system of care to offer adequate behavioral health services
19 to meet the needs of children under the age of 21 who had a
20 behavioral health diagnosis and then require intensive home
21 and community-based services that Dan was speaking about
22 earlier.

1 So while the consent decree laid out the general
2 parameters for what components that system of care should
3 include -- you know, some of those pillars that John
4 discussed, the assessment, the individual plan of care,
5 intensive care coordination, and then additional home and
6 community-based services -- we had to make some decisions
7 regarding the design of the program and the federal
8 authority to utilize, and I think this is where we can talk
9 about some additional tools, additional technical
10 assistance.
11 We initially pursued an 1115 waiver that included
12 pilot programs to address substance use disorder treatment,
13 supportive housing and employment, home visiting, intensive
14 in-home services, more in an attempt to bring effective
15 behavioral health services to both adults and children,
16 because we knew this was one of our major cost drivers for
17 both populations. We also pursued the integrated health
18 home option under Section 2703, but also sought to address
19 the behavioral health needs of both adults and children.
20 So the utilization of these two authorities
21 proved to be a real challenge. The evaluation and
22 oversight components of the 1115 required an immense amount

1 of staff time and attention. And while the pilot design in
2 the 1115 offered some of the additional home and community-
3 based services, it didn't address the full continuum that
4 we really needed.

5 And the integrated health home design through
6 Section 2703 for the children's services, which we wanted
7 to mirror what Dan was talking about, was quite
8 significantly different from the design for adults, and we
9 would have to launch both of those services at the same
10 time to maximize our eight quarters of enhanced match.

11 In addition, the integrated health home offered
12 enhancements for coordination and integration, so we still
13 needed to develop additional services through other state
14 plan authorities in order to have services to coordinate.
15 So we really would have ended up with this patchwork of
16 federal authorities that didn't necessarily meet all of our
17 system needs.

18 We ultimately decided the 1915(I) state plan
19 amendment would be the most advantageous federal authority
20 since we could establish our own eligibility criteria,
21 including the intensive care coordination, the additional
22 home and community-based services for children under the

1 age of 21, into a coherent, cohesive benefit. We are
2 focusing on children with the most complex needs in our
3 1915(I). We are going to be offering the high-fidelity
4 wrap-around and the intensive care coordination, the
5 intensive home-based care, with the addition of respite,
6 therapeutic mentoring, and then utilizing that vehicle to
7 also enhance our mobile crisis response so that it is not
8 so much responding to psychiatric emergencies, but to any
9 type of crisis that a child may experience. And then we're
10 adding some additional supportive services that offer us a
11 little bit more flexible spending.
12 This isn't without its own challenges, though.
13 When you look at the 1915(I), we've got some conflict-of-
14 interest standards that require key areas of our existing
15 system to be redesigned and for existing community-based
16 providers to determine if they want to provide the existing
17 Medicaid-covered behavioral health services or if they want
18 to provide the 1915(i) benefit services. And we have some
19 concerns that this additional stress is going to stretch
20 our system even further, and right now, as has been laid
21 out in many of these conversations, we are already fairly
22 thin, fairly stretched.

1 So while the consent decree and the 1915(i)
2 benefit are focusing on the children with the highest and
3 most complex behavioral health needs, Illinois is also
4 working to establish additional services and supports for
5 children with the lower-acuity needs. So we have
6 established a standardized assessment tool. It is based on
7 the CANS. It also includes an assessment of ACEs, so I'm
8 very excited that we are going to have statewide data on
9 those ACEs that our population experience. We're going to
10 utilize this to stratify children into tiers of service
11 intensity based upon their functional needs. The two
12 highest tiers are going to be in the 1915(i), like I said,
13 and then the children in the less-intensive tiers are still
14 going to receive some care coordination through their
15 managed care plans along with team-based or individual home
16 and community-based services.
17 At the same time, we're focusing on the earlier
18 identification and intervention strategies utilizing
19 standardized screening and referral in the PCP and school
20 settings. So this process is going to mean a full review
21 and revision of our current screening requirements for
22 well-child visits as well as the establishment of a clear

1 and efficient referral process from the PCP office or the
2 school, because what we do not want is yet another
3 screening that does not lead to services being completed.
4 So we're going to have a very tight connection between that
5 screening and that referral process and getting those
6 children into services.
7 So I was asked about additional flexibility that
8 we could ask for, so I do have a few things to put on the
9 table. They're very similar to some of the things that
10 John laid out.
11 Additional guidance and structure at the federal
12 level relative to the design and implementation of
13 behavioral health systems for children would be really
14 beneficial. I don't know that we need more flexibility
15 around EPSDT. It's very broad. It covers just about
16 everything for the child. But kind of as John was alluding
17 to, having clearer standards regarding how the benefit
18 should be structured, particularly in addressing children's
19 behavioral health needs and services, and how that can be
20 harnessed into that fully functional system for children I
21 think would be extremely helpful with some additional
22 technical assistance offerings.

1 There are a couple other areas where flexibility
2 I think could be really helpful. We briefly touched on
3 telehealth. We've had some additional flexibilities
4 relative to the COVID-19 public health emergency, and
5 maintaining those is really going to be critical. You
6 know, particularly in Illinois in engaging our individuals
7 who are in the more rural areas, the flexibility in
8 telehealth has been immensely helpful. John also touched
9 on this, really expanding our HEDIS quality measures for
10 children, particularly around behavioral health,
11 functioning on more meaningful areas. John touched on
12 school attendance and performance. We're also looking at
13 contacts with police and juvenile justice, involvement with
14 child welfare. We're also looking at more of those
15 functional improvements based on the CANS that we will be
16 implementing.
17 I'll quickly mention any flexibility that we can
18 get for two-generational or even multi-generational
19 approaches that allow the family to be treated as a unit,
20 not having to focus solely on the benefit of the covered
21 child, would offer a great expansion of the types and
22 allowable interventions for our providers.

1 One other thing I'll mention -- this hasn't come
2 up yet, might be a little bit of an outlier issue, but as
3 we're moving towards this coordination that we need to do
4 for kids, this is coming up more and more. Streamlining
5 privacy and confidentiality requirements for protected
6 health information under mental health, substance use
7 disorder, and education would really assist in the
8 coordination and continuity of services. Trying to
9 navigate HIPAA, FERPA, and 42 CFR Part 2 can be really
10 daunting, so that's one of the things that we're trying to
11 take on as we're moving in this direction of a much more
12 functional and effective children's system of care.
13 So, with that, I'll conclude my remarks just by
14 saying thank you again. I think that this topic is so
15 germane to all of the services that we need for our
16 children and families, and I think we just need much more
17 attention on it. So, again, thank you to the Commission
18 for having this topic and this panel.
19 VICE CHAIR MILLIGAN: Thank you very much to all
20 of the panelists for giving us your time, your expertise,
21 and really helping to contribute to our discussion and
22 work. Peter I do, if you don't mind, want to make sure

1 you have an opportunity to go first, because I know that
2 you need to leave fairly soon for your other commitment.
3 So if you are ready I would like to go to you first.
4 COMMISSIONER SZILAGYI: Sure. Thank you, and I
5 am sorry I do have to leave in about 12 minutes.
6 These were really incredibly thoughtful
7 discussions. And so I guess I have two questions. One is,
8 if you were going to suggest for us, out of all of the
9 suggestions that you gave, for one or two policy changes,
10 what would they be? So, in other words, kind of
11 prioritize. And my second question is maybe more for Dan
12 but potentially for everybody. You know, all of you talked
13 about the wrap services, comprehensive services for those
14 with several behavioral health problems. In primary care,
15 in primary care pediatrics or family medicine we are
16 dealing with an overwhelming number of children who don't
17 necessarily have the severe problems, but it is just a very
18 high prevalence.
19 And so, specifically, what policy changes would
20 you suggest in the primary care arena, in terms of
21 screening, diagnosis, treatment, including integrated care
22 within primary care settings, you know, programs like MCPAP

1 in Massachusetts, or what policy changes for Medicaid or
2 CHIP would you suggest for us, to help us in primary care?
3 So first question is, if you were going to
4 prioritize specific policy changes, and the second is,
5 focusing down on the primary care setting, what would you
6 suggest?
7 MR. TSAI: Are we each invited to jump in, or
8 what's the most efficient way, Chuck?
9 VICE CHAIR MILLIGAN: Yes, please. I think for
10 the Commissioners if you want to target a question to a
11 specific person, but I think in this context I think Peter
12 is inviting all three of you to participate. So, Dan, if
13 you don't mind going first and others can come in.
14 MR. TSAI: Sure. I think my answer to both your
15 questions is very similar, which is I would make sure there
16 is focus on, I call the basis, and separate from high-
17 fidelity wrap services, in both the primary care setting
18 and, say, community mental health centers, et cetera, can
19 do around much more routine behavioral health care. In the
20 primary care setting that looks like having a greater
21 expectation and level of payments for basic routine
22 behavioral health screening and treatment and diagnosis to

1 be able to happen in the primary care setting, much more of
2 a level of payment or sub-capitation that reflects some of
3 the collateral services, whether with an LCSW or a
4 community health worker, to help with all that follow-on
5 that sometimes an MD-level clinician is left with a day
6 around that. And, in some senses, having some supports for
7 practices, like MCPAP in Massachusetts, which is a consult
8 thing, so that primary care practices have more comfort
9 with some level of that basic or routine behavioral health
10 care.

11 You basically want more of that to be handled in
12 the existing system, where it really can't be today, so
13 people at all levels of the pyramid are needing to go to a
14 very specialized system, and in my mind that comes down to
15 also a parity issue. We wouldn't accept that for a range
16 of other physical health care conditions in the primary
17 care and pediatric space.

18 So I think it starts with that and a similar set
19 of things around what standard outpatient behavioral health
20 providers should be able to do around kids and pediatrics.
21 There is a ton of detail we have been thinking about in
22 Massachusetts. I won't go into it, but it all has to do

1 with how you bolster the support expectation, payment
2 level, and the possibilities of the types of services
3 involved in those settings so that you can get the top of
4 the pyramid more focused on the most intensive level of
5 care and much more routine sets of things happening in the
6 base.

7 COMMISSIONER SZILAGYI: By the way, I agree, and
8 before we go to Kristine and John, could you just also
9 comment on integrated care and just describe for the
10 Commissioners MCPAP?

11 MR. TSAI: What do you mean by -- we define
12 integrated care in many ways. Do you mean in the primary
13 care setting?

14 COMMISSIONER SZILAGYI: Like in terms of primary
15 care, in terms of how you see the importance of whether
16 it's payment or services in providing behavioral health
17 services within primary care.

18 MR. TSAI: So in the ideal, and we know that not
19 all of our practices can do that, we would like the vast
20 majority of routine and moderate behavioral health to be
21 able to be handled, at least from a screening, diagnosis,
22 and initial treatment perspective, in the primary care

1 setting. That is inclusive for kids. And we are not
2 talking about primary care practices being able to do a 12-
3 week course of CBT, psychosocial therapy and things of that
4 sort, but at least some of the pharmacological treatments,
5 and having master's-level clinicians, social workers, be
6 able to help do both collateral and some of the engagement
7 with kids. In order to do that, you need a much more
8 flexible payment model, and ideally having a bar of
9 expectation -- primary care practices, this is what we are
10 expecting. It is not optional to be thinking about these
11 things. It is actually a core part of the expectation.
12 And yes, there is a commensurate level of payment
13 investment and flexibility to go along with that.
14 The last thing I would note, one of the biggest
15 barriers to this, we are not talking about behavioral
16 health carveouts here, but one of the biggest barriers is
17 when you get to primary care practices in Medicaid, and
18 beyond Medicaid, people are having to bill around physical
19 health care services. They want to get to the behavioral
20 health component. You end up having to credential and get
21 into a different payer network sometimes, a different
22 treatment plan that is sometimes required in order to do

1 billing from a payer standpoint there, and instead of
2 thinking about as one integrated piece and then having mid-
3 levels or LCSWs, master's-level, others helping around
4 that.
5 So those are all things that are fundamental
6 barriers that I think would need to happen in how you think
7 about integrated behavioral health. And the path, just to
8 answer your question, is a consultative, telephonic service
9 for behavioral health specialists that are available for
10 primary care practices to do more of the diagnosing and
11 treatment of behavioral health and to have a phone-a-
12 friend, essentially, around that, so they have got a little
13 bit more comfort, without having to refer fully out to a
14 specialty practice, where you might have a wait.
15 COMMISSIONER SZILAGYI: I agree with you about
16 everything you said, and MCPAP, which is now spreading
17 beyond Massachusetts has been extremely helpful.
18 Kristine or John, do you have thoughts about
19 this?
20 MR. O'BRIEN: Well, Peter, as I said in my
21 remarks, you know, I don't know if there are additional
22 federal policies that you need to reconsider or rethink. I

1 think, you know, for the most part a lot of the tools that
2 states need, they have.
3 I think some of the major barriers -- again, this
4 has been conversations both with plans and providers and
5 state agencies -- has been, number one, some of the
6 practice acts that are in place in different states. And
7 so some of those practice acts haven't been reviewed or
8 touched in a while, and some of the papers of those
9 practice acts are good keepers but they don't want to have
10 much flexibility when it comes to thinking about changing
11 practice acts that might be able to expand the scope of
12 someone's practice, to be able to provide some of the basic
13 treatment services that others could provide.
14 So, you know, Chuck, I know you mentioned in New
15 Mexico, and I think even in Louisiana, there was a time, or
16 is a time, that psychologists could do prescribing of
17 medication if, in fact, it was being supervised by a
18 physician. Well, I can remember, we looked at the number
19 of psychologists four years after those provisions were put
20 into place and very few of them were prescribing, and some
21 of it was because, number one, the education for those
22 psychologists wasn't readily available, and number two,

1 there weren't a lot of psychiatrists that were willing to
2 supervise those psychologists. So practice acts is a big
3 barrier.
4 Also, again, at the state level, I think that's
5 where some of the barriers are. Some of the licensure
6 around agencies tend to be a little bit archaic. We
7 brought in all the MCOs, just before we were going to go
8 live with expansion. We said, "What is going to keep you
9 up at night?" assuming they would say, "It's going to be
10 the expansion into primary care docs and the availability,"
11 and it wasn't. It was around substance use disorder, and
12 them saying, almost all in unison, states have not revised
13 their licensing as it relates to some of these facilities,
14 and therefore we can't create new facilities because it's
15 just too much of a heavy lift.
16 So, Peter, again, I don't know if there's
17 anything at the federal level that I would change right
18 now.
19 COMMISSIONER SZILAGYI: Okay. Thank you.
20 Kristine?
21 MS. HERMAN: Yeah, I mean, I would just echo what
22 John and Dan brought up. This is something that we are

1 dealing with right now in Illinois, is the silos in
2 payments, the silos in services, and then the guidance that
3 we are going to be giving to PCPs. So any of those
4 additional tools or additional technical assistance that we
5 can put out to help us walk through, you know, how do we
6 make this system of screening for PCPs, integrating care,
7 work best under our Medicaid authorities that we already
8 have? I mean, unfortunately, I don't have those answers,
9 but I can tell you that on the ground that is what we are
10 trudging through right now.

11 COMMISSIONER SZILAGYI: Can I just make one quick
12 point, just because I'm not going to be here after 12? One
13 of the new frontiers in mental health for children is
14 trauma-informed care, which is actually different than
15 typical mental health care. And if we are really going to
16 do justice for children and adolescents who have trauma-
17 related mental health problems -- and that is a very large
18 number of children and adolescents -- then we have to
19 figure out ways to provide them access and high-quality
20 trauma-informed care and not just regular mental health
21 care.

22 So that will be my last point. Thank you, Chuck,

1 for letting me take so much time.

2 VICE CHAIR MILLIGAN: Thank you, and God speed

3 with the work you've got ahead of you the rest of the day.

4 So other Commissioners who want to follow Peter

5 with our panel? I see Brian and then Fred.

6 COMMISSIONER BURWELL: Thank you all for coming.

7 This is a great discussion. I am particularly concerned

8 about the issue of opioid use among adolescents, and John,

9 you are the one that taught me that most adults who have

10 opioid use disorder began using opioids as adolescents. I

11 won't get into the background, but, you know, we all know

12 it is a difficult population to intervene with, you know, a

13 lot of risky behaviors, don't like to seek treatment.

14 It seems to me that our approach to intervening

15 with this population has not been very successful, and I

16 just think there is a large opportunity that is being

17 missed to try to nip this problem while people are still

18 quite young so that they don't proceed onto a lifetime use

19 of using opioids. I just wondered if you had ideas about

20 what things seem to really work in preventing initial

21 opioid use among this population or intervening early

22 successfully?

1 MR. O'BRIEN: Good question, Brian. So two
2 things. One is my two cents about the availability of
3 SUD/OUD services in general for children and adolescents.
4 And thanks to Toby Douglas, to some respect -- Toby, I will
5 put you under the bus -- when we did the initial 1115
6 guidance around substance use disorder we were pretty clear
7 that one of the expectations was that states needed to re-
8 examine their SUD/OUD benefit for kids, because, again, we
9 knew EPSDT existed but, for the most part, what was
10 available for the kids that had an SUD and OUD really were
11 either residential programs or day treatment programs and
12 not really getting at some of where you are going, Brian,
13 which might be early intervention, and, to some extent,
14 prevention.
15 So I still think that there is a fair amount of
16 work and messaging and push that should be done on trying
17 to get states to pay more attention to the adolescent
18 benefit. They don't have a whole lot of adolescent
19 providers, unfortunately, and so I do think that's one of
20 those things where, again, states are in the driver's seat
21 to be able to create some capacity in that particular area.
22 The other thing, too, is about the prescription

1 of OUD drugs, and again, I think CMS has done a good job
2 messaging about the drugs that are available and the extent
3 to which those drugs are indicated or contraindicated for
4 adolescents and young adults. The issue being is that we
5 don't necessarily have the number of prescribers that are
6 able to do or willing to do the prescribing, and probably
7 they are even more leery of thinking about doing
8 prescribing for younger adults or older adolescents.
9 And so, again, both the research, the clinical
10 research is there to be able to do treatment. It is just
11 that I think that states find it hard to get some traction
12 on this issue.
13 VICE CHAIR MILLIGAN: Thank you. I have Fred and
14 then Martha.
15 COMMISSIONER CERISE: Thanks, Chuck. First, I
16 want to thank the panel. I appreciate the work you are
17 doing. I mean, you are doing heroic work. The problem is
18 so large, though. When 1 in 5 kids needs services it makes
19 me wonder, you know, I don't know that we can keep up with
20 treatment. We talk about a lot of things where we need
21 more providers and we need to add and add and add, and
22 you're going through these processes to try to make it more

1 accessible, but the numbers are just staggering.

2 And so it makes me think about, you know, what

3 are the causes of these situations, and what are we doing,

4 and what can we do on the prevention side to try to do

5 something, because I just don't -- I mean, we can keep

6 adding and adding but the numbers are so large.

7 I'm going to give you one example, and it's

8 relevant because we talked about maternal health yesterday,

9 and that is, Kristine, you made me think about it when you

10 were talking about HEDIS measures. There is a home

11 visitation program for new moms that has long-term outcome

12 measures that include school performance, contact with

13 police and juvenile justice system and child welfare,

14 evidence-based that shows you can reduce those things by

15 intervening early with moms and teaching them how to be

16 moms, and reducing adverse childhood experiences and the

17 things that lead to these later situations.

18 So for one I would like Martha to consider that

19 type of prevention in the work that she is doing right now,

20 but then I just want to ask the panel, what are your

21 thoughts about causes and prevention, and do you see

22 anything we can be doing within the Medicaid program, or

1 beyond that, on that end?

2 VICE CHAIR MILLIGAN: It seems like that's to the

3 panel as a whole. Does anybody want to start?

4 MR. TSAI: I think I'd note, as a whole, some of

5 the prevention topics are actually just tackling this issue

6 overall, because, I mean, when you look at the adult

7 population, we recently did an analysis, 80 percent of our

8 total cost-of-care dollars are linked to an individual with

9 a behavioral health need. And not 80 percent of the

10 dollars are behavioral health spend. It is total cost of

11 care, medical and otherwise, related to that. And those

12 issues start on the kid side, where there has historically

13 been a lack of a sufficient enough treatment system with

14 providers and investments.

15 So I think there are two pieces to it. One which

16 is related to the report, the analysis that was discussed

17 just before this panel. There is a need for the right

18 level of clinicians, specifically with a kid-and-youth

19 focus, both child psychiatrists but I think it was one of

20 the previous Commissioners that mentioned trauma-informed

21 care and some of the evidence-based practices. Some of

22 those things where they don't exist require a way for a

1 state or the federal government to think about scaled
2 funding and incentives to get more of the workforce into
3 place around that, which we've thought about in
4 Massachusetts but gets really hard when you start to think
5 about things in the context of an annual budget and things
6 of that sort.

7 The second piece is, we talked about ACE events
8 quite a bit, and when you get into some of the underlying
9 social factors, we always say for any Medicaid program our
10 PMPM for kids is like $220, relative to $450 to $600 PMPM
11 for the adult population. And so it's not like kids, as a
12 whole, are really high cost at the outset, but you have a
13 bunch of things, whether related to educational outcomes
14 and some of the social factors that are really hard to
15 target, and often fall, I think, in the cracks to what a
16 typical health care agency like Medicaid would do, or some
17 of the social service pieces and education.

18 And that mix of things leads to some of, I think,
19 the extension of the issues we are seeing later on, as kids
20 get into adolescent years as well. So I'd like to see
21 people thinking creatively about how to address some of
22 those factors beyond a typical purview of what people think

1 about for health care, is probably some of the most ROI
2 intensive relative to long-term, not just on the behavioral
3 health piece for youth and adolescents but more broadly as
4 well.
5 VICE CHAIR MILLIGAN: John or Kristine?
6 MS. HERMAN: I would just echo that. I mean, we
7 found that 25 percent of our population, as I said earlier,
8 that had a behavioral health diagnosis or had access to
9 behavioral health services, it was, you know, over half of
10 our overall spend for both physical health and behavioral
11 health. We've been trying to work across the aisle with
12 our Department of Human Services on social-emotional
13 learning in schools. So that's been a big push that we
14 have had to try to do some of that early intervention
15 actually in the learning environment, where kids are coming
16 in.
17 The other thing -- and I mentioned this before,
18 too, but it's really working with our PCPs to see those
19 early signs, to understand, you know, when a screening
20 needs to be done, when a child may need intervention, and
21 making sure they've got access to those services.
22 We also have in Illinois a DocAssist program,

1 which, Dan, sounds like the program that you've got, where
2 we've got a university partner who can offer immediate
3 consultation to our PCPs if there's an issue that comes up
4 and they say, hey, you know, I think this child has a
5 behavioral health need that needs to be addressed, they can
6 get immediate consultation. So we're going to expand that
7 as we are looking into, you know, our screening process and
8 our referral process, making sure the PCPs understand that
9 that sort of resource is out there, and then giving them
10 the tools that they need to actually, you know, get that
11 child into services. I think that's going to be a key
12 component as we're trying to, you know, push our whole
13 system forward.
14 VICE CHAIR MILLIGAN: Thank you. Did you have
15 anything you wanted to add, John?
16 MR. O'BRIEN: No. I think that Kristine and Dan
17 have covered it pretty well.
18 VICE CHAIR MILLIGAN: Thank you. So I had Martha
19 next. Martha?
20 COMMISSIONER CARTER: Thanks. Yeah, I wanted to
21 follow up quickly on something that Peter said, so I'll
22 just lay a little groundwork. So trauma-informed care is

1 related to adverse childhood experiences, which are
2 traumatic experiences in childhood, and scored on a 1-10
3 scoring system. So there's research that shows that people
4 with an ACE, adverse childhood experience, score of 5 or
5 higher are seven to ten times more likely to use illegal
6 drugs, to report addiction, and to inject illegal drugs.
7 So there's our connection. Was it Brian, I think, who
8 brought that up? I think it's really important that we
9 recognize that connection and make sure we have systems in
10 place to deal with that.
11 To the panelists, it sounds to me that what we
12 really need to be looking at is examining the barriers to
13 integration, and they don't seem to be as much CMS related
14 or sort of higher level, but they're at the payment level
15 and at the systems level, you know, scope of practice,
16 integrating HIPAA, FERPA, and Part 2, which after
17 administering school-based health centers is, you know,
18 quite a challenge. And so I guess my question is maybe
19 just reiterate for us what you see are the main sort of
20 system barriers that we really need to look at, because I
21 don't know that it's the higher level. It seems like it's
22 payment and local level stuff. Do you agree?

1 MR. TSAI: I think that's right, meaning -- and,
2 John, I think you were hinting at this. It's not that we
3 see federal barriers that prevent primary care practices
4 from integrating more. It's a mix of expectations,
5 capacity, and investment. And so to the extent -- you
6 know, CMMI, which has had more of a historic Medicare
7 focus, has put out all sorts of models, CPC Plus from the
8 early days, things of that sort that really get at a very
9 specific notion of enhancing the role of primary care, the
10 sort of things, I think, that could push something more at
11 scale more broadly, thinking about that same sort of
12 dialogue, but what it looks like to have, you know, much
13 more dollars but with an expectation of much more
14 integration and a different way of thinking about financing
15 for that.
16 Given how underfunded behavioral health has
17 typically been relative to physical health, a bunch of
18 states probably want to make investments of that sort, but
19 it's very challenging within a state budget context. So to
20 the extent there are, you know, glide paths in FMAP
21 enhancement or support for states who would roll out a
22 specific payment model and a set of expectations for

1 integration that feels meaningful enough, can break down
2 some barriers, those are the types of things that I think
3 we would start to see more of a shift towards that versus
4 right now, you know, individual practices for health
5 centers that are really committed to this are figuring out
6 a way to kind of do this to the best they can, but it's not
7 the most sustainable and certainly not scalable by any
8 means.

9 MS. HERMAN: Yeah, I would just echo that. You
10 know, you have providers that are very interested in doing
11 this more integrated care, but managing the bureaucratic
12 silos at the state level is incredibly challenging. Our
13 state has different divisions -- you know, some states have
14 everybody under one roof. That makes it just a little bit
15 easier. We're actually separated out into various
16 departments, and each of those departments has their own
17 regulations and their own rules and their own billing, and
18 providers are just -- they have to have like, you know, an
19 army of people who understand all of the billing
20 regulations in order to do the types of services that they
21 need.

22 So we are trying at the state level, you know, to

1 bridge some of those gaps just in terms of building the
2 relationships between the people that need to be built to
3 make sure we can break down some of these barriers. We
4 also know that we need a much more streamlined regulatory
5 structure within the state in order to make that happen.
6 The payments would be good. Absolutely we need that. That
7 would help ease some of the burden. But until we can
8 really break down some of those state-level bureaucratic
9 silos, I think we're still going to struggle.
10 VICE CHAIR MILLIGAN: I wanted to do a quick time
11 check. We're at the time that the panel would have
12 concluded. Panelists, can you hang in there for five or so
13 minutes?
14 MR. O'BRIEN: Sure.
15 VICE CHAIR MILLIGAN: Great. Thank you. So I
16 had a couple questions, but I don't want to jump the gun if
17 others do. Darin, and then I'll go. Darin?
18 COMMISSIONER GORDON: So, you know, Kristine,
19 building on your comments about the silos, I mean, we saw
20 that in Tennessee, and I think there's multiple silos
21 within different state agencies, but also how many Medicaid
22 programs have set up their own systems, silos within silos?

1 And I don't think it's the only step, but I think it is a
2 necessary step that getting integration at the payer level
3 I think helps enable more integration at the buyer level.
4 We saw that firsthand. To Dan's point, it didn't solve
5 every problem, but it did create some opportunities where
6 we saw both on the physical side but also on the CMHC side
7 more progressive providers able to navigate and move toward
8 the direction of integration. So I think we have to think
9 about that at several different levels when we say
10 integration.
11 Dan, I'd be curious. When you were talking about
12 the more enhanced wrap services and how that progressed and
13 what's really stuck with me is Kristine's -- you know,
14 they're 10 years behind in that journey. She may be able
15 to chime in here, too, but I'm just trying to understand.
16 What were some of the biggest hurdles getting to that more
17 developed aspect of the system?
18 MR. TSAI: Well, it didn't hurt that the
19 commonwealth was under -- you know, there was strong legal
20 action to require the commonwealth to do that. But what
21 that --
22 COMMISSIONER GORDON: [Inaudible.]

1 MR. TSAI: It creates immense fodder for trying
2 to figure out a system and how it would best work. And so
3 many of those types of services, which were consistent with
4 what John was ticking off in that previous bulletin, are
5 exactly the right things because what we see on the youth
6 side, kid and family side, if you're not finding a way to
7 engage with the parents in some way, in many cases you've
8 essentially lost the battle. So people love the family
9 partner piece where you've got someone with lived
10 experience coming by next to the parent in tandem sometimes
11 literally in the home at the same time as -- while
12 therapeutic reports are being delivered. So those types of
13 things and the intensive wrap get at all the issues in a
14 behavioral health system where people know where to go and
15 know how to navigate the damn thing. You know, you go to
16 one provider. They figure out your needs. You get a care
17 plan. You get an intensive care coordinator. That is a
18 really, really effective model for that and what I would
19 encourage folks to think about, but ideally that can be
20 targeted to the most intensive level. I think it's a
21 challenge when the underlying system fails and people are
22 having to go to the high-fidelity piece to kind of fill

1 some of those underlying gaps, which was part of my other
2 point.
3 COMMISSIONER GORDON: I think that was a very
4 good point. You have got to build up the base so as not to
5 overstress the services for those in most need.
6 I am curious. Providers of that service, are
7 those also your community mental health centers, or are
8 they other providers that have engaged on that front?
9 MR. TSAI: By and large, of the 25 to 27
10 providers, many of them community mental health centers,
11 the vast majority serve folks across the age continuum, and
12 some of that evolved over the course of ten years as well,
13 because you get a little bit more diversification in the
14 set of services that folks have. I think there are a
15 handful, a very small number that are still focused just on
16 youth-specific services.
17 COMMISSIONER GORDON: Thank you.
18 VICE CHAIR MILLIGAN: So I had two questions.
19 I'll try to be targeted so we can get to the next part of
20 this discussion.
21 You all have commented that maybe there aren't a
22 lot of things the federal government could do, or barriers

1 there, it's other types of barriers. And at the risk of
2 venturing into a territory that maybe is out of scope for
3 MACPAC, John, my question really is specifically to you and
4 specifically to your tenure working with SAMHSA and when
5 sort of part of the CMS team. Are there barriers in how
6 SAMHSA does grantmaking or SAMHSA does guidance that
7 enables a lack of integration or lack of joint planning
8 that we should be aware of? And as briefly as you can
9 answer my question, that would be great.
10 MR. O'BRIEN: I will be brief. I think in this
11 sphere, especially for some of the higher-end kids, they
12 did a fabulous job with paying attention to integration.
13 Unfortunately, you know, over the last couple years, that
14 opportunity has been minimized, and so I do think that, you
15 know, hopefully some light could be brought back in there.
16 I also think that they were trying to pay
17 attention mostly on the adult side, not so much on the kid
18 side, to kind of the physical health/behavioral health
19 integration. They were actually pretty helpful, putting a
20 fair amount of money out there both to behavioral health
21 providers at FQHCs to get them as catalysts to think about
22 integration. So they've been and could be good partners in

1 the future.

2 VICE CHAIR MILLIGAN: Thank you.

3 MR. TSAI: Can I add, I think we were identifying
4 -- it wasn't that there were a lot of regulatory statutory
5 barriers. I would gather all this, there is a tremendous
6 amount the federal government can do, whether it be from a
7 CMCS, CMS, CMMI, SAMHSA to think about helping to get
8 things going with grants, funding, the CCBHC models, those
9 things I think would have tremendous impact. So I do think
10 there could and should be more done from the federal
11 standpoint there.

12 VICE CHAIR MILLIGAN: I agree, and, you know,
13 we've talked about school-based health centers, and I want
14 to -- contributing to access for this issue. And we've
15 talked in other conversations around how HRSA thinks about
16 FQHC sites and services and Medicaid. So I think there are
17 ways in which those things can stitch together.

18 My other question, again, as kind of briefly as
19 folks can keep it. With respect to telehealth -- and
20 Martha Carter raised this right before the panel started as
21 a mechanism to expand access. I'm starting to see some
22 backlash or some concerns about potential overutilization

1 of telehealth, that it's so convenient potentially that
2 states are going to need to worry about overutilization,
3 and there has been some -- like Ohio's reprocuring their
4 managed care program, and there were questions in their RFP
5 around managing overutilization.
6 So I don't think that that's a particular thing
7 to be concerned about with BH where there's so much
8 capacity and access challenges. But if there are any
9 comments about telehealth, something we should keep an eye
10 on in terms of as we come out of the public health
11 emergency and some of the expansions we've seen with
12 telehealth, just keeping an eye on that with respect to
13 access to care for children and adolescent. Any quick
14 comments would be appreciated, and then I think we need to
15 wrap the panel part of this up.
16 MR. O'BRIEN: Chuck, you know, I'll just be
17 brief. I think that we're still in a learning mode as it
18 relates to telehealth. You know, I'm hearing some of what
19 you're hearing in terms of overuse, but I'm also hearing,
20 you know, some issues, even just getting some ongoing
21 utilization. And so, you know, I think states are in the
22 process of trying to figure out what makes sense to do the

1 monitoring in telehealth but also what good lessons learned
2 can they use moving forward on what's the best way to use
3 telehealth for kids and adolescents. That's their primary
4 -- I mean, honestly that's their kind of primary vehicle of
5 communication anyway. So, you know, I think stay tuned.
6 VICE CHAIR MILLIGAN: Thank you.
7 MR. TSAI: That's also really important. It's
8 filling a lot of gaps. Yes, there's some things around the
9 edges that require program integrity. No different than
10 any other service. So I think that -- I wouldn't let that
11 set of concerns, problems that are solvable, versus kind of
12 holding back on a very important increase in the modality
13 of care there.
14 VICE CHAIR MILLIGAN: Thank you. Kristine?
15 MS. HERMAN: Yeah, I would just absolutely agree
16 with that. And, you know, to John's point of being in this
17 learning period, you know, because we are rolling out a lot
18 of these new enhanced services, we're shifting all of our
19 training to include telehealth, which it really didn't
20 before. So we're actually learning how to do these
21 services under that different modality, and I think as they
22 roll out, we're going to have to see, you know, how did

1 this impact our effectiveness? But I wouldn't want to see
2 restrictions on it just yet until we can kind of get more
3 learning on that.
4 VICE CHAIR MILLIGAN: I appreciate all of that,
5 because I do think this in particular is a service that we
6 need to not err too much in worry about fraud, waste, and
7 abuse and program integrity. So I want to thank the panel
8 very much for what you've contributed in terms of your
9 expertise and time. We're going to go to a Commissioner-
10 only discussion on all of this. Feel free to stay if you
11 have time. And, Melinda, thank you very much for kind of
12 organizing the panel and really helping enable such a good
13 discussion.
14 So, John, Kristine, Dan, thank you very much for
15 contributing to our meeting.
16 MR. O'BRIEN: Thanks for having us.
17 MR. TSAI: Thanks.
18 MS. HERMAN: Thank you.
19 **### FURTHER DISCUSSION BY COMMISSION**
20 * VICE CHAIR MILLIGAN: Thanks.
21 Okay, Commissioners, is there anybody who wants
22 to kind of take what we've heard and maybe frame up where

1 you would like our work and considerations to go? Sheldon
2 and Kisha, then Martha.
3 COMMISSIONER RETCHIN: I'm just going to circle
4 back to Stacey's point and maybe some things that Martha
5 and others have said. But going back to the workforce,
6 which is a dear subject to me, I'm going to maybe surprise
7 you a little bit. There's actually a study -- and maybe
8 you saw this, Melinda, or certainly I can send it to you --
9 in 2016 by the Center for Health Care Workforce Analysis at
10 HRSA. Half of it -- and what it did was it looked at the
11 demand-supply of adult psychiatrists and the demand-supply
12 by child psychiatrists. Not surprisingly, for adult
13 psychiatrists, between 2016 and 2030, they predict a
14 growing deficit and a workforce shortage for adult
15 psychiatrists of about 20,000 by the year 2030, starting
16 with already a deficit now. We know that, and I think
17 primary care has stepped into that void, but it's still a
18 problem.
19 Check our child psychiatry, though. Between 2016
20 and 2030, they project a growing surplus because the
21 attrition will be way outstripped by the number of child
22 psychiatrists being turned out by training programs.

1 Now, if you believe their model and look at it,
2 it's not a trivial surplus. Then what we have is not an
3 issue of a workforce deficit, but a workforce
4 maldistribution, and I would submit it's because in part
5 the mental health parity is over coverage, not
6 reimbursement. So the pricing differential, I've seen this
7 in a study that I'm conducting now in terms of the
8 commercial insurance platform where we see many
9 psychiatrists, child psychiatrists, who don't participate
10 in commercial insurance. So I'd be glad to send you the
11 issue brief, but I think we have an issue that has to be
12 addressed in terms of workforce distribution and
13 participation in Medicaid.
14 VICE CHAIR MILLIGAN: Thank you, Sheldon.
15 Kisha and then Martha.
16 COMMISSIONER DAVIS: Thanks, Sheldon. My
17 comments actually kind of are in the same vein of that. We
18 see as a shortage of behavioral health professionals, and
19 then when you look at those who are participating in
20 Medicaid, that shortage goes down, you know. That shortage
21 increases exponentially.
22 So I really hope that our kind of future work in

1 this area looks at what are some of those carrots to
2 encourage providers to participate in Medicaid. Part of
3 that is reimbursement and looking at parity and how we are
4 incentivizing folks to work in that space, but also just
5 looking more broadly and doing some blue-sky thinking.
6 What I heard from Dan was while the federal
7 government hasn't put up a lot of barriers, they also
8 haven't put up a lot of incentives to encourage some of
9 that collaboration and coordination. As much as we can
10 help continue that conversation and thinking about what
11 some of those programs could look like, that would
12 encourage more integration in the behavioral health space,
13 especially for kids.
14 VICE CHAIR MILLIGAN: Thank you, Kisha.
15 Martha?
16 COMMISSIONER CARTER: To follow up, I think I'm
17 looking at sort of a large frame that would look at what
18 can be done at the federal level, similar to the emphasis
19 that HRSA put on funding health centers for integrated --
20 physical, behavioral, and dental, actually -- care. There
21 could be other programs that the feds could do to support
22 integration.

1 Then looking at the state level, because it is
2 part of our mandate to advise the states, is it not? So
3 what can be done at the state level to reduce barriers?
4 Like I was talking about earlier, the payment barriers,
5 just having to credential people and bill, bill different
6 systems. Sometimes if you've got a carve-out, you're
7 billing here and you're billing there. Oh, my God. You
8 know, so it's really a barrier. It's a functional
9 operational barrier every day to the practice that wants to
10 integrate behavioral health care. So I think we need to
11 really dig into those systems barriers.
12 VICE CHAIR MILLIGAN: Thank you.
13 Are there others who want to contribute?
14 [No response.]
15 VICE CHAIR MILLIGAN: Okay. I have heard several
16 things that I do think we've got a couple of themes. One
17 is really workforce-related themes. Sheldon and Kisha
18 touched on this, and we've touched on it. I think it plays
19 into the telehealth comments as well, but what are the
20 barriers for workforce? What are the implications of
21 parity to workforce? What are the implications of
22 incentives and some of the incentives that the federal

1 government contributes to but also just reimbursement?

2 Martha, I think, a couple of times now has made

3 really good comments around examining barriers to

4 integration, whether it's payment-related mechanisms,

5 credentialing, licensure issues, and some of the comments

6 that we heard from the panelists around how states approach

7 licensing, not just individual behavioral health providers,

8 but more of the facility types as well as -- and we've

9 touched on this a little bit -- well, more than a little

10 bit, but just data sharing and data barriers to integration

11 as well.

12 I'm not sure if I've missed any themes to promote

13 further work. I know there's been a lot of other

14 discussions, Melinda and Erin, that as you kind of go

15 through the comments in the transcript that you'll pull

16 out.

17 Let me, Darin, come to you in a second and Toby

18 in a second. It would be helpful -- I'll go to Darin and

19 then Toby, but it would be helpful if others captured

20 anything I might have missed.

21 Darin?

22 COMMISSIONER GORDON: There's one thing that we

1 heard from John was around the scope of practice, and I
2 think when we think about this and we think about barriers,
3 I think that's something that's worth examining in that
4 same context. When we talk about workforce, I think that's
5 a theme that came up that's worth considering in that
6 context.

7 VICE CHAIR MILLIGAN: Yeah, thank you. I had
8 embedded that under the license aspects, but I think
9 calling it out specifically is a good way to also make sure
10 it's captured.

11 Toby?

12 COMMISSIONER DOUGLAS: Yeah. I just don't want
13 to forget ACEs and the need to really focus upstream, at
14 least some acknowledgement, because there's both the
15 treatment side and we really ought to acknowledge the vast
16 amount of work.

17 It does even go back to our work we talked about,
18 about equity, because so much of the underlying issues that
19 we're talking about go back to that.

20 If there's just some focus on that and the work
21 that needs to happen in that sphere so that 20, 30 years
22 from now, we can see a different place.

1 VICE CHAIR MILLIGAN: Thank you.

2 Okay. So I'm going to turn next to public
3 comment and see if we have anybody in the public who wants
4 to make comment on this particular -- you know, the
5 sessions we've had this morning, and then I'll turn it back
6 over the Melanie to kind of wrap up the morning part of the
7 meeting.

8 Are there any individuals who -- and it would be
9 by raising your hand in the attendee box. And I'm not
10 seeing where people can raise their hand. Oh, there it is.
11 Okay. Are there any members of the public who want to
12 comment on this?

13 [No response.]

14 VICE CHAIR MILLIGAN: Okay. Seeing none --

15 EXECUTIVE DIRECTOR SCHWARTZ: Chuck?

16 VICE CHAIR MILLIGAN: Yep.

17 EXECUTIVE DIRECTOR SCHWARTZ: Nataki MacMurray
18 has her hand raised.

19 VICE CHAIR MILLIGAN: Oh, I'm sorry. Nataki,
20 thank you.

21 **### PUBLIC COMMENT**

22 * MS. MacMURRAY: Good morning. Hi, guys.

1 So my question -- Office of National Drug Control
2 Policy. I'm Nataki MacMurray from Office of National Drug
3 Control Policy.
4 I heard you mention HRSA a few times and the work
5 that they've been doing around FQHCs and supporting
6 integration on the adult side. So can you talk a little
7 bit more about your thoughts of where HRSA could be engaged
8 to increase both the workforce issues, especially when we
9 think about developmentally appropriate practice --
10 practitioners as well as geographically available
11 practitioners in the rural and suburban areas?
12 And then also what you think HRSA can -- how HRSA
13 can team with CMS on reducing some of those barriers that
14 you just mentioned at the state level that could help
15 support better access to care.
16 VICE CHAIR MILLIGAN: So I'm going to defer to
17 Erin and Melinda, and, Martha, if you have anything you
18 want to add to this as well. No?
19 Erin McMullen or Melinda, any comments about
20 that?
21 MS. McMULLEN: I would just say that I think it's
22 something that at least we are thinking about how we can

1 start looking at some of these other datasets as we
2 continue our work in this area. It's something that we
3 definitely need to kind of dig into more.
4 VICE CHAIR MILLIGAN: Thank you.
5 Sheldon. And then I will have one quick comment
6 on this as well. Sheldon, did you want to contribute to
7 this?
8 COMMISSIONER RETCHIN: Well, it's just
9 interesting that there are HPSAs, which are health
10 professional shortage areas by HRSA get a bonus payment for
11 behavioral shortages, but it's Medicare. So it's funded
12 federally. I don't know if anybody has ever thought to do
13 that on the Medicaid side with a federal bump in terms of
14 shortage area. I don't know if you could do that.
15 VICE CHAIR MILLIGAN: To me, the one part -- and
16 I'll just offer this comment, and it ties back to something
17 Fred said earlier. A lot of school-based health centers
18 are actually administered by FQHCs that kind of embed an
19 FQHC clinic in a school, and FQHCs then are able to serve,
20 regardless of payer status, and include a lot of uninsured
21 kids. And also, FQHCs are also very good at kind of
22 helping facilitate Medicaid enrollment for those

1 individuals who qualify.

2 I do think that to the extent that we can help --

3 and FQHCs often have very integrated models of care to

4 begin with -- physical health, dental, behavioral health.

5 So, to me, as we look at HRSA sites of service and FQHCs, I

6 think it will play back directly into this topic in a very

7 focused way with school-based health centers. So just, I

8 think, that that's kind of part of where my thought process

9 was.

10 Martha?

11 COMMISSIONER CARTER: There has been some

12 additional funding for National Health Service Corps

13 placements in HPSAs, especially in mental health HPSAs,

14 Sheldon, but I think that can be a message to Congress that

15 we need more funding to expand National Service Corps,

16 which are then required to work in health professions or

17 mental health shortage areas, and expand the types of

18 providers.

19 We could take a look at what's included now in

20 the National Service Corps and whether that could be

21 expanded to supplement the behavioral health workforce.

22 VICE CHAIR MILLIGAN: Okay. Thank you all.

1 Melinda and Erin, do you have what you need from
2 us at this point? Do you have any questions for us before
3 we wrap up this session?
4 [No response.]
5 VICE CHAIR MILLIGAN: Good shape? Okay.
6 MS. ROACH: All set. Thanks.
7 VICE CHAIR MILLIGAN: Okay. So, Melanie, turning
8 it back over to you to wrap up our morning for us.
9 CHAIR BELLA: Thank you, Chuck. I appreciate
10 that.
11 For the public folks, we are getting ready to
12 take a lunch break, and we'll be back at 1:30 to talk about
13 elections and implications for Medicaid.
14 We actually would like to do a small thing with
15 Anne and the staff. So if you all could stay on for just a
16 minute. This is our first attempt at this virtually, and
17 so I'm actually going to turn it over to Martha Carter to
18 do what we would be doing were we in person in the Reagan
19 Building, but we're obviously not. But, Martha, please
20 take it away.
21 **### STAFF RECOGNITION**
22 * COMMISSIONER CARTER: And, actually, thank you,

1 Melanie. I'm going to turn it over to Sheldon.
2 COMMISSIONER RETCHIN: Oh. And I'm going to turn
3 it over to my golden doodle.
4 [Laughter.]
5 COMMISSIONER RETCHIN: This has become a
6 tradition. I've been drafted, which is an honor, to
7 actually talk to the staff at this holiday time. Martha
8 started this tradition, and each year, it keeps getting
9 bigger and bigger.
10 This year, it was extraordinary from the
11 Commissioners, and just a shout-out particularly to Toby
12 and Darin who have pledged to endow this gift for the
13 coming 20 years with a $20,000 gift. I was overwhelmed.
14 [Laughter.]
15 COMMISSIONER RETCHIN: No, in all seriousness, it
16 was just a little over half of that.
17 But I will say that the Commissioners were
18 unanimous in terms of their recognition of the
19 contributions of staff, and I'll speak for all of us that
20 the products that are delivered just have so much
21 scholarship. You guys work so hard year in and year out,
22 and in this particular time with the pandemic, I know it's

1 been difficult.

2 But one thing that I've noticed, that even with
3 the pandemic and the separation physically of all of you --
4 and I know it makes collaboration so much more difficult --
5 if anything, the scholarship, you've upped your game even
6 more. So we appreciate the staff, your devotion, your
7 loyalty, and we just are thankful. You make the Commission
8 look better every day, whether it's at the Hill in terms of
9 the public's need, but I know the programs for Medicaid and
10 CHIP are that much better off with the quality of our
11 staff.

12 And, Anne, for your leadership, not only in
13 recruiting but retaining this talented staff.

14 So I don't know what's -- I'm sure I've already
15 broken over many barriers, but in terms of the size of the
16 gift, that probably matters less than really the intent.
17 But I'll be interested creatively how you can use the gift,
18 but we're just very appreciative.

19 I don't know if any Commissioners want to jump in
20 and echo what I've just said.

21 CHAIR BELLA: Well, it's almost -- it's
22 impossible to follow you, Sheldon.

1 I guess I just want to echo those remarks are
2 made on behalf of all of us and especially the “up your
3 game” part, even in light of the pandemic, and what you do
4 to allow us to have our public face is pretty remarkable.
5 I don't know if you'll enjoy this gift virtually
6 or when you all are in person again. At some point, we
7 will all be in person again, and we'll look forward to
8 saying this to your face. But in the meantime, thank you
9 to Martha for year after year, keeping us organized. Anne,
10 thank you for your leadership with the team.
11 COMMISSIONER RETCHIN: How about a virtual
12 applause.
13 [Applause.]
14 EXECUTIVE DIRECTOR SCHWARTZ: I'll just say thank
15 you on behalf of the staff who have been really working
16 incredibly hard, and I thank our operations team that has
17 made the transition and sustaining our virtual work
18 possible.
19 I do hope that we will all get a shot in the arm
20 at some point before too, too long. I’m grateful we're not
21 in high-risk groups, but also looking forward to being back
22 in the office and being back together again in 2021 and

1 being together with the Commission, because even though I
2 think we've been able to keep going and have this tool,
3 it's pretty incredible. I can't imagine what this would
4 have been like in the pre-internet world. But I do think
5 there's something missing without those face-to-face
6 interactions. But, anyway, thank you very much.
7 CHAIR BELLA: Martha, any last words?
8 COMMISSIONER CARTER: No. I think it's all been
9 said. Thank you so much to the staff and to Anne for your
10 leadership.
11 CHAIR BELLA: All right. Now, see, we tried to
12 surprise you a little bit. Hopefully, that was new and
13 surprising.
14 Okay. So now we are actually taking a lunch
15 break. We will be back at 1:30 Eastern Time. We'll kick
16 it off with Anne, and then we'll go into state recovery and
17 finish out with a couple of other sessions for the day.
18 Thank you all.
19 * [Whereupon, at 12:30 p.m., the meeting was
20 recessed for lunch, to reconvene at 1:30 p.m. this same
21 day.]
22
23

1 AFTERNOON SESSION

2 [1:30 p.m.]

3 CHAIR BELLA: All right. Welcome back, everyone.
4 Thank you for being prompt. And it looks like most
5 everyone is here, and I know we have a lot to cover in this
6 session, so let's go ahead and get started.

7 **### THE 2020 ELECTIONS: IMPLICATIONS FOR MEDICAID**
8 **POLICY**

9 * EXECUTIVE DIRECTOR SCHWARTZ: Okay. Thanks. The
10 purpose of this session is really to give you all a high-
11 level overview of what we might expect in the months ahead,
12 and more importantly, to have a discussion if you want to
13 send some kind of letter, and what the main points of that
14 letter would be.

15 I also want to provide a caveat that I
16 personally, and I think I speak for the rest of the MACPAC
17 staff, that we don't have any particular special entrée or
18 insights beyond just an outsized interest in these issues.
19 So I have no secrets to share.

20 I'm going to talk a little bit first about the
21 117th Congress, then I will talk about what we know about
22 the Biden administration, and then talk a little bit about

1 what MACPAC might say.

2 Well, apparently my slides are backwards from

3 what I said I was going to do, so starting with the new

4 administration, President-elect Biden is obviously taking

5 office at a very difficult time, and he has consistently

6 noted his intent to focus on the pandemic, and he has

7 signaled that he will extend the public health emergency,

8 which actually expires on Inauguration Day. So that is a

9 clear focus.

10 From the campaign website, the campaign made a

11 number of statements regarding support for caregiving,

12 including some changes to Medicaid home and community-based

13 services such as addressing the institutional bias and

14 getting rid of waiting lists. He also made a number of

15 campaign pledges around substance use disorder.

16 I think that the greatest expectation are the

17 administrative actions that CMS will take specific to

18 Medicaid, which includes rescinding guidance and revisiting

19 waivers that were put in place during the current

20 administration, such as the work and community engagement

21 requirements and the Healthy Adult Opportunity guidance.

22 They also have the ability to withdraw regulations from the

1 unified agenda or to not move those forward, such as the
2 proposed MFAR and proposed rescission of rules on access
3 monitoring requirements.
4 As you know, the HHS Secretary has been named,
5 and there is no CMS administrator yet named, and CMCS will
6 obviously happen subsequent to that.
7 In terms of the 117th Congress, what remains
8 unfinished from the current Congress, (and I don't think
9 we'll know exactly what is unfinished for at least another
10 week yet), but that will likely inform future actions.
11 Obviously, the health-relevant pieces that are being
12 considered right now include aid to state and local
13 governments, and also there is active discussion of some
14 maternity legislation. But again, we'll have to wait until
15 next week to know what actually makes it across the finish
16 line.
17 There is obviously an opportunity for MACPAC to
18 educate new members and new legislative staff. We are
19 updating the Medicaid 101 section of our website and we'll
20 be sending out email blasts to acquaint folks with our
21 resources. But it is also an opportunity for direct
22 communication, to highlight policy issues of interest and

1 any prior recommendations that have not yet been
2 implemented.
3 So in terms of possible topics for a letter to
4 Congress, on this list, two are COVID focused, and both
5 have come up at some point in this meeting so far. One
6 might be to comment on the need for additional federal
7 funds for Medicaid. You have talked about the amount of
8 the FMAP, the length of the FMAP bump, given that it is
9 related to the public health emergency, and some of you
10 have mentioned the likelihood that the economic damage of
11 the pandemic may outlive the public health emergency.
12 Yesterday, during our conversation around the
13 interim final rule, there was considerable conversation
14 about coverage of the COVID vaccine after the public health
15 emergency ends. As you know, under the Families First
16 bill, all Medicaid beneficiaries would have access to the
17 COVID vaccine, but after the public health emergency ends,
18 it reverts to normal, which is that certain groups are
19 covered -- children, the new adult group -- and some of the
20 other groups are at state action.
21 I have also listed here a number of prior MACPAC
22 recommendations from our last couple of reports, just to

1 remind you of what we've spoken on recently. The amount of
2 detail on these is certainly something that you might want
3 to adjust or you might want to share at a later date.
4 So that was the speed tour of the issues that are
5 going to be facing the new Congress and the new
6 administration, and I will sit back and listen to your
7 conversation.
8 CHAIR BELLA: Thank you, Anne. I am sure you are
9 going to get a lot of input on this. I will just start and
10 say there are three things that resonate for me with what
11 you said. One is vaccine and how we want to talk about the
12 vaccine coverage. Second is -- and maybe this is a little
13 less direct -- state relief and provider relief, just
14 making sure that the Medicaid providers in particular are
15 not forgotten in reiterating the need for state relief.
16 And then third would be how we want to talk about our prior
17 recommendations, and making sure that those are clear and
18 at the top of their list as they come into the new
19 Congress.
20 Let's just get kind of a round robin from the
21 Commissioners, and I hope that many or all of you have
22 thoughts on this. So who would like to start? Thank you,

1 Tom.

2 COMMISSIONER BARKER: I will go first. I think,

3 Melanie, all three of the issues that you just raised are

4 important. I think vaccine coverage and ensuring no

5 copayments for vaccines, that's an important point. I

6 agree that MFAR is not going to come back in the new

7 administration so I'm not sure that we need to address

8 that. I agree with Melanie's points about provider relief

9 and provider sustainability. I also think maybe we could

10 address the issue of telehealth, especially in light of the

11 discussions we were having at the tail end -- that second

12 question that Chuck asked at the tail end of the morning

13 session about the growth in telehealth and the concern

14 about the growth in telehealth. I think that is an issue

15 we might want to focus on as well, because that's an issue

16 that the Biden administration is going to have to focus on.

17 CHAIR BELLA: Thank you, Tom. Kisha?

18 COMMISSIONER DAVIS: Thanks. I echo everything,

19 Melanie, that you said, and Tom, also I appreciate you

20 highlighting the telehealth piece, and again, I'll

21 reiterate around the provider network advocacy. But I also

22 think this is an opportunity to highlight some of the work

1 and the conversations that we've been having around health
2 equity and how the Medicaid program can be a tool to help
3 achieve health equity. And so really how our work has been
4 weaving through that and how the administration, the next
5 administration, can really look to Medicaid to address some
6 of the issues in health disparities.

7 CHAIR BELLA: Thank you, Kisha. I totally agree.
8 And just so everyone has the framing, we'll take comments
9 on kind of a welcome letter to the administration as well
10 as a letter to the new Congress, because the issues might
11 vary a bit, depending on whose domain something is in. But
12 this one obviously falls in both domains, so thank you.

13 I'm going to start calling on people. Okay, Kit
14 and then Chuck.

15 COMMISSIONER GORTON: So I agree with what's been
16 said, and I feel pretty strongly that we should send a
17 letter to the administration at the same time we send a
18 letter to the new Congress. The present administration has
19 done a lot of policymaking through administrative action,
20 including executive orders. We can expect the incoming
21 administration will be extending a number of executive
22 orders on Inauguration Day. I personally will be surprised

1 if that doesn't include something that treats the pandemic
2 and the response to it.
3 So with respect to the incoming administration, I
4 think there are some things, which we have flagged in our
5 conversations, which need to be top of mind for them. And
6 first is we have gotten a lot of feedback over the course
7 of the pandemic about the serious impact on Medicaid
8 providers. You have already mentioned that. I think there
9 are actions that the incoming administration could take
10 even before the new Congress acts, in terms of providing
11 state flexibility around provider attention and potentially
12 using funds that are currently available, assuming that
13 they pass a new budget. And that could be directed towards
14 providers and the safety net.
15 We have seen a lot of evidence that particularly
16 in rural communities the safety net is taking a hammering,
17 and, you know, a practice that closes is closed, and it
18 takes a long time to bring one back. So I think we really
19 should flag for them, that there is an urgent need for them
20 to address workforce particularly in rural communities.
21 We have talked a lot about the confusion around
22 redeterminations and eligibility under the Maintenance of

1 Effort, and I think they give the states and everybody else
2 some clarity about what their thinking is on that, sooner
3 rather than later, so that, one, if states are doing stuff
4 which will turn out to be not useful activity, they stop,
5 and if states are worrying about something that they don't
6 need to worry about they can stop that too.
7 And then I think the third most critical timing-
8 wise is the CDC recommended, or authorized a moratorium on
9 evictions. That one won't keep until the new
10 administration, but I think we should be using every
11 opportunity to try and throw light on that. Becoming
12 homeless in the middle of winter, in the middle of a
13 pandemic, is just not a good public health outcome.
14 And so we really need to, I think, raise those
15 issues. With respect to the Congress, you know, I think if
16 you fully resurface, as Anne has listed, the
17 recommendations we made in the last year or so that haven't
18 been acted on, and so I'm supportive of sending letters
19 both to the Congress and to the incoming administration at
20 the earliest opportunity.
21 CHAIR BELLA: Thank you, Kit. Chuck?
22 VICE CHAIR MILLIGAN: I will be brief. I think

1 that we should reiterate our request that states be given
2 as much lead time as possible about the transition out of
3 the PHE, whenever that might occur. And the second part,
4 to me, is that I think we should reinforce the message we
5 heard, I think, at our last meeting, that the process of
6 resuming the redetermination process, in light of state
7 resources and in light of facilitating eligibility
8 evaluations, it will take time and that states should be
9 given the time necessary to resume those activities without
10 risk of program integrity audits or findings around, you
11 know, people who shouldn't be eligible not immediately
12 being off the program.
13 So I think we should reinforce the simple
14 logistical challenge of going back to ordinary business
15 once the PHE ends.
16 CHAIR BELLA: Thank you, Chuck. Darin and then
17 Toby, and I do want to remind folks, Anne's initial ask is
18 what do we want to be saying to Congress, so please
19 remember this isn't just about the administration. This is
20 also about Congress.
21 COMMISSIONER GORDON: Yeah. I'm just wanting to
22 make a point on Chuck's comment. I don't disagree with it

1 but I think the one thing -- I don't know if we've given it
2 enough discussion. When you think about the tail and
3 states getting back -- and this may end up touching on a
4 congressional comment -- but the tail to get back in
5 compliance and to reverify all those folks from suspension
6 and reverification, during that time, as I understand it,
7 they will no longer be eligible for that 6.2 percent
8 additional match, because, you know, at that point I think
9 they will declare the public health emergency ended.
10 And so there is this time where you have got this
11 built-up enrollment, fairly significant build-up of
12 enrollment, the public health emergency ends, and now I
13 have all of this enrollment that's pent up because of what
14 was required as part of the Maintenance of Effort, now
15 reverts back to the original state metric. And, you know,
16 I think this adds, to Chuck's point, this puts pressure on
17 states to move very quickly, and in some cases maybe more
18 quickly than they would otherwise, because now they have
19 much more financial exposure from the compliance with the
20 MOE that has since expired, if that makes sense.
21 So I don't think we've talked about that aspect
22 of it, the matching, in that context, but I think it's

1 super important because I think it only can make the
2 problem more difficult.
3 CHAIR BELLA: Chuck and then Anne.
4 EXECUTIVE DIRECTOR SCHWARTZ: Could I just
5 mention the timing thing, relative to what Darin just
6 brought up, which is that eligibility redeterminations have
7 to restart at the end of the PHE but the increased match
8 continues to the end of the quarter. Now you may not think
9 that's long enough --
10 VICE CHAIR MILLIGAN: Yeah, it isn't long enough
11 but that is helpful clarification.
12 EXECUTIVE DIRECTOR SCHWARTZ: Okay. Thanks.
13 VICE CHAIR MILLIGAN: And, Melanie, I appreciate
14 your reminder about the focus on the congressional
15 communication. I just want to, I guess, put my support in
16 the comments that others have made and Anne presented,
17 which is our previous recommendation, the provider digress
18 issues, and the Medicaid funding piece. And that would be
19 an area where we could urge that the enhance FMAP be
20 considered for some period of time after the PHE, as part
21 of congressional financing of the reality of unwinding from
22 the MOE.

1 CHAIR BELLA: Toby and then Tricia.
2 COMMISSIONER DOUGLAS: So I agree with all the
3 comments. The one thing that I hope we can make sure we
4 focus on too is just planting a seed on some of the longer-
5 term, structural changes that we've raised, even if we
6 don't have full recommendations. We talked yesterday, a
7 great discussion on the FMAP and the GAO, and I think
8 planting seed on the need, that we will be coming forward
9 with the recommendations in that area. The same on duals,
10 so if there are others. So some of the big areas where we
11 are still working through, but that these are areas where
12 there is the immediate here and now, and the long-term that
13 we think have implications on where we are today, as we
14 could see changes that would have had, especially like on
15 the nursing facility front. So just some thoughts on that
16 to add.
17 CHAIR BELLA: Yeah. I think we could have sort
18 of the immediate fires that need to be handled that are
19 COVID, right, and then we could have the recommendations
20 we've had, and then we could have here's what's coming, as
21 we look at this next, something like that. And maybe we do
22 the fires first. We can figure out the sequence to make

1 sure we don't dilute our message.

2 Okay. Good thing I have a note in front of me so
3 I don't have to remember the order in my head. Tricia and
4 then Sheldon.

5 COMMISSIONER BROOKS: Yeah, I definitely think we
6 should indicate that extending FMAP relief beyond the end
7 of the quarter, following the end of the public health
8 emergency, is really important. You know, who knows what
9 Congress is thinking, how long this was going to last, but
10 we know the economic impact is going to be so much greater,
11 and prior boosts to the FMAP have always extended out,
12 based on economic conditions more than public health.

13 On workforce, I just think we have to keep
14 reiterating the importance of recruiting people of color to
15 come into the health care field. We can start to better
16 address health equity.

17 But I would be remiss to just focus on Congress
18 for a moment, because a couple of things. We really
19 haven't talked too much about -- well, one a little bit but
20 the other not so much -- the necessity of the
21 administration reinstating funding for consumer assistance
22 and outreach. You know, we have not seen the new

1 application volume that we would like to see, based on
2 assumptions, you know, suggestions that the number of
3 uninsured are growing. And part of that is because people
4 really need to be helped through the system. So that's a
5 piece.

6 I also, when we talk about providers and relief
7 for providers, I think we still have to emphasize that
8 there are managed care companies that are sitting on
9 accruing surpluses because they are not paying providers,
10 and we have got to make the connection between the
11 accountability for those funds and making sure that
12 services are accessible.

13 And then, of course, public charge.

14 CHAIR BELLA: Yeah. Public charge. Sheldon and
15 then Brian.

16 COMMISSIONER RETCHIN: I actually want to double
17 down and support what Kit said and almost everything we
18 talked about.

19 In terms of our concerns post-COVID, you could
20 triple in the rural setting, and after COVID and the dust
21 settles, we will continue to see, I would predict, an
22 acceleration of rural hospital closings.

1 It also feeds back to the issue we talked about
2 yesterday, which is maternal morbidity and mortality.
3 We've seen a number of obstetrical programs close in the
4 rural area, and I mention this in the context that I think
5 the new administration, whether we call it a Marshall Plan
6 or whatever the rehabilitative term will be, I think
7 they're going to have to look at the consequences of the
8 urbanization that has gone on in particularly the last
9 three decades, because we have an infrastructure that's
10 collapsing particularly in the rural area. And health care
11 is square in the crosshairs.
12 CHAIR BELLA: Brian.
13 Thank you, Sheldon.
14 COMMISSIONER BURWELL: I'm supporting Toby's
15 point that in addition to these kind of what I would see as
16 relatively minor issues, fixes, that we should lay out kind
17 of some of the big policy areas that we've been working on,
18 you know, duals, behavioral health, increasing capacity for
19 home- and community-based services, opioid use disorders
20 and getting people into treatment. I'm sure there are
21 others that I -- improving the quality of services around
22 delivery for both mothers and infants, those kinds of

1 things.

2 I think we should also offer to brief them and/or
3 their staff on these issues, and we should also elicit from
4 -- in the letter, you know, we are interested in policy
5 areas that you would like us to address in our work.

6 CHAIR BELLA: Thanks, Brian.

7 Anne can say more, but she and I have talked
8 about when there is a transition, there is always an offer
9 to meet, the Chair and Anne, offer to meet with both the
10 new administration and the committees. So we will extend
11 that offer as part of normal course, but thank you for
12 those, just to let you know that is the intent. Thank you,
13 though.

14 Other -- Tom.

15 COMMISSIONER BARKER: Sorry, Melanie.

16 Tricia just reminded me of something in her
17 comments. I agree completely with Tricia that we should
18 say something about the public charge rule. I think it's
19 going to be -- I think the Biden administration is going to
20 have to -- is going to want to undo a lot of the
21 immigration changes that were made in this administration,
22 but I wouldn't want public charge to fall between the

1 cracks. And so I just want to say that I agree with
2 Tricia's comment on that.
3 CHAIR BELLA: Yeah. Thank you, Tom.
4 Other folks? Toby and then Bill.
5 COMMISSIONER DOUGLAS: More of a question. We
6 did a lot of work on work reform, and I kind of am
7 ambivalent. I just don't know if we should be raising it
8 in the sense of, back to our comments, not in saying yes or
9 no but around the thoughtful -- the evaluation that some --
10 from our letters, before anything that we could cull from
11 that. That would be a question mark, and I don't know how
12 others think about that one.
13 CHAIR BELLA: I think we're going to want to go
14 back and look. I mean, this isn't our only communication
15 to folks, right? And so, like, figuring out what goes in
16 this one and what we're prioritizing and when we continue
17 to communicate what, I think, is something we can ask Anne
18 to do and bring back to us and make sure it is there at
19 some point.
20 COMMISSIONER DOUGLAS: Yeah.
21 CHAIR BELLA: Bill and then Kit.
22 COMMISSIONER SCANLON: I'm supportive of

1 virtually everything we discussed, but I guess I was
2 concerned about what you just raised, which is the issue of
3 priorities. I can't imagine sort of Congress getting this
4 almost laundry list of all these things and being able to
5 cope with it in some ways.
6 Earlier you mentioned sort of that three groups,
7 COVID-related, sort of pressing, and then sort of longer
8 term, and there's a question of whether there should be a
9 letter for only the first one or only the first two, and --
10 because I think that you've got to give them something they
11 can manage and have the time to work on.
12 Among and COVID-related and this whole idea of
13 the FMAPs expiring at the end of the quarter, I would sort
14 of take the opportunity to maybe lay some groundwork from
15 our discussion yesterday about the need for FMAP
16 adjustments to be sensitive to economic data, that you
17 don't tie it just to a public health emergency, but you
18 tell them that there's concern that the economic downturn
19 is going to continue beyond the end of the public health
20 emergency and to be sensitive to using economic measures to
21 decide when the FMAP should end. And I don't know if that
22 scoops the recommendation too much, but I think if you do

1 it in general terms, then we can come back to more
2 specifics when we do a recommendation.
3 CHAIR BELLA: Okay. Thank you.
4 Kit?
5 COMMISSIONER GORTON: Yeah. I'm sorry to talk
6 twice.
7 I forgot, though, with respect to COVID, there's
8 the issue of the PHE ending and COVID covers ending for
9 people after the MOE. I expected Peter to talk about it.
10 I forgot he was leaving. But we need to figure out some
11 way to get COVID vaccine to people who will not be able to
12 pay for it once the MOE and the PHE end.
13 CHAIR BELLA: I'm pretty sure just about every
14 topic has been mentioned. However -- which is good. It is
15 a matter of prioritizing and kind of figuring out what
16 needs to go in and to whom, but anybody have any last
17 comments?
18 [No response.]
19 CHAIR BELLA: Anne, do you have what you need and
20 then some?
21 EXECUTIVE DIRECTOR SCHWARTZ: I've got plenty,
22 and there are different ways of dealing with this in terms

1 of what you go into in detail and what you raise and follow
2 up on later. So I think I'm fine with that.
3 CHAIR BELLA: Bill?
4 COMMISSIONER SCANLON: I would ask, sort of, are
5 we going to do a letter for the administration? Because to
6 me, it almost would be the same letter.
7 If we remember back to 2009, ARRA was put
8 together in great part by the administration to get the
9 economy going again. Sure, there were provisions or
10 portions that were sort of already on the Hill, but it was
11 a joint effort between the administration and the Congress.
12 CHAIR BELLA: I believe we will do two letters or
13 three letters. We need to determine what goes to the
14 administration right now while there's unnamed people, when
15 we don't know who's going to be receiving that message and
16 what goes to the administration a little bit latter in
17 January and to the extent that there are urgent things and
18 we need to answer that question. But I think that we just
19 have some sorting out to do.
20 Chuck?
21 VICE CHAIR MILLIGAN: Yeah. I think what I'm
22 hearing Bill say is there's one aspect of a letter to an

1 administration which is administrative-related issues, but
2 the other is informing their legislative agenda from -- I
3 mean, so I think what Bill is saying is that the extent to
4 which the Biden administration puts their shoulder behind a
5 legislative agenda is -- and I'm sort of agnostic on that,
6 but I think that's the point he's raising that wasn't
7 necessarily related to unwinding various administrative
8 activities or other things like public charge or whatnot.
9 COMMISSIONER SCANLON: No. And that's exactly
10 right because I do think it has to be a collaborative
11 effort if we want to accomplish anything in a reasonable
12 amount of time. We don't want introductory legislation,
13 sort of, then hearings, and then deliberations, et cetera.
14 It has got to be something that's accelerated.
15 CHAIR BELLA: Thank you both.
16 I am going to trust Anne and staff to kind of
17 take this information and bring us back. They've been
18 through this before and trying to figure out -- granted,
19 not in the middle of COVID. Understood. Appreciate that.
20 But I think that they can come back to us, and I think
21 we've given them quite a bit to work with. So thank you
22 all.

1 EXECUTIVE DIRECTOR SCHWARTZ: Thank you.
2 CHAIR BELLA: Anne, we're done with this session
3 if you're done.
4 EXECUTIVE DIRECTOR SCHWARTZ: I'm done.
5 CHAIR BELLA: Okay, great. Thank you everyone.
6 We're going to turn to Medicaid estate recovery.
7 This is a continued discussion of what we started and
8 moving on a path to determine if we would like to make a
9 recommendation in this area.
10 So Kristal and Tamara are going to lead us
11 through this. So they will give us a brief update, and
12 then we'll have some Commissioner discussion. Again, what
13 we're trying to get out of this is interest in a
14 recommendation and direction on various options for a
15 recommendation. So we'll turn it over to you guys. Thank
16 you.
17 **### MEDICAID ESTATE RECOVERY: UPDATES ON ANALYSES AND**
18 **DRAFT RECOMMENDATIONS**
19 * MS. HUSON: Okay. Can you hear me okay?
20 CHAIR BELLA: Yes.
21 MS. HUSON: Great, okay. Sorry. My audio wasn't
22 working there. Okay.

1 So good afternoon, Commissioners. Kristal and I
2 are back to share with you some updated analyses on
3 Medicaid estate recovery and to walk through three draft
4 recommendations. This is simply an overview of what we'll
5 be discussing.
6 Next slide, please.
7 So, as you will remember from our September
8 presentation, since the passing of OBRA in 1993, states
9 must pursue estate recovery from beneficiaries who were
10 permanently institutionalized, received Medicaid when they
11 were age 55 or older, or under certain circumstances, had
12 long-term care insurance policies.
13 For beneficiaries who used Medicaid-covered
14 services when they were 55 or older, states must seek
15 recovery for amounts at least equal to benefits paid on
16 their behalf for nursing facility services, HCBS, and
17 related hospital and prescription drug services. States
18 also have the option to seek recovery from any other items
19 or services under their state plan.
20 Next slide, please.
21 So there are multiple exemptions for estate
22 recovery, including if a sibling resides in the house and

1 has lived there at least one year prior to the
2 beneficiary's admission to an institution, and if a child
3 resides in the house and has resided there for at least two
4 years immediately prior to the beneficiary's admission to
5 that institution and can show that they've provided care
6 that delayed that admission and has continued to live in
7 the home since the beneficiary's admission to an
8 institution.
9 States may also defer recovery if a beneficiary
10 has a surviving spouse or a child who is under age 21,
11 blind, or disabled.
12 States can also waive recovery when they
13 determine that it is not cost effective, and state cost
14 effectiveness thresholds vary.
15 Finally, states must establish a process to grant
16 hardship waivers but have flexibility in setting criteria
17 for these waivers. CMS has provided some examples of
18 common situations that may cause undue hardship, including
19 if the estate claim would remove the sole income-producing
20 asset of survivors and the asset produces only limited
21 income, if the home is of modest value, which is roughly
22 half the average home value in the county, or other

1 compelling circumstances such as that without the receipt
2 of the estate proceeds, the survivor would become eligible
3 for public or medical assistance or recovering the assets
4 would deprive the survivor of necessities, such as food and
5 shelter.
6 Next slide, please.
7 So we have a few updates on our analytic work
8 from what we presented in September. Since September,
9 we've received four additional state survey responses,
10 bringing the total to 10. We've also reviewed additional
11 state plans received from CMS, now capturing at least
12 partial information for all 50 states and D.C., and this
13 gives us a more full picture, as in September we were able
14 to report on 38 states and D.C.
15 In general, the patterns we reviewed in September
16 in terms of the average size of the estates recovered and
17 state use of optional policies did not change.
18 One example is that among states responding to
19 our survey, there is a wide range in the number of estates
20 recovered and then the average recovery amount, with
21 average recoveries ranging from less than $3,000 in one
22 state to more than $70,000 in another. In general, states

1 that recovered from fewer estates had higher average
2 recovery amounts, which may be due to differences in cost-
3 effectiveness thresholds. And for more information, please
4 see the appendix in your materials.
5 Next slide, please.
6 So we conducted nine interviews with federal and
7 state officials, beneficiary advocates, elder law
8 attorneys, and others. And views on whether estate recovery
9 should be made optional were mixed. Generally, beneficiary
10 advocates and the elder law attorneys were in favor of
11 eliminating estate recovery or making it optional.
12 You will see in your materials that we received a
13 letter from 31 organizations representing a wide variety of
14 beneficiary advocacy organizations and elder law attorneys
15 supporting the elimination of Medicaid estate recovery, and
16 concerns about the inequities of estate recovery was one of
17 the key factors cited by all of these stakeholders.
18 Medicaid and state officials varied in their
19 views. While estate recovery does not bring a lot of money
20 back into this system, one interviewee described it as an
21 important policy because it is a reminder of the
22 significant cost for LTSS and that Medicaid finances the

1 majority of the nation's LTSS. One state official noted it
2 would be difficult to forego the revenue from estate
3 recovery echoing comments received through our state
4 survey. Another state, however, expressed equity concerns
5 and was in favor of it being optional.
6 Stakeholders also spoke about how estate recovery
7 can negatively affect access to LTSS, and while no one
8 could provide quantifiable data, beneficiary advocates,
9 elder law attorneys, and state officials all commented that
10 some people choose to forego or delay Medicaid LTSS for
11 fear of estate recovery and losing their home.
12 Next slide, please.
13 Awareness and understanding of estate recovery
14 policies by the general public and by Medicaid
15 beneficiaries is low. Individuals may first learn about
16 estate recovery during the Medicaid application process.
17 Two stakeholders, however, noted that this can get lost in
18 the fine print of long applications and question how many
19 people read or understand that information. Interviewees
20 also noted that individuals who have urgent needs for
21 services may not have the time or the ability to consider
22 estate recovery policies. Finally, while a Medicaid

1 enrollee may be aware of estate recovery, if they do not
2 pass that information along to the beneficiaries of their
3 estate, it can come as a shock to those individuals after
4 the enrollee's death.
5 Beneficiary advocates and elder law attorneys all
6 acknowledge that individuals with greater financial means
7 are able to plan their estates in ways that will protect
8 them from estate recovery and allow resources to be passed
9 on to their heirs. Individuals with very low incomes and
10 few assets beside a home, however, do not have the same
11 awareness for estate recovery or the resources to obtain an
12 attorney and thus are often the ones that are subject to
13 estate recovery. As multiple interviews affirm, this can
14 contribute to generational poverty and wealth inequity.
15 Next slide, please.
16 Hardship waivers also raise equity concerns. As
17 one elder law attorney stated, the ability to prove
18 hardship usually requires the help of lawyer, which not
19 everyone can afford, and even with legal representation, an
20 individual's success in getting approval for a hardship
21 waiver depends upon state policies. We spoke with elder
22 law attorneys from five different states, but only two of

1 them indicated that the assistance of an elder law attorney
2 could improve a person's chance of obtaining a hardship
3 waiver.
4 One stakeholder thought it could be beneficial to
5 set out more specific standards for hardship waivers, while
6 another one wanted to see the minimum standards in their
7 state raised.
8 Finally, many stakeholders said that few people
9 are even aware of the option to apply for a hardship
10 waiver, although one stakeholder who assists multiple
11 states with their estate recovery program commented that
12 they typically include information on hardship waivers with
13 materials sent to the representatives of the beneficiary's
14 estate from which recovery is being sought.
15 Lastly, estate recovery for MLTSS capitation
16 payments are difficult to understand and inequitable. Five
17 stakeholders said that they do not think people understand
18 what MLTSS capitation payments are, let alone how they
19 affect the estate recovery claim. It is easier for people
20 to understand recovery claims that are derived from the
21 direct cost of care, and several stakeholders noted that
22 recovering the capitation payment creates potential

1 inequities, as amounts recovered from individuals using few
2 services will be more than those actually spent on their
3 care. In other instances, however, the opposite is true.
4 And now I'm going to turn it over to Kristal to
5 walk us through the three draft recommendations.
6 * DR. VARDAMAN: Thank you, Tamara.
7 Okay. Now I'll go over the three draft
8 recommendations and rationales. As a reminder, last
9 December I brought you all a variety of policy options on
10 estate recovery, and Tamara and I brought to you a slimmed-
11 down list this past September. Today we're bringing you
12 three draft recommendations based on the discussions you
13 had then and the additional work we've done since that
14 meeting.
15 The first draft recommendation is that Congress
16 should amend the Social Security Act to make estate
17 recovery a state option for the populations and services
18 for which it's currently required. As Tamara has already
19 mentioned, OBRA ‘93 made estate recovery mandatory for
20 three categories of beneficiaries and specified the
21 benefits for which states are required to seek recovery.
22 Proponents of estate recovery say that it's a

1 useful program integrity tool and fosters good stewardship
2 of public resources. Critics say it recovers little and
3 does not reach its intended targets, as those with
4 substantial assets may avoid estate recovery through estate
5 planning.

6 As Tamara noted, in our interviews advocates and
7 elder law attorneys were generally supportive of making
8 estate recovery optional, although several would prefer it
9 be eliminated entirely. In our survey, we asked states
10 whether or not they would cease recovery if that option
11 were made available, and many provided some answers that
12 spoke to whether or not this recommendation should be made.

13 For example, one state official said they
14 supported making estate recovery optional and would be
15 interested in having discussions with stakeholders on how
16 to proceed, although the outcome of those discussions were
17 uncertain.

18 Another state official said that some
19 stakeholders and legislators might be interested in
20 eliminating estate recovery but did note that budget
21 constraints would make it difficult to forgo that revenue.

22 Six of the ten said they would likely continue to

1 pursue recovery if it were made optional, and some other
2 states either did not answer the question or said that more
3 analysis was needed.
4 Reverting estate recovery back to a state option
5 would give states increased flexibility, allowing some to
6 cease recovery if they determined the return on their
7 investment is low, while others could continue the
8 practice.
9 Prior to 1993, only 22 states had estate recovery
10 programs, and a few states were resistant to the OBRA
11 mandate. States most likely to opt out could be those with
12 lower collection amounts relative to other states.
13 For example, in fiscal year 2019, eight states
14 recovered less than half a million dollars each. We might
15 also expect that states that only pursue for mandatory
16 population services would be more likely to opt out than
17 those with more extensive programs or those that have
18 higher recovery amounts.
19 To understand the effects of this and the other
20 two recommendations on federal spending, we asked our
21 colleagues at the Congressional Budget Office to provide us
22 with estimates, and we thank them for their work. Please

1 note here that these are ranges rather than point
2 estimates, as our recommendations are not legislative
3 language and, therefore, CBO cannot give us an exact
4 figure.
5 For this first recommendation, CBO estimates that
6 it would reduce estate recovery collections from state
7 Medicaid programs which would increase federal spending.
8 Federal spending would increase by $50 to $250 million per
9 year during that budget horizon. States that cease
10 recovery would forgo the revenue, which would be offset
11 somewhat by administrative costs.
12 In terms of the effects on beneficiaries, if
13 states were to cease recovery, some individuals may pursue
14 Medicaid-covered LTSS who had not done so previously,
15 because, as Tamara mentioned, we did hear from stakeholders
16 that they believe some people forgo Medicaid benefits due
17 to estate recovery.
18 For heirs, the inheritance of an estate of even a
19 modest size could protect them from economic hardship. We
20 do not see any direct effects of this recommendation on
21 plans and providers.
22 The second recommendation is to allow states with

1 managed long-term services and supports, of which there are
2 currently 24, to pursue estate recovery based on the cost
3 of care rather than the capitation amount. This too would
4 require changes to the Social Security Act.
5 Currently, if a state elects to pursue recovery
6 for all Medicaid services, they must pursue recovery for
7 the total capitation payment provided for beneficiaries.
8 If a state only pursued recovery for some state plan
9 services, they must pursue recovery for the portion of the
10 capitation payment attributed to those services.
11 Pursuing recovery for some or all of the
12 capitation payment, as Tamara noted, means that some
13 beneficiaries who receive small amounts of services might
14 have their estates pursued for more than what was spent on
15 capitation payments, and the opposite is true for
16 beneficiaries who spent large amounts of care, such as
17 those who were institutionalized. It may also be the case
18 that an individual is enrolled in a managed care plan but
19 receives no services, so the letter that Tamara noted
20 raises one such example.
21 Allowing states to pursue recovery for the actual
22 cost of care would avoid these circumstances and would give

1 states additional flexibility. This approach would be more
2 equitable and easier for heirs to understand. We spoke to
3 one state that does have MLTSS, and they noted that they
4 would be interested in pursuing recovery based on the cost
5 of actual care.
6 In terms of implications, CBO estimates that this
7 recommendation would reduce estate recovery collections and
8 thus increase federal spending to Medicaid. This amount
9 would be well under the lowest thresholds of CBO's
10 estimates, which are $50 million per year between 2022 and
11 2030. States that opt to pursue recovery based on the
12 actual cost of care would see some decreased collections.
13 This recommendation may remove a barrier to enrollment for
14 individuals who only need small amounts of care, as we
15 noted before, and would again be easier to explain to
16 heirs. And we think that there would be little effect on
17 plans as many already submit the type of information states
18 would need to seek recovery based on the cost of care, and
19 we don't anticipate any effect on providers.
20 The last draft recommendation is for the
21 Secretary to set minimum standards for hardship waivers;
22 furthermore, it directs the Secretary to consider factors

1 that are currently outlined in CMS guidance. We currently
2 believe that OBRA ’93 gives CMS the authority to do this
3 without a change in statute, but we'll confirm this prior
4 to the January vote.

5 As a reminder, OBRA mandated that states
6 establish procedures to waive recovery where its
7 application would cause undue hardship, and Tamara outlined
8 those examples that are currently outlined in CMS guidance.

9 We found in our review of state plans that a
10 majority of states consider the sample criteria of whether
11 the asset is the sole income-producing assets of heirs, but
12 fewer consider waiving recovery for homes of modest values.
13 States have also defined their own criteria that they use
14 either in addition to or instead of CMS's examples.

15 Our survey results demonstrated that the number
16 of applications received and granted vary widely among
17 states. The highest number of waivers granted by a state
18 in a single year was 57, and some states reported no
19 hardship waivers granted or reported granting them in the
20 single digits in a given year.

21 Given what we heard from stakeholders again about
22 the difficulties in completing hardship waivers,

1 beneficiaries may not be aware of these policies, or it
2 might be difficult to complete the application. Setting
3 some federal standards for hardship waivers would address
4 some of the concerns we heard in our interviews about how
5 estate recovery can perpetuate poverty and will provide
6 more consistent treatment of heirs across states. CMS
7 could begin this process by considering that states be
8 required to follow the criteria currently outlined in the
9 guidance. Under this recommendation, though, states would
10 continue to be allowed to use their own criteria that could
11 supplement the minimum standards.

12 CBO estimates that this recommendation would
13 reduce estate recovery collections, and, again, this would
14 be well below the lowest thresholds for CBO's estimates
15 which are $50 million per year from 2022 to 2030.

16 States may see a reduction in revenue if more
17 states qualify for hardship waivers. We say here that they
18 would also be pursuing fewer estates, which might reduce
19 some administrative costs, but they would also be spending
20 perhaps some additional costs on processing waivers. So
21 I'm not sure exactly how that would -- where that would
22 land. If the minimum standards for hardship waivers are

1 increased, more beneficiaries are likely to qualify for
2 exemptions, and these standards would ensure that classes
3 of assets such as homes are treated similarly across
4 states, even as the value of the assets vary. In addition,
5 again, we believe that an inheritance of even a small
6 estate could protect some heirs from economic hardship, and
7 once again, we don't see any effects of this recommendation
8 on plans or providers.
9 With that, we will turn it back to you all. We
10 look forward to your discussion and feedback on these draft
11 recommendations. The current plan is that in January,
12 Tamara and I will bring back a draft chapter for your
13 review and also final language on the recommendations
14 you're interested in voting on for your vote at that time.
15 Thank you.
16 CHAIR BELLA: Thank you, Kristal and Tamara.
17 So we have a little less than 30 minutes left to
18 discuss this, and I just want to remind us that we've spent
19 time in the past and I believe we're here today because
20 we've already established that, regardless of the intended
21 impact of estate recovery, the actual impact is that lower-
22 income beneficiaries without means to shelter their assets

1 are bearing an undue burden. And so we've indicated that
2 we wanted to take some action to try to address that, so
3 what I'd like to focus the discussion on is there are three
4 recommendations of proposed actions, but I'd like to
5 understand where the Commission is on those options for
6 action, and then if there are other steps of action that
7 folks would like to take. I'm just suggesting I don't
8 think we have to rehash the problems. I'd like us to focus
9 on the solutions today, getting feedback on these three as
10 well as anything else that you think would be a good
11 option.
12 I'm going to start with Brian and then go to
13 Darin, then Fred.
14 Brian, we can't hear you.
15 COMMISSIONER BURWELL: Thank you, Melanie, and
16 thank you, Kristal and Tamara, for framing this issue in an
17 excellent way so that we can have further discussion on it.
18 I'm going to give a little policy context. I'm
19 not going to dwell long on that. I think it's something
20 that people are well aware of. And then I'm going to make
21 four comments on the recommendations themselves.
22 For the policy context, as you know, Medicaid is

1 the primary payer for long-term services and supports,
2 paying for almost half of all public expenditures -- or all
3 expenditures for LTSS. So it is partly in that position
4 because it is the insurance program by default. Both the
5 private insurance market and other efforts to develop and
6 get support for a public insurance program for long-term
7 services and supports have been unsuccessful, and Medicaid
8 stays the primary payer for long-term services.
9 As a result of that and because of the high cost
10 of long-term services and supports, which can include many
11 years in a nursing home, many years receiving HCBS, a long
12 time in a functional state requiring services, many people
13 try to get Medicaid coverage for getting access to their
14 services and has created a fairly large incentive for
15 people to obtain Medicaid coverage without spending down
16 their assets to meet the means test. And so there has been
17 a lot of activity around people getting rid of their assets
18 in a way that they still retain some control over them or
19 they can pass them on to their heirs while still qualifying
20 for Medicaid and also avoiding estate recovery at the end.
21 So Medicaid estate recovery is a part of
22 Medicaid's program integrity strategy to prevent those

1 kinds of things from happening and keeping the mission of
2 Medicaid on providing services to truly those who cannot
3 afford to purchase their own services. And applying for
4 Medicaid eligibility either in the community or in the
5 nursing home, the home is an exempt asset, so we're
6 primarily talking about the home. It makes policy sense
7 for Medicaid to allow people to keep ownership of their
8 home because there's always the possibility they may get
9 better or leave a nursing home, and it provides a place for
10 people to return to. So the basic agreement at the point
11 of eligibility is we will not count your home equity as
12 part of your financial eligibility, but if you stay on
13 Medicaid and you die on Medicaid, we will recover what we
14 paid for your LTSS upon your death from your estate.
15 That's the way it is.
16 The point is made that often people aren't really
17 aware of that or that's part of the fine print of the
18 Medicaid eligibility -- financial eligibility process. It
19 should not be. It should be made very clear to people at
20 the point of eligibility that we are approving your
21 eligibility for Medicaid and Medicaid coverage, but we
22 fully expect to take equity out of your home upon your

1 death. That's an execution problem. It's often done very
2 poorly, and people are not aware and their heirs are not
3 aware. So that's some policy context for our discussion
4 here.
5 I have four comments. My fundamental comment is
6 I am not necessarily opposed to all these policy
7 recommendations, but I don't think that they go far enough.
8 I do think the Medicaid estate recovery program is
9 fundamentally flawed in that it unfairly burdens people of
10 low wealth, at the low end of the wealth distribution upon
11 their death, people who have relatively few assets, who are
12 not aware of Medicaid estate recovery, and who cannot
13 afford the services of an attorney to help shelter their
14 assets, while at the same time people of more financial
15 means who are aware of the program and the fact that they
16 may be liable for the costs of the care that Medicaid has
17 provided them secure the services of attorneys who then
18 ensure that their estates do not include their countable
19 assets, primarily their home, and that they're able to pass
20 on their home to their heirs upon their death without
21 Medicaid estate recovery.
22 So the way the program has played out is exactly

1 the opposite of its original intention. It favors those at
2 the higher end of the wealth distribution and penalizes
3 those at the bottom.
4 CHAIR BELLA: Brian, I'm not trying to be rude or
5 rush you, but we have several people that want to talk and
6 not very much time.
7 COMMISSIONER BURWELL: Okay. I will finish up.
8 I'll be very brief.
9 CHAIR BELLA: Thank you.
10 COMMISSIONER BURWELL: I think it's a classic
11 example of what we heard about yesterday as institutional
12 racism and that people at the bottom are obviously much
13 more likely to be people of color, and people who can
14 afford attorneys to avoid estate recovery are much more
15 likely to be white. I won't get into that.
16 One of the options is to make -- one of the
17 recommendations is to make the program optional, not
18 mandatory or to eliminate the program altogether. I just
19 want to point out that if you eliminate estate recovery
20 altogether, it essentially raises the financial eligibility
21 standard for Medicaid to the value of the home equity that
22 somebody has, so the home would be exempt at the point of

1 initial eligibility and would not be an asset to recover at
2 the back end. The current home equity limit, the minimum
3 home equity limit is $603,000. You can have a home worth
4 up to that amount, $600,000, still be eligible for Medicaid
5 on the expectation that it would be used as an asset during
6 the Medicaid estate recovery program. That's the minimum.
7 There are nine states that use the maximum, which is
8 $906,000, and there's one state, California, which has no
9 limit on the amount of home equity that someone can have.
10 If you have a $5 million home, you can still get Medicaid.
11 So I am worrisome about making the program
12 optional. I think that there will be a lot of political
13 pressure on states not to have a Medicaid estate recovery
14 program, and having it mandatory would relieve that
15 political pressure somewhat.
16 My last comment has to do with hardship waivers
17 and providing some relief to people at the bottom. I
18 believe that a very simple way of protecting people at the
19 bottom would be to set a minimum threshold below which
20 states would be prevented from pursuing recovery, and that
21 can be a very modest amount, $25,000, $30,000, probably
22 even $50,000. The wealth distribution of Medicaid

1 recipients upon their death, as you can imagine, the median
2 is somewhere around zero, and the people with significant
3 financial assets are at the top 10 percent or -- I mean,
4 nobody knows how much money is escaping from Medicaid as a
5 result of all this sheltering of assets, but I think we
6 could easily provide an exemption for estates of very low
7 value, and it would avoid the necessity of people applying,
8 which I think is somewhat demeaning, applying for hardship
9 waivers. Just okay, New York State's are below this
10 amount, we will not pursue recovery. So that is, I think,
11 an alternative solution to that issue.
12 That's it. I look forward to everybody else's
13 comments.
14 CHAIR BELLA: Thank you for all the thought you
15 put into this.
16 Kristal, can I ask one clarifying question? If
17 we were to do Recommendation 1, which is to make it
18 optional, could we also do Recommendation 2? Would we need
19 to do Recommendation 2 then to let the states that choose
20 to pursue it follow that path for LTSS recoveries? Or do
21 they not relate at all?
22 DR. VARDAMAN: These are not intended to be a

1 package. I should have mentioned that. So they could all
2 be done separately.
3 CHAIR BELLA: So we could make it optional and
4 then also for the states that are making it optional pick
5 up 2 and 3. Is that right?
6 DR. VARDAMAN: Right.
7 CHAIR BELLA: Okay. Thank you, Brian. We don't
8 have a ton of time. I'm going to ask each of you who
9 comment going forward to be very clear about your feelings
10 on these three recommendations, and if these three
11 recommendations are not ones that you support or oppose to
12 be very explicit about what you do support or oppose, so
13 that we can get through everybody.
14 We are going to Darin and then Fred.
15 COMMISSIONER GORDON: So I did agree with Brian's
16 commentary and I did have some concerns thinking about some
17 of the comments made in yesterday's panel on health equity.
18 You know, one of the panelists was talking about home
19 ownership. You know, neither of our recommendations really
20 hit that directly but it does give flexibility to states,
21 that if they do the analysis that they can adapt their
22 programs, I think, to prevent that and/or limit that.

1 So, you know, Melanie, you hit what I was
2 thinking. I was thinking about, all three of these, I am
3 fine with, actually I'm consistent. I'm not a big fan of
4 mandates and I like state flexibility, so giving states the
5 flexibility to do it I think would be helpful. I think
6 that all the recommendations combined actually complement
7 each other and address issues that you articulated very
8 well, Kristal and Tamara. Thank you.
9 CHAIR BELLA: Fred and then Chuck and then
10 Martha, I think I saw your hand, and Leanna. Thank you.
11 COMMISSIONER CERISE: Yeah, thanks. Brian, I
12 appreciate your explanation. It was helpful, actually.
13 I'm in favor of all three of them. I'm in favor of number
14 1 so much that I would consider not making it a state
15 option but just eliminating it, if that was within the
16 bounds for us. But I would agree with all three of them.
17 The third one, I also agree with Brian's comments that in
18 addition to setting minimum standards, if you can just sort
19 of push those, and so it's kind of automated where you
20 don't have to understand them and learn them and be able to
21 apply for them, but it's just kind of an automatic, you
22 know, that this is the standard that is applied.

1 CHAIR BELLA: Thank you, Fred. Chuck and then
2 Martha and then Leanna.
3 VICE CHAIR MILLIGAN: I'm in support of number 1,
4 and like Fred, if the Commission's will was to propose a
5 repeal I would go there as well. I think that the language
6 around the estate tax or the death tax for rich people and
7 the family farm and small business, I think there is a
8 fundamental inequity here, a fundamental distinction about
9 how Medicaid is financed. But I support 1 and would be
10 willing to go further, but I support 1.
11 I support number 3. I think Brian's comment
12 around setting a minimum below which recovery isn't allowed
13 and having that kind of recommendation around how we define
14 hardship I think is something I would be supportive of.
15 I'm more neutral on number 2, and I'm not opposed
16 or against number 2. I think it would have disparate
17 effects on individuals, based on their cost within their
18 rate cell, and I think it would hurt as many people as it
19 helped. I think it would be more precise around the actual
20 cost, but there would be winners and losers within that
21 rate cell, so I'm a little bit neutral on number 2.
22 CHAIR BELLA: Thank you, Chuck. Martha?

1 COMMISSIONER CARTER: I want to specifically
2 speak to recommendation number 3. We know that people who
3 probably qualify for these hardship waivers don't apply for
4 them, don't know about them, don't have the means to apply
5 for them. And so echoing what Brian has said, I think I
6 would like to even strengthen that and prohibit states from
7 collecting -- have certain thresholds, and that would be a
8 recommendation. Of course, we can't require that. And use
9 a benchmark that's already been set, which is if the assets
10 left to the heirs are less than 50 percent of the value of
11 the average homes in the county. That was somewhere in the
12 text already, so it's already out there. And then so the
13 burden is on the state to prove that they are not creating
14 a hardship, rather than on the beneficiary to prove that
15 they have a hardship. Turn it around to benefit the
16 beneficiary.
17 CHAIR BELLA: Can we please pull up the slide
18 with Recommendation 3 so we at least have one of the
19 recommendations in front of us? Thank you.
20 Martha, any other comments?
21 COMMISSIONER CARTER: No.
22 CHAIR BELLA: Thank you. Leanna, then Bill, then

1 Stacey.

2 COMMISSIONER GEORGE: This is Leanna. I'm in

3 agreement with Brian and Martha. Yeah, protect the asset,

4 or estates that are valued under a certain amount. That

5 might vary slightly by state. But I think we need to

6 preserve the lower estates for the families who would

7 inherit them.

8 Recommendation for recovery of the cost of care

9 without the capitation, and I think we just kind of

10 discussed, and for making it an option, not mandatory.

11 CHAIR BELLA: Okay. Thank you. Bill. Bill,

12 you're on mute.

13 COMMISSIONER SCANLON: Sorry. I'm supportive of

14 the three recommendations. I would modify 3 to make it

15 explicit that among the minimum standards for hardship

16 waivers that there be an exemption for small estates. And

17 I'm not sure just based on sort of having the house, as

18 opposed to small estates with financial assets as well.

19 In terms of the first one, this idea of sort of

20 just eliminating the revision entirely, the question then

21 arises, could a state do this on its own? I mean, would

22 you eliminate the ability of states to actually recover

1 from people with large estates? So I think that this idea
2 of making it optional is the right approach.
3 CHAIR BELLA: Okay. Thank you, Bill. Stacey?
4 COMMISSIONER LAMPKIN: I just wanted to express
5 my support for the first recommendation and the third
6 recommendation. I don't think I support the second
7 recommendation, for mostly the reasons that Chuck outlined,
8 although it's possible that we could adapt it some way so
9 that there was some kind of floor circumstance under which
10 you didn't collect in that situation. I'm not sure exactly
11 what that would look like but I think there are a lot of
12 people in the high end of the average that would not
13 benefit from that recommendation.
14 CHAIR BELLA: Thank you, Stacey. Have I missed
15 hands? Kathy?
16 COMMISSIONER WENO: I was just going to say,
17 although this seems to be a very flawed program and I
18 probably would rather that it was done away with, I support
19 the recommendations as well.
20 CHAIR BELLA: Thank you. Let me just do a little
21 bit of round robin. So we've heard -- everyone seems to
22 support optional. Some folks support getting rid of it

1 altogether. Brian doesn't think it goes far enough, but I
2 think he said he wouldn't vote against the first option, to
3 make it optional. Is there anyone --
4 COMMISSIONER BURWELL: Yes I would, and I want to
5 explain why.
6 CHAIR BELLA: Okay. Hang on one second, please.
7 Is there anyone who is against making it optional?
8 COMMISSIONER CARTER: I think I want to hear
9 Brian's explanation. I think he's worried about -- well,
10 go ahead. I'd like to hear that, because I'm not sure I
11 can decide yet.
12 CHAIR BELLA: Go ahead, Brian.
13 COMMISSIONER BURWELL: So eliminating Medicaid
14 state recovery altogether to me, in my mind?
15 CHAIR BELLA: Hold on. We're talking about
16 making it optional. We're not talking about eliminating
17 it.
18 COMMISSIONER BURWELL: Well, I think that some
19 states would withdraw from the program and don't have a
20 program, right?
21 CHAIR BELLA: It means that the state would have
22 an option.

1 COMMISSIONER BURWELL: I'm supporting that it
2 still be mandated. So isn't that the same thing?
3 CHAIR BELLA: You don't want to make any changes
4 to the program?
5 COMMISSIONER BURWELL: No, no, no. I don't want
6 it to be optional to states. I want it to stay mandated.
7 CHAIR BELLA: Okay. All right.
8 COMMISSIONER BURWELL: I am in support of Option
9 2. Recommendation 3, I want a minimum exemption for
10 states at low value.
11 CHAIR BELLA: Okay. Chuck.
12 COMMISSIONER BURWELL: Let me say why I don't
13 want it to be optional. In the absence of Medicaid estate
14 recovery, the institutional racism of the program is
15 exacerbated because it exempts the home at the front end
16 and the back end, and non-white households have much higher
17 rates of home ownership. So among people over age 65,
18 about 90 percent of whites own a home. Only about 50
19 percent of African Americans over the age of 65 own homes,
20 and they obviously have very lower value.
21 CHAIR BELLA: But you yourself said that it's the
22 lowest-income folks and that we're perpetuating

1 institutional racism by keeping it in place. So I don't --
2 do you believe that it perpetuates institutional racism the
3 way it is?
4 COMMISSIONER BURWELL: Yes, I do.
5 CHAIR BELLA: Okay. And you don't believe making
6 it optional would help that? You think that would make it
7 worse?
8 COMMISSIONER BURWELL: I think if states withdraw
9 from the program and do not have a program, it exacerbates
10 the institutional racism of Medicaid, by not counting the
11 house as part of the financial eligibility asset test.
12 CHAIR BELLA: Okay. Chuck?
13 VICE CHAIR MILLIGAN: So, Melanie, in the
14 interest of trying to move through rapidly, I skipped a
15 comment I wanted to make, which is I don't think states are
16 complying with the mandate now, by and large, I mean many
17 states. And I do think part of the reason I'm recommending
18 optional is because I do think that there is a lot of state
19 recovery recoupment risk right now, if a very active HHS
20 OIG decided to go after states for non-compliance.
21 And I guess the other thing is just picking up on
22 what Brian just said, and I'm trying to interpret, Brian,

1 what you're saying too, and it seems like what you're
2 really saying is keep it mandatory but maybe use
3 Recommendation 3 and exempt $150,000 or $200,000, or some
4 version that wouldn't be $600,000 or $900,000. I'm
5 interpreting what you're saying as keep the mandate but let
6 individuals retain some home value.
7 Maybe I'm mucking this up, Melanie. I just
8 wanted to raise that compliance and recoupment risk issue
9 as why I support optional, because I do think there are a
10 lot of states out there that are kind of looking the other
11 way right now, that there's some risk the way it's treated
12 right now.
13 CHAIR BELLA: Okay. Thank you.
14 COMMISSIONER BURWELL: Let me explain. If you
15 exempt home equity in determining Medicaid, financial
16 eligibility for Medicaid, you much more favor white people
17 who have a lot more home equity, in terms of billions of
18 dollars that would be diverted from Medicaid eligibility.
19 CHAIR BELLA: Kit and then Toby.
20 COMMISSIONER GORTON: So I came into this
21 conversation in favor of all three. As with many of my
22 colleagues, if we did away with the whole program I would

1 be fine. I just have to say, Brian’s a pretty smart guy
2 but I'm not persuaded by his argument here, and so I would
3 go for optional, given that I don't think we have the
4 ability to get rid of it completely.
5 I like 2 and 3. I wonder if Stacey's objection,
6 and others who objected, and Chuck's, could be solved on
7 Recommendation 2 by making it a lesser-of kind of
8 statement, so that you didn't get more recovered than was
9 actually spent on your care. You know, what that
10 essentially does is it puts the plans at risk. But oh
11 well.
12 It seems to me that if you have people who are
13 already living in poverty, whose families are living in
14 poverty, and then they are subject to recovery which is far
15 in excess of what was spent on their behalf -- and, you
16 know, I know about capitation. It's the world I came from
17 -- but it just doesn't feel fair to me. And, you know,
18 I'll just leave it there, in the interest of time. But if
19 we could put some guardrails around it so that we didn't
20 recover a lot from people for whom care was really
21 purchased, it was just a capitation thing.
22 CHAIR BELLA: Thank you, Kit. Toby?

1 COMMISSIONER DOUGLAS: Yeah, I'll just be brief.
2 I support all three. I do -- whether it's -- in a
3 subsequent meeting, Kristal and Tamara attached a memo from
4 a whole group of elder law attorneys, advocates, and
5 providers that just is fundamentally a different side of
6 what Brian is saying. So I hear you, Brian, but there
7 seems to be a wealth of people and advocates who are
8 working in this area who are saying the opposite of what
9 you are saying. So we just need to reconcile that, and I
10 just want to make sure, both for the stakeholders in the
11 audience and the Commission, that that's clear.
12 CHAIR BELLA: Yeah. I'm glad you raised that,
13 Toby. I thought that letter was very persuasive. And just
14 so folks know, it's a letter from over 30 organizations
15 compelling us, actually, to get rid of the program. But
16 I'm sure that even optional would feel like a step forward.
17 Sheldon?
18 COMMISSIONER RETCHIN: I actually -- I support
19 Brian's position. I'm just not sure what it is. I just
20 need to think through this a little bit more in detail.
21 But I think I support all three recommendations, actually.
22 CHAIR BELLA: Okay. Kristal -- well, let me see.

1 Does anyone else who hasn't spoken want to make a comment?
2 Tricia. We lost her.
3 COMMISSIONER CERISE: Wrong button.
4 COMMISSIONER BROOKS: Pushed the wrong thing.
5 Sorry.
6 So I think I'm in support of all three. I'm a
7 little confused about who, when people mention the
8 capitated rate versus the cost of care, I mean, could it be
9 -- could the capitated rate be incorporated in that
10 recommendation so that it could be the cost of capitation
11 but not to exceed the cost of care? I don't know. I've
12 gotten totally confused by the conversation.
13 CHAIR BELLA: Can you put up the slide, please,
14 just so everyone has it in front of them?
15 So using an example of if it was a $100 cap --
16 right, they got $100 worth -- there's a $100 cap, their
17 actual services were $200, they would pay $200, right?
18 COMMISSIONER CERISE: That's the recommendation.
19 CHAIR BELLA: Okay. So does that make sense,
20 Tricia?
21 COMMISSIONER BROOKS: Well, does -- would they be
22 responsible for the $100 if they got no services, the cap?

1 CHAIR BELLA: I read it cost of share provided,
2 so Kristal, you should -- I thought it was cost of care
3 provided.
4 DR. VARDAMAN: Right. As it's written, if the
5 capitated payment is $200 and someone received $100 worth
6 of care, their state would only be pursued for $100. But
7 if they received $300 worth of care, they would be pursued
8 for $300. But some of the comments suggest that maybe we
9 go back and make it a lesser-of, so that you would never be
10 pursued for more than the capitated payment, but your
11 estate could be pursued for less because you received less
12 care.
13 CHAIR BELLA: So zero care, they would be
14 responsible for zero.
15 DR. VARDAMAN: For zero. Right.
16 COMMISSIONER LAMPKIN: You’re talking about a
17 managed long-term care program, there are not very many
18 people who receive zero care.
19 CHAIR BELLA: I know. We're just going through
20 the math. We're just talking about different options.
21 They also don't get $100. I realize that. We're just sort
22 of -- Leanna and then Bill.

1 COMMISSIONER GEORGE: Yeah. I think I was just
2 trying to maybe clarify Recommendation 2 to be the cost of
3 care, not to exceed the cost of capitation.
4 CHAIR BELLA: Okay. Stacey, do you have a
5 comment on that?
6 COMMISSIONER LAMPKIN: No. That's generally in
7 line of what I said about I could support it if it had a
8 floor.
9 CHAIR BELLA: Okay. Bill?
10 COMMISSIONER SCANLON: Yeah. Just a quick
11 comment. The way I read the recommendation is giving the
12 states the freedom to choose whether they are going to
13 collect the capitation amount or the cost of care. So it
14 allows states. It doesn't say "require states."
15 CHAIR BELLA: Sheldon, was that a hand?
16 COMMISSIONER RETCHIN: Yeah. I was just getting
17 back to -- I'm still bothered a little bit about that Brian
18 knows this more than anybody. Now that I think further
19 about it, then as somebody explained it, the position that
20 by mandating it you're getting rid of basically a
21 regressive tax benefit. Is that right, Brian, that you
22 wanted to keep it mandated, pair it up with recommendation

1 3 so that there is a hardship out, and that way you're
2 getting rid of the $5 million house. Is that right?
3 COMMISSIONER BURWELL: Yes. I do think that it
4 is regressive. Am I advocating for fundamental reform?
5 I'm for exempting estates of low value, but I also want to
6 go after the estate --
7 COMMISSIONER RETCHIN: Okay.
8 COMMISSIONER BURWELL: That's a more difficult
9 question.
10 I just want to clarify, I just want the
11 Commissioners to understand that if you're in support of
12 eliminating Medicaid estate recovery altogether, what you
13 are essentially doing is exempting a home of any value in
14 determining eligibility for Medicaid. No matter what the
15 value of your home, you get to keep it and get Medicaid and
16 pass it on. That is what I'm opposed to.
17 CHAIR BELLA: Chuck?
18 COMMISSIONER RETCHIN: I understand that now.
19 CHAIR BELLA: Chuck and Fred, and we're going
20 into our break, so I'm going to let the conversation go,
21 but I'm not giving you a break. So keep on going. There
22 will be no break.

1 Go ahead, Chuck.

2 VICE CHAIR MILLIGAN: Well played, Melanie. So,
3 Brian, many years ago I was an elder law attorney. I think
4 what Brian is getting at here is let's say there's somebody
5 who has $250,000 of cash in a bank account, now, and they
6 have long-term care needs. They could invest all of that.
7 They could pay off their mortgage. They could put an
8 addition on the house. They could replace the roof. They
9 could do whatever they do, and immediately, on paper,
10 become eligible for Medicaid. So when Brian talks about
11 the front end it's the eligibility front end, and they
12 would be cash poor, house rich, but the house isn't going
13 to jeopardize eligibility on the front end, and if we don't
14 have a recovery on the back end, that $900,000 house then
15 is free and clear to the heirs, and it's a new gimmick in
16 the elder law playbook. That's, I think, what Brian is
17 getting at is not wanting to incent a huge uptake on the
18 eligibility front end by giving people like amnesty on the
19 back end.

20 Having said all of that, I still support the
21 optional perspective. So just to clarify, I think that's
22 really what Brian is getting at.

1 CHAIR BELLA: Can I ask a question? Whether we
2 make it optional or not, I mean, that's what's happening
3 today. I don't think people -- we're not getting at that
4 today. We're not worried about those people either. We're
5 worried about the people that are getting -- what's the
6 right word that's appropriate to say in this audience? --
7 unduly harmed by this, and this at least helps that.
8 If we can't get the $900,000 house today, the
9 $900,000 house is not who I'm worried about. Of course, it
10 is not the intent of Medicaid.
11 I'm worried about the folks who are getting stuck
12 by this policy, and they can't afford to do anything else.
13 So if they lived in a state where we wanted to give that
14 state a little more flexibility, I don't think that would
15 be a bad thing because it helps them today. It doesn't
16 change the $900,000 house guy.
17 VICE CHAIR MILLIGAN: That's why --
18 COMMISSIONER BURWELL: I want to change the
19 inequity at both ends, Melanie, but you're only concerned
20 about one side of it.
21 CHAIR BELLA: No, no, no. We said if you don't
22 like this, you can suggest that now, or we can continue to

1 do work in this area. This doesn't have to be the end of
2 this discussion. I guess I'm trying to figure out is this
3 a bad thing for helping the people that are getting harmed
4 by it today. It's not to say it's enough, but if we're
5 focused on helping them, does this help them? Forget about
6 the other people that keep shelter in their absence.
7 That's what I'm trying to understand, Brian.
8 COMMISSIONER BURWELL: I'm saying you can exempt
9 those estates as just part -- I mean, under recommendation
10 3, you can do that without making it optional altogether.
11 CHAIR BELLA: Okay.
12 COMMISSIONER BURWELL: The whole thing is
13 preventing -- is trying to preserve the initial mission and
14 policy objective of Medicaid, and it's not supposed to be a
15 long-term care insurance program for everybody.
16 Chuck was exactly right in articulating my
17 position.
18 CHAIR BELLA: Okay. As Chuck, as former elder
19 law attorney who I hope never did these things, you still
20 support No. 1?
21 VICE CHAIR MILLIGAN: I do still support No. 1
22 because I do think that per that letter that was in our

1 materials, the impact right now is on the people who can't
2 afford the elder law attorney or its modest incomes, and I
3 think it perpetuates generational poverty. And I think it
4 perpetuates inequity, and I could editorialize for quite a
5 long time, but I'll leave it there.
6 CHAIR BELLA: Okay. Because I'm taking away your
7 break, I'm going to go to public comment in case any of the
8 folks who were part of that letter or anyone else who wants
9 to make a comment on this has a chance to make a comment,
10 and then Kristal will summarize -- and Tamara -- where we
11 want to go with this.
12 By the way, I appreciate the fact that we're all
13 getting heated on Friday afternoon near the end of the
14 meeting. That is a very good sign that everyone is still
15 engaged.
16 COMMISSIONER GORDON: And on estate recovery.
17 CHAIR BELLA: I know.
18 All right. Do we have any folks in the audience
19 who would like to comment? If so, please use the little
20 hand thing.
21 [No response.]
22 CHAIR BELLA: All right. I am not seeing any.

1 Anne, are you seeing any?
2 MS. HUGHES: No hands at this time.
3 CHAIR BELLA: Okay. Okay. I think, Brian,
4 you've given us a lot to think about on Recommendation 1.
5 It still feels like that's a recommendation that should
6 come back to us that has majority support, and so I think,
7 Kristal and Tamara, please bring that one back for January.
8 Recommendation No. 2, I think, is worth bringing
9 back with some modified language on the "lesser of" or "not
10 to exceed the cost," however you want to do that, and we'll
11 bring that back and see if folks are comfortable with that.
12 And Recommendation No. 3, I think, also, you have
13 a sense of how we might tweak that to address what Brian
14 and others have said about having a threshold amount or
15 some sort of exception, and it feels to me that all three
16 of those should come back. And they will be up for a vote
17 in January, and we will have had more time to think about
18 it by then, and we will have another conversation then.
19 But I'm getting the will that they're all worth
20 bringing back. Does anyone have any last comment or
21 concern to make on that plan of action?
22 COMMISSIONER CERISE: I do.

1 CHAIR BELLA: Fred.

2 COMMISSIONER CERISE: Just one last -- as you
3 bring those back, some clarity on Brian's point, on the
4 front end, what the asset limit, what the limit on the
5 house is, that would be helpful to understand, if you
6 really can have a $5 million house or is there a limit of
7 exclusion on the front end. And I thought you said that
8 there was that may vary by states, but that clarity would
9 help.

10 DR. VARDAMAN: Sure. In January, we'll be
11 bringing you all the draft chapter, and so we'll make sure
12 to set up some more of the front-end issues that Brian has
13 brought up.

14 COMMISSIONER CERISE: Great. Thanks.

15 CHAIR BELLA: Oh, Chuck, you look pained. Go
16 ahead.

17 [No response.]

18 CHAIR BELLA: You're on mute, though.

19 VICE CHAIR MILLIGAN: You're correct. I was on
20 mute.

21 So I do think that bringing it back in exactly
22 the way you said makes sense, but I do think that not for

1 now, but when we come back, if Recommendation 3 had a
2 provision that said a quarter of a million dollars of home
3 value should be considered nonrecoverable, would that
4 obviate the need for No. 1? And I think that's to me -- I
5 made up a number, but to me, I think it would be good to
6 think about with respect to Brian's comment and this front-
7 end eligibility, sheltering issue. Is the issue that some
8 value should just not be recoverable and that the program
9 could then remain mandatory?
10 I think that that alternative -- and, again,
11 Anne, I defer to you and Melanie about process management
12 for all of this, but it seems like that is a different way
13 of getting at this sheltering issue and the equity issue.
14 CHAIR BELLA: Chuck, were you concerned about
15 Brian's issues with the states, though, that they're not
16 doing it --
17 VICE CHAIR MILLIGAN: I do. I continue to
18 support No. 1 as is, but what I'm trying to say is, if the
19 Commission is concerned about an $800,000 house getting
20 passed on and incentivizing elder law sheltering, et
21 cetera, et cetera, because it's all optional and it's going
22 to be a freebie, I'm just trying to -- that seems to be the

1 tension to me.

2 CHAIR BELLA: Anne?

3 EXECUTIVE DIRECTOR SCHWARTZ: So what I'm

4 concerned about here is we can work on No. 3. In the

5 paper, it points out that -- or maybe Kristal just told me.

6 I can't remember now. Georgia has such an exemption, but

7 it's for $25,000.

8 And I've overheard conversations in the Congress

9 arguing over what's the value of a modest house, and it

10 obviously depends on where your modest house is.

11 I'm just a little bit concerned, even though I

12 appreciate, Chuck, what you're trying to get at. I don't

13 know how we are going to be able to resolve whether it's

14 $25,000 or it's $250,000 or some number in between or some

15 other number. The alternative would be to let the

16 Secretary decide or just kick it to Congress to decide, but

17 if we don't have some sense of parameter, I don't think it

18 has much teeth.

19 I know we don't have a lot of time now, and we

20 can think about what we can bring back to you, and then you

21 all can make a decision about whether a beefed-up No. 3

22 solves the problem around No. 1. But that's just the thing

1 that I'm concerned about in crafting a No. 3.

2 CHAIR BELLA: I would rather solve Brian's issue

3 separately and deliberately and then try to solve it by a

4 modified No. 3. So I would like to ask that we bring them

5 back the way we went through them. I would like to ask

6 that we can continue to work with Brian outside of this.

7 We can be signaling in the chapter, and we can identify

8 other things that we could take to start to address the

9 front-end issues and give ourselves more time to do that.

10 I just want to reemphasize, Brian, this doesn't

11 have to be a one-and-done thing. I appreciate that this

12 doesn't feel big enough, and so let's keep working on it.

13 But let's not do something until we get the real big thing.

14 Martha?

15 COMMISSIONER CARTER: I think to Anne's point,

16 that's why I was proposing language that isn't a set number

17 but uses language that's already in current guidance, which

18 is define "modest value" as roughly half the average home

19 value in the county. So that puts it relative, and it

20 changes across the country. So that would be a more

21 equitable way, I think, to approach it.

22 CHAIR BELLA: Thank you, Martha.

1 Okay. Thank you, everyone, for this discussion.
2 Kristal and Tamara, thank you. We will look forward to
3 seeing what you bring back to us.
4 I am not kidding about not giving you a break.
5 We are moving right into the quality rating systems. If
6 anybody needs to do anything in lieu of a break, please
7 feel free to do so, but we're not stopping.
8 Amy is going to join us. There she is, and we
9 will turn it over to you.
10 COMMISSIONER BURWELL: I want to credit our
11 keeping the conversation heated on Friday afternoon.
12 **### QUALITY RATING SYSTEMS IN MEDICAID MANAGED CARE**
13 * MS. ZETTLE: It's a tough act to follow.
14 All right. Well, today I'm going to be sharing
15 some findings from recent work that's examining quality
16 rating systems in Medicaid managed care.
17 So I'll start by providing some background on
18 quality rating systems that are currently in place and
19 provide background on CMS's requirement that states adopt
20 and publish a quality rating system for Medicaid managed
21 care plans. Next, I'll share our approach to our recent
22 work, and I'll share some of our key findings. And then,

1 lastly, I'll discuss some next steps.

2 Quality rating systems rate plans based on their
3 performance across a variety of measures. Typically, plans
4 will be rated on a five-star scale, with five stars being
5 the highest. Federal officials have implemented these
6 rating systems in Medicare Advantage plans and more
7 recently in qualified health plans that are sold on the
8 exchange, and then 13 states have established quality
9 rating systems for managed care plans.

10 In recent rulemaking, CMS has identified three
11 potential uses for quality rating programs. First, they
12 can be used to help inform beneficiaries in their selection
13 of type of plan. Secondly, they can be used to incentivize
14 plan performance across specific measures, and then,
15 lastly, CMS notes that these systems can be used as a tool
16 for accountability.

17 So in 2016, the Medicaid managed care rule
18 included a requirement that states adopt a quality rating
19 system for Medicaid managed care plans. This rule was
20 updated last month, and CMS noted that they will continue
21 to meet with states and stakeholders on the development of
22 this program.

1 Future rulemaking will offer more details on the
2 Medicaid QRS, and once it's finalized states will have
3 three years to implement a rating system.
4 States have the option to adopt a CMS-designed
5 framework and methodology, or they can develop their own
6 system, which would require prior approval from CMS and
7 show that they're producing substantially comparable
8 results in that federal system.
9 Now, regardless of whether or not the states
10 design their own system or use the federal framework, all
11 of the states will be required to use a mandatory set of
12 performance measures that will be selected by CMS.
13 In the 2020 final rule, CMS noted that it expects
14 to use measures from the CMS scorecard, which includes
15 measures from the child and adult core set. The selection
16 of these measures will be done for future rulemaking.
17 CMS's goal here is to ensure that plan ratings
18 can compare across the states and to reduce administrative
19 burden. States, however, can or will be allowed to include
20 additional state-specific measures if they so choose, and
21 CMS noted that the federal framework will be aligned with
22 Medicare Advantage and QHP rating systems to the extent

1 that it's appropriate.

2 In advance of this upcoming work that CMS and
3 states will be doing to implement rating systems across
4 Medicaid managed care, we wanted to understand how states
5 are already designing and using these rating systems and
6 how they compare to those systems that have already been
7 designed by CMS.

8 To help us with this work, we contracted with
9 Mathematica, and I would like to thank Patricia Rowan and
10 her team for all of their work on this project.

11 Mathematica's review of state managed care
12 programs found that 13 states have implemented some type of
13 managed care rating system. We selected five states to
14 examine more closely that are illustrative of the way that
15 states are designing and using these systems.

16 The states we selected had fairly established
17 rating systems and had variation in their managed care
18 environments.

19 So, in addition to a detailed document review, we
20 interviewed state officials in the five states, health
21 plans, external quality review organizations, enrollment
22 brokers, consumer advocates, individuals across CMS, and

1 then also national experts.
2 As you can see from this table, we looked at
3 Florida, Michigan, Ohio, Pennsylvania, Texas, and we
4 compared them to CMS design systems. When you're looking
5 at this table, the CMS design systems are at the far right.
6 This table highlights some of the key design and
7 methodology differences across the systems, and it also
8 shows the extent to which measures that are used to
9 calculate the rating are tied to payment programs.
10 We'll come back to some of these similarities and
11 differences in the discussion of our findings, but I just
12 wanted to highlight a few design components first.
13 First, as I said, most of the programs do use a
14 five-star rating scale, but there is a range of how many
15 measures are used to calculate that rating. For example,
16 in the CMS design systems, Medicare Advantage uses 37
17 measures, and qualified health plans use 46 measures.
18 Texas, however, for their adult managed care plans, they
19 use 12 measures.
20 The CMS design systems for MA and QHPs, along
21 with Michigan and Texas, they all provide an overall plan
22 rating for health plans, which reflect a composite score

1 across all the measures, but all of the systems across the
2 board provide ratings by domain, which are subcategories in
3 quality. And in Medicaid, that tends to include more
4 population-specific domains, like children's health or
5 women's health.
6 So now I'll turn to examples. This is an example
7 that comes from Texas, which publishes its ratings by
8 program and by region. Here, we are looking at children's
9 health plans that are compared to other children's health
10 plans in a specific region of Texas. You can see there are
11 three options. There's a three-star plan and 2 four-star
12 plans.
13 In addition to that overall rating, we see three
14 domains: experience of care, staying health, and common
15 chronic conditions. These are summary scores that show how
16 the plan is doing on the underlying measures related to
17 that topic.
18 This system looks different than, let's say,
19 Ohio, which has one rating system for its comprehensive
20 care plans, which include a variety of populations,
21 including both children and adults.
22 The plans are compared statewide and not

1 regionally, and they also do not have an overall score, but
2 they rate plans only across domains, which reflect
3 different performances across populations and services.
4 For example, there would be a separate domain for
5 children's health, pregnancy, chronic conditions, and then
6 more standard domains like getting care and patient
7 experience.
8 For this project, six major themes emerge from
9 our work. First, the rating system are designed to help
10 beneficiaries understand the performance differences among
11 their plan options. We found that while the methodological
12 approaches varied across these programs, they're
13 essentially designed to show how plans compare to each
14 other.
15 The plans are all rated based on observed
16 differences in performance rather than performance related
17 to a predetermined threshold. So, under this approach, a
18 health plan does not know in advance what performance level
19 would produce a given rating. Instead, the rating is based
20 on how that plan performs to the other competitors.
21 As an example, let's say the underlying measure
22 is breast cancer screening. There's no predetermined

1 threshold saying that if a plan received -- hits 80 percent
2 that it would be five stars. Rather, the rating is
3 designed to show how much better one plan does relative to
4 the other, with the highest-performing plan receiving a
5 higher rating. Now, this comparison can be done at a
6 regional level, a state level, or a national level.
7 Second, across all the programs, interviewees
8 stated that the primary goal of these systems was to serve
9 as a tool for beneficiaries. In four out of the five
10 states studied, the quality ratings are provided to
11 beneficiaries as part of their paper enrollment materials,
12 but these quality ratings can also be found on the state
13 websites. This approach differs from QHPs and Medicare
14 Advantage, which more predominantly display the quality
15 ratings on their enrollment website. So, when a
16 beneficiary goes online to enroll, they see that rating
17 right alongside the premium information and plan
18 information.
19 Thirdly, it is unclear whether Medicaid
20 beneficiaries are using the rating systems to select their
21 plan. While it's a goal that beneficiaries use this
22 information, state officials participating in our study

1 reported that they are not actively tracking whether or how
2 beneficiaries are using this information.
3 We did speak to enrollment brokers, and all of
4 them shared that the information regarding plan quality was
5 not included in their state-approved scripts, which are
6 used to help guide plan selection. So quality was not
7 discussed in these enrollment conversations.
8 The enrollment brokers and beneficiaries’
9 advocates suggested that beneficiaries are likely
10 prioritizing provider networks and value-added services
11 when selecting a plan.
12 In Medicaid, unlike MA or QHPs, many of the
13 beneficiaries are not actively selecting health plans.
14 They're being automatically assigned into a plan at the end
15 of the enrollment window. In our study, three state
16 officials shared their auto-enrollment assignment rates,
17 which ranged from 25 percent to 80 percent. Three of the
18 five states tied their auto-enrollment assignments to some
19 sort of performance measures that are also included in the
20 rating system.
21 Next we found that incentivizing plan performance
22 was a secondary goal of these rating systems, and then most

1 of the study states reported aligning key quality measures
2 with other payments incentives to further these efforts.
3 Most of the interviewees shared that they view the rating
4 system as an important tool in driving plan performance.
5 We examined how the underlying measures used to
6 calculate the quality ratings aligned with those being used
7 for payment or enrollment incentives tied to quality. These
8 incentives include pay-for-performance initiatives,
9 capitation withholds, auto-assignment, and other related
10 initiatives. We found that generally there was overlap.
11 For example, in Florida, 86 percent of the
12 measures used in the QRS are also used to calculate the
13 capitation withhold and any liquidated damages. And in
14 Texas, recent legislation now requires that the beneficiary
15 who does not select a plan will be automatically enrolled
16 based on plan quality.
17 So several state Medicaid officials reported that
18 aligning QRS measures with the payment initiatives signaled
19 to plans where they should focus their performance
20 improvement efforts. Plans shared the these payment
21 programs can be drivers of performance efforts and
22 alignment with the quality rating system reinforces that.

1 Of all of the rating systems that we studied, MA
2 is the only one that directly ties plan ratings to
3 payments, so in MA, if the plans scores a four or a five,
4 they get a quality bonus payment, and five-star plans
5 receive preferences for enrollment.
6 There was a wide range of agreement among the
7 interviewees that once MA tied payments to quality ratings
8 in 2014, plans immediately responded by aligning their
9 quality efforts with those performance measures included in
10 the rating system. The rating system for qualified health
11 plans, however, does not have any tie to payment at all.
12 Finding No. 5, unlike Medicare Advantage, study
13 states do not directly use their quality rating system for
14 oversight and accountability purposes. So while most
15 states report monitoring performance on quality measures
16 over time, the states did not report using it as a direct
17 tool. This does differ from MA, which more directly ties
18 the QRS for oversight and accountability. In MA, plans
19 that consistently perform poorly do receive letters and can
20 ultimately be terminated from the program if they have a
21 rating of 2.5 stars or below for three consecutive years.
22 So, lastly, our sixth finding looks ahead to the

1 upcoming CMS requirement on states. Study states generally
2 supported alignment of the quality rating systems across
3 the states and programs but would like to see flexibility
4 in future rulemaking. So states interviewed generally felt
5 confident that their existing programs could come into
6 compliance with rulemaking, and several noted that they are
7 having continued engagement with CMS on this issue.
8 While state officials and stakeholders agreed
9 that a common set of measures would allow for greater
10 state-by-state comparison, some officials noted that they
11 would like to ensure that they can maintain flexibility to
12 select performance measures that are important to their
13 particular state and different regions.
14 As CMS moves forward with the development of the
15 QRS framework and methodology for Medicaid programs,
16 federal officials are considering how to design a program
17 that rates plans based on measures that are most meaningful
18 to beneficiaries and will help inform their plan selection.
19 So Mathematica is preparing a contractor report
20 that provides more details on these findings, and we plan
21 to publish that in January. The report will serve
22 hopefully as a resource to CMS and state officials as they

1 move forward with designing and implementing a Medicaid and
2 CHIP QRS. As we expect to see future rulemaking from CMS
3 on this framework and the design of the system, the
4 Commission may want to draw on this study to comment on
5 proposed rules and the guidance.
6 So, with that, I will turn it back over to the
7 Commission.
8 CHAIR BELLA: Thank you, Amy. Appreciate you
9 taking us through that clearly and relatively quickly.
10 It's very helpful.
11 Just so I'm clear, no action today, but you'd
12 like some -- any questions and any areas that we want to
13 further explore and talk a little bit about what comes
14 next. Is that right?
15 MS. ZETTLE: Exactly.
16 CHAIR BELLA: Okay. Questions from the
17 Commission? Kit.
18 COMMISSIONER GORTON: So a couple of comments,
19 actually. First off, my memory may be a little fuzzy, but
20 Pennsylvania's rating system was put in place in 1999, if I
21 remember correctly. By mid-2000 we published the first
22 one, but we were certainly working on it in 1999. And

1 that's important because the purpose of the rating system
2 at that time was to build consumer confidence in the
3 program. It wasn't about -- it was a transparency
4 exercise, right? We don't have any way of knowing how
5 these plans are doing. Pennsylvania has always had a very
6 active and vigorous stakeholder community in health care,
7 and the stakeholders pushed very hard to have some insight
8 -- this would have been year five of the program, and to
9 how it was working, how people were being served. And so
10 the metrics were chosen to support that transparency.
11 That's why there are some child measures and some adult
12 measures, because people wanted those things in. And I
13 think it's important as we compare and contrast -- you
14 talked about CMS and MA doing mostly online. It was 1999.
15 There wasn't a "mostly online" then. So we did things in
16 fairly high-quality printed paper. It was a little
17 expensive.
18 But my point is that I do think it's important to
19 wrap context around these things. So states that have been
20 doing these for any length of time undertook them not under
21 a mandate but to meet certain state-specific needs. So in
22 Pennsylvania, we rolled out managed care by regions, so we

1 rolled out the reporting by regions. We did in the early
2 days look and see who was using them, and it's low, and it
3 was about 10 percent then of people used the information to
4 inform their choices.
5 But at the same time, it really helped in terms
6 of public confidence in the program, and that was really
7 what it was about. We did use it with the plans because
8 they really wanted to be fairly compared to their
9 competitors, and it was a great talking point. We didn't
10 use it for accountability because we wanted to keep those
11 separate. Quality improvement is supposed to be about
12 making things better, not about whac-a-mole. And so that's
13 just one -- that's my one comment in terms of -- I think
14 it's really critical to think about if you're going to roll
15 these things out, what is the purpose of it, right?
16 I read the CMS rule as they want something like
17 Medicare Advantage, which is accountability and the other
18 things, and I don't think that's wrong. But I do think if
19 you're going to give this report as a reference to people
20 who are designing these things, it's important to think
21 about the different contexts and the different ways these
22 reports were used. Right? We chose four stars because we

1 didn't think we had the sensitivity in the data to
2 differentiate in the five categories. So there was that
3 kind of stuff that went on.
4 The other comment I want to make is about the
5 comparison to Medicare Advantage, and I think it's
6 important to remember that a Medicaid managed care program
7 is very different from a Medicare Advantage program in
8 terms of if you want to do Medicare Advantage, then you go
9 through this process with CMS, and there can be two --
10 there can be zero Medicare Advantage plans in a county;
11 there can be 20. You go to a state process, and there's
12 usually a limited number of people, right? So there's this
13 whole other layer of accountability in a state Medicaid
14 managed care contract that doesn't exist in a Medicare
15 Advantage construct.
16 And so it's important to realize that just
17 because states don't do this in their quality rating
18 system, they may be doing it somewhere else. And they're
19 hiring plans for a longer period of time. You know, the
20 Medicare Advantage plans come up, and they get rated. They
21 drop in and out any given year. And so it's important to
22 look at how people are performing in the years that they're

1 doing Medicare Advantage. I just think they're two very
2 different programs. They need to be measured differently.
3 And that's why, you know, using enrollment in those sorts
4 of things in Medicaid is a trickier play than I think it is
5 in Medicare Advantage.
6 It's important work, and I'm glad you're doing
7 it.
8 CHAIR BELLA: Thank you, Kit. Sheldon and then
9 Toby and then Martha.
10 You're on mute, Sheldon. We can hear you now.
11 COMMISSIONER RETCHIN: Okay, thanks. Amy, I
12 think that was a great report, and we have to walk before
13 we can run, and I appreciate the historical context from
14 Kit.
15 So one thing as an aside, I went online and
16 looked at a couple or a few programs in different states to
17 see how understandable it was, which is interesting. I
18 don't know where Michigan gets the three apples as a
19 rating. What is that? But maybe you'll -- I couldn't find
20 it, but -- so I wondered about this, and maybe Kit and
21 others could respond as well, Amy. At first, I thought,
22 well, that's clever that you would actually preserve or

1 enhance your auto-assignment by superior ratings. Then I
2 started thinking about it, and really what you're doing is
3 front-loading favorable selection. I guess -- and you have
4 a tail out where people, they're not going to opt out of
5 the plan. That may be the most valuable to a plan to get
6 up front and then, you know, their ratings may deteriorate,
7 and yet -- if you catch my drift. I wonder if others have
8 any concern about this being a gateway to auto-assignment.
9 CHAIR BELLA: Darin, you did auto-assignment that
10 way. Do you want to make comments? Toby, I think you guys
11 did, too. Do you want to make comments on that?
12 COMMISSIONER RETCHIN: Based on quality ratings.
13 COMMISSIONER GORDON: Yeah, I would say we were
14 building that while I was still there. We needed the
15 system capabilities to effectuate it, which later came.
16 But, yes, I mean, it was intended to be the tool by which -
17 - more sophisticated tool by which to do auto-assignment in
18 the event that a member doesn't select a particular plan.
19 And we weren't concerned about that because the measures we
20 were working toward were measures that we did want to
21 promote. So I may be missing why, Sheldon, you think there
22 could be a concern there.

1 COMMISSIONER RETCHIN: It was really just in
2 terms of the auto-assignment would smooth the selection.
3 Other plans would get less favorable selection. So I was
4 just concerned about the longevity of the effect rather
5 than just getting a bonus like you do with Medicare
6 Advantage.
7 COMMISSIONER GORDON: Right, right. And I would
8 tell you from looking at the Medicare Advantage model, we
9 talked about -- because I've talked with folks in that
10 sector, talked with the health plans in the sector. You
11 have to give them a lot of credit because it does make the
12 plans focus in a hyper --
13 COMMISSIONER RETCHIN: It really does.
14 COMMISSIONER GORDON: Maybe to an extreme way, I
15 would say, to the neglect of others. So I would say it's
16 maybe not perfect in that regard, but as far as getting
17 folks to focus, it's an effective tool. And, you know, I
18 do think it is a little bit you've got to walk before you
19 run. That if you look at the states here, we haven't
20 really had a lot of information out there. So I think it's
21 -- when you start putting it out there, start refining what
22 you're measuring, then you think about the ways in which

1 you can leverage that, whether it's an assignment, per
2 member assignment, or if it's some kind of pay-for-
3 performance type of activity. I think it's an added tool
4 in the Medicaid quiver that is going to ultimately prove
5 beneficial. But I still think we're early on in that
6 development journey.
7 CHAIR BELLA: Toby, do you have anything to add?
8 Then I was going to you next for a comment, anyway.
9 COMMISSIONER DOUGLAS: No. I'll just -- it's
10 been a longstanding part of California, and it was
11 definitely important. But overall in terms of, Amy, the
12 report, this is really important and I think just more in
13 the context of the maturity of the Medicaid managed care
14 and where we're going, and QRS is there.
15 I would comment around this idea of how states
16 are using QRS for overall performance management. It needs
17 to be put in the context that states have used quality, but
18 more through a contractual route in terms of, you know,
19 there could be withholds or corrective action plans based
20 on quality measures, not necessarily using a QRS but going
21 in. And the same -- and then the biggest tool here, which
22 kind of goes back to Medicare Advantage, is the procurement

1 process. Do you have an ongoing procurement that is going
2 to take quality and some states put an even higher -- I
3 just don't -- I think we just need to say there's evolution
4 and QRS might be where they go eventually to aggregate and
5 really drive performance overall and accountability. But
6 states have been using tools around quality to create these
7 enforcement mechanisms.

8 MS. ZETTLE: Can I just jump in there? Because I
9 realized I didn't say this at the outset and I should have.
10 But this is really part of broader work that we're doing
11 looking at the different tools that the feds have and
12 states have to incentivize quality. So this is one
13 component of that, so we will certainly continue to frame
14 it in that way.

15 COMMISSIONER DOUGLAS: Great. Thank you, Amy.

16 CHAIR BELLA: All right. Martha.

17 COMMISSIONER CARTER: I think I may be getting in
18 the same region that you were in, Toby, but maybe more
19 specific, between CMS and the states and the plans, and
20 then you've got the beneficiaries, but where the rubber
21 meets the road, of course, on this is the practices and the
22 clinicians. And so it might be helpful to look at how

1 plans are working with the provider communities to make
2 sure that, say, the measures are standardized, you know,
3 that the EHRs that the clinicians and the practices are
4 working with are responsive to the measures that are --
5 that ultimately the plan needs them to collect in order to
6 report to the beneficiaries. And so I just want to make
7 sure we don't forget that layer of care in there because
8 that's where the quality actually happens.
9 CHAIR BELLA: Thank you, Martha. Chuck?
10 VICE CHAIR MILLIGAN: Amy, thank you very much
11 for this. There's just a couple of comments I wanted to
12 make.
13 One of the challenges I think we should keep an
14 eye on over time is states do use a lot of state homegrown
15 measures and the implications of all of that for better or
16 for worse in how quality programs are designed and
17 developed.
18 But the second comment is the one I really want
19 to put more emphasis to. There's a separate kind of
20 evidence base or literature base around how to design
21 quality programs where you introduce a measure and you
22 don't change the measure too quickly because how you build

1 in enough time for that measure with whatever incentives it
2 has to actually change behavior and then for the outcomes
3 to be reported, it takes a little bit of time. And one of
4 the things I think that states too often do is they're
5 changing measures frequently year over year in a way that
6 it's difficult to ascertain the effectiveness of some of
7 those measures because they -- the time for the
8 intervention to be demonstrated isn't part of the quality
9 management approach.
10 And the other related aspect of that is -- and I
11 think Medicare Advantage does a better job with how they
12 add and also remove HEDIS measures -- is that sometimes a
13 measure has been optimized or there's such small gradations
14 over time in improvements that it's in some ways a less
15 useful way of distinguishing health plans because there is
16 a kind of asymptotic relationship, if you will. But I
17 think as we look into all of this, I think the design of a
18 quality management system over time and how that produces
19 outcomes and produces the right incentives I think is
20 something I want to make sure that we keep an eye on.
21 CHAIR BELLA: Thank you, Chuck. Are there
22 others? Amy, I have a question. I imagine you said this

1 at the outset and I just missed it. Do we have any sense
2 of timing from CMS on the sub-regulatory guidance, or do we
3 know the last -- when's the last time we talked to them
4 about it?
5 MS. ZETTLE: So the final managed care rule came
6 out in November. We had interviewed them prior to the
7 release of the final rule, and they indicated that they are
8 continuing to meet with stakeholders and states and are
9 developing the framework and methodology. That framework
10 and methodology will be released through formal rulemaking,
11 so we will see that in a proposed rule, laying out the
12 framework, but also those measures as well. They want to
13 make sure that on those mandatory measures -- folks will
14 have an opportunity to comment. But they didn't give a
15 timeline or say whether we would see that in the next
16 year. They're still working on it.
17 CHAIR BELLA: And will we be able to share this
18 report with them before it goes --
19 MS. ZETTLE: We certainly will. Yeah, our plan
20 is to share a draft report before anything is finalized.
21 CHAIR BELLA: Great. Other questions or comments
22 for Amy? Well, look at that. You could have had your

1 break. Sorry, guys. We're going to keep plowing through
2 because it's Friday.
3 Amy, do you need anything else from us?
4 MS. ZETTLE: No, I don't think so. Thank you
5 very much. I appreciate the feedback.
6 CHAIR BELLA: Thank you.
7 CHAIR BELLA: Last but not least -- I feel like
8 Rob gets the last spot a lot. Maybe we should go back and
9 look. That must mean you're going to keep us entertained,
10 Rob, because we're in the home stretch. It's been you and
11 Sheldon, to do a song and dance in the next half hour, 45
12 minutes.
13 All right. Welcome. You are going to tell us
14 about your interviews, and then I think we're going to give
15 you some feedback on what might be interesting to continue
16 to explore in this area. Is that right?
17 **### THEMES FROM INTERVIEWS ON THE DEVELOPMENT OF**
18 **NURSING FACILITY PAYMENT METHODS**
19 * MR. NELB: Yes. I'm hoping this will be a
20 starting point for discussion about where to build on our
21 work going forward.
22 Last but not least, we're going to talk about

1 nursing facility payment methods, and I will begin by
2 giving some background and talking about the methods for
3 our study, and then I'll spend most of the time talking
4 about the themes from our interviews, which are listed here
5 in this slide.
6 I should note that we began this project last
7 fall, after the Commission had finished its compendium of
8 state fee-for-service payment policies. Commissioners
9 wanted to understand a little more about the reasons for
10 some of the variation in payment policy among states, about
11 some of the barriers to use of value-based payment, the
12 growth of supplemental payments, et cetera.
13 But obviously since we have started this work,
14 the COVID pandemic has had a disproportionate effect on
15 nursing facilities. And so when we did these interviews
16 this summer and this fall, COVID was on the top of mind as
17 many of our interviewees. So I will conclude today by
18 talking a little more about the way that Medicaid payment
19 policy might be used to help address some of the quality
20 concerns in nursing facilities that have been exposed and
21 exacerbated by the pandemic.
22 So first some brief background. Medicaid payment

1 policy for nursing facilities is important, in part because
2 it is the second-largest category of Medicaid spending and
3 also because of the large role that Medicaid plays in
4 financing care for most nursing facility residents in the
5 country. In addition, as discussed before, a large
6 majority of Medicaid-covered nursing facility residents are
7 dually eligible for Medicare and Medicaid, and so this
8 complicates the financing a little bit. So the first part
9 of their stay is typically covered by Medicare and then
10 Medicaid picks up to cover subsequent days of custodial
11 care and any other types of care needs for that patient.
12 States have broad flexibility to design their
13 payment methods for nursing facility services, just like
14 any other type of Medicaid state plan service. There are
15 two broad categories of payments: base payments, which are
16 tied to a particular service for an individual, and
17 supplemental payments, which are lump-sum payments,
18 typically for a fixed period of time. And then states can
19 make payments in fee-for-service or in managed care.
20 As you can see on this slide, in 2016, most
21 payments to nursing facilities were made through fee-for-
22 service base payments, but the use of supplemental payments

1 in LTSS is growing.

2 So to better understand some of the factors that
3 affect the development of state nursing facility methods,
4 we contracted with RTI International to conduct structured
5 interviews in seven states, and for each state we talked to
6 state officials, nursing facility associations, and managed
7 care representatives. Then we also interviewed some
8 national experts and staff from the Centers for Medicare
9 &Medicaid Services.

10 The states we selected for the study varied
11 widely in their payment methods for base, supplemental
12 payments, and managed care. For example, as you can see on
13 this table, three states didn't make any supplemental
14 payments to nursing facilities, four states did, ranging
15 from 5 percent of Medicaid payments in New York to 33
16 percent of Medicaid payments to nursing facilities in Utah.
17 And then we had four states with managed care and three
18 states with fee-for-service.

19 So now let me dive into some of the themes of
20 what we heard from our interviews, starting with what we
21 heard around value-based payment. Consistent to what we'd
22 found in our review of state fee-for-service payment

1 methods, most states in our study still used cost-based
2 methods to pay for nursing facilities. And during our
3 interviews we heard that progress towards price-based or
4 other methods has been slow. Many of the experts that we
5 spoke with viewed price-based methods as more efficient
6 than cost-based methods, especially for some of the direct
7 care components of the rates, but many of the states we
8 spoke with noted that it was difficult to change nursing
9 facility payment methods because of resistance from
10 industry and limited state capacity to do the complex work
11 of changing payment methods.
12 One state in our study, New York, did recently
13 switch from a cost-based to a price-based system, and they
14 shared the considerable effort that it took to undertake
15 that change and the fact that the phased in the change over
16 five years to help minimize effects for providers.
17 In terms of value-based payment, only a few
18 states in our study had pay-for-performance incentives, and
19 they were limited to particular measures, such as pay-for-
20 performance for quality, culture change, and staffing. But
21 there wasn't any discussion about any more advanced
22 alternative payment models.

1 One of the challenges of doing a shared savings-
2 like arrangement for nursing facility care is the fact that
3 because many Medicaid nursing facility residents are dually
4 eligible for Medicare and Medicaid, some of the savings
5 that they accrue from reducing avoidable hospital using for
6 nursing facility residents, those savings accrued in
7 Medicare rather than Medicaid.
8 Some of the states in our study did participate
9 in some recent CMMI demonstrations that aimed to crack some
10 of these financing incentives, but the results of some of
11 those initiatives are mixed, and the states hadn't
12 continued the initiatives after the demonstrations ended.
13 Next, in terms of supplemental payments, we found
14 that states' decisions to use supplemental payments was
15 related to the sources that they used to finance the non-
16 federal of their payments, similar to what we found
17 previously in our work on hospital payment policy. In
18 general, nursing facilities noted that they would prefer a
19 base rate increase financed with state general funds, but
20 in the absence of state funding most states have used
21 funding from the providers to help supplement the rates.
22 And states chose to distribute that funding as a

1 supplemental payment rather than a base rate increase
2 because it was easier to target the funding to providers in
3 a way that made them whole for the amount that they
4 contributed in provider taxes or intergovernmental
5 transfers.

6 It is important to note that the situation that
7 we observed in Utah was a bit different from some of the
8 other states, because of the mechanics of their arrangement
9 resulted in a large number of the facilities in the state
10 being reclassified as government-owned in order to receive
11 IGT-funded supplemental payments. As you may recall, the
12 MFAR, Medicaid Fiscal Accountability Rule, raised some
13 questions about these issues of ownership and how these
14 government facilities should be defined. Although that
15 rule has not been finalized, CMS staff and other experts
16 that we spoke with noted that CMS is placing greater
17 scrutiny on sort of this definition of government-owned for
18 nursing facilities and other providers. So other states
19 that have sought to implement the same type of arrangement
20 as Utah haven't been approved, most recently.

21 Next turning to managed care, we found that
22 managed care organizations in our study tended to pay

1 nursing facilities according to fee-for-service rates and
2 methods. In many cases, this was required, but the MCOs
3 that we spoke with also noted that it would be
4 administratively burdensome for them to develop their own
5 rates.
6 We talked to a few managed care plans with
7 aligned D-SNPs, but they didn't share much about efforts to
8 coordinate the Medicare and Medicaid nursing facility
9 benefits for dually eligible individuals.
10 In some states there was some interest in another
11 type of Medicare Advantage plan, institutional special
12 needs plans, or I-SNPs, which are limited to individuals
13 residing in a nursing facility.
14 As we talked about at our October meeting,
15 Medicare recently changed the method that it uses to adjust
16 Medicare payments for patient acuity, which has
17 implications for state Medicaid programs that currently use
18 the RUG method that Medicare previously used. Many of the
19 states that we talked to were in the early stages of
20 assessing the implications of these changes, and they noted
21 that in order to make some of these changes there would be
22 a need for more analysis at their state level to figure out

1 exactly how the new payment methods would affect payments
2 to their particular providers. And they noted that this is
3 a really complex undertaking, and there was a lot of
4 concern about doing so right now, given limited state
5 capacity to analyze these issues, especially in the midst
6 of the COVID pandemic.

7 So speaking of COVID, as you know COVID has had a
8 disproportionate effect on nursing facilities. Nursing
9 facility residents and staff account for less than 1
10 percent of the U.S. population, but so far they have been
11 about 40 percent of COVID deaths. In addition, nursing
12 facility occupancy has declined about 10 percent since the
13 start of the pandemic, adding increased financial strains
14 to many providers.

15 As we talked about in September, there has been a
16 variety of different federal efforts to help support
17 nursing facilities, including the Provider Relief Fund, but
18 in addition, several states have chosen to supplement
19 funding to nursing facilities through a variety of means.
20 Of the seven states in our study, five made some sort of
21 increased payment to nursing facilities, either in the form
22 of a rate increase for all facilities or a targeted

1 increase for COVID-specific facilities. However, because
2 of limited state funds, most of these states finance the
3 rate increases with funding from the CARES Act. These are
4 grants that expire at the end of the year.
5 At the time of our interviews, the state
6 officials that we spoke with didn't have any specific plans
7 for long-term changes that they were planning to make in
8 response to the COVID pandemic. That being said, many
9 other stakeholders nationally have called for changes in
10 Medicaid payment policies to help address some of the
11 quality and staffing issues raised by COVID. Some of the
12 state officials we spoke with, though, I think were less
13 optimistic about the potential for long-term change, just
14 given the limited state capacity, strained state budgets,
15 and sort of resistance from providers that sort of gets in
16 the way of larger reforms in this area.
17 So that concludes my presentation for today.
18 Again, we welcome your feedback on the findings, but I
19 really hope we can use this time to think about how we can
20 help inform our future work in this area. Thanks.
21 CHAIR BELLA: Thank you, Rob. Can I just ask you
22 one question to start? What surprised you or disappointed

1 you in what you heard?

2 MR. NELB: Yeah. So I think I was a bit
3 disappointed in terms of the value-based payment. I guess
4 we've been working, in our other work on value-based
5 payment, you know, there's been a lot of moving, getting
6 beyond just pay-for-performance to more advanced payment
7 models. I mean, there were a couple of initiatives, you
8 know, particular measures one, but it didn't seem like the
9 measures were particularly ambitious or that they were
10 really resulting in sort of the large type of change that
11 we would need. I think especially at this time, when we're
12 seeing a lot of the quality issues in nursing facilities,
13 in some ways it would be nice to have the higher bar there.

14 CHAIR BELLA: Okay. Bill?

15 COMMISSIONER SCANLON: Yes. Rob, thank you very
16 much. This is, I think, incredibly useful. As you
17 mentioned, sort of there's a lot of attention now on
18 Medicaid payment for nursing homes, and the spotlight has
19 only increased because of COVID, but it's never been not
20 there. I mean, we've been hearing about Medicaid nursing
21 home payment for decades, literally. So I think this is
22 very, very useful.

1 While the big ultimate question may be, is
2 Medicaid paying enough, I mean, I think that's beyond us in
3 terms of actually doing a quantitative analysis and saying
4 this is the result in terms of how often Medicaid pays
5 enough or does not pay enough. But what I think we get
6 from this kind of work is a much greater understanding of
7 sort of how Medicaid pays, what's the rationale behind
8 Medicaid payment methods, what kinds of incentives are
9 created, and that's both potentially reassuring at time but
10 it's also helpful in terms of for states when they're
11 thinking about making changes, sort of what kinds of
12 changes that they might want to consider.
13 Let me just talk a bit about sort of the lack of
14 value-based payment, because I understand that that's the
15 current sort of gold standard across the board, but I also
16 am very pessimistic about applying that in nursing
17 facilities where you have got this incredibly heterogenous
18 population that has some very bad outcomes that are going
19 to be inevitable. And so how does one sort of think about
20 what is the right outcome for people that are deteriorating
21 and ultimately going to die? And that's, I think, a
22 challenge that we have to face.

1 I actually am going to go back, since I've been
2 around doing this a long time, to think about when we first
3 started talking about quality, and this was like 40 years
4 ago, we were talking about structure, process, and
5 outcomes. And I don't want to give up on structure. What
6 are the resources that are being devoted to actual caring
7 for people, and I think that's important, and that goes to
8 the whole workforce issue in nursing homes. And there
9 certainly has been a lot of attention on whether or not the
10 workforce is adequate.
11 So a real question for nursing home payment is,
12 is your money going to get a better workforce, more
13 resources for the residents, and that is actually, I think,
14 a very key question. I mean, when you said about
15 disappointment, I was disappointed that when you did those
16 set of states that there were three that have a pricing
17 system. And the details matter, and so maybe those pricing
18 systems aren't so bad, but at the same time, a pricing
19 system, while it creates this great incentive for reduced
20 cost, there are two ways to reduce costs. One is you can
21 become more efficient. The second one is you reduce the
22 product, you cheapen the product, and that can involve less

1 staffing.

2 And kind of the classic example of a pricing
3 system that is not really doing a great job is the Medicare
4 SNF payment system. Last week, MedPAC, again, said don't
5 increase the rates. I think it's almost been 20 years
6 since they've said increase the rates, because the average
7 profit under the Medicare SNF system, last week it was 11
8 percent, and there are a lot of homes making 20 percent
9 profit, which just does not reflect sort of efficiency. It
10 reflects that they're not doing as much for their
11 residents.

12 So I think that going forward, it's understanding
13 the details that might be behind sort of cost-based
14 systems, understanding the details that might be behind
15 price-based systems, and that would be sort of instructive
16 to the states.

17 Among some of those details are, what are the
18 cost centers that are targeted in the cost-based systems?
19 What are the limits that are placed on them? What's the
20 frequency of updates? How well do those updates reflect
21 inflation in the cost of resources? What kinds of limits
22 do states have on allowable costs?

1 One of the things that we've seen problems with
2 is related party transactions, where the price of inputs is
3 inflated because they're being provided by a subsidiary or
4 some other related party.
5 States have been aggressive. I've always thought
6 that state Medicaid nursing home payment was the leader in
7 terms of sophistication of payment policy. We went back
8 when we started with Medicare and Medicaid, and it was
9 basically we're going to pay reasonable costs, we're going
10 to pay reasonable charges. The states said for nursing
11 homes, "No, we're not. We're going to open our eyes, and
12 we're going to only pay for what we think we're getting."
13 So I think we shouldn't lose the lessons that the states
14 have assembled over the years, and we should make them much
15 more public for everyone.
16 Thanks very much again for doing this.
17 MR. NELB: Actually, I will add that there are a
18 lot of benefits to a cost-based systems, as you know as
19 well, and one particular with the staffing, there was
20 interest in sort of these -- like a direct wage passthrough
21 or sort of ways particularly to address some of those
22 staffing issues trying to incorporate the costs for those

1 direct care workers more specifically in the rate. So
2 those are good points, and we'll try to get to them.
3 COMMISSIONER SCANLON: I agree completely. I
4 think that in some ways, sometimes you hear from people on
5 the supply side saying that we really don't want to be
6 micromanaged, and I can think of it more from the payer
7 side and consumer side as saying, "No, we're picking
8 consumers, and we really want to get what we're paying
9 for."
10 CHAIR BELLA: Other folks?
11 Toby and then Chuck and then Fred.
12 COMMISSIONER DOUGLAS: Just on this point that
13 Rob said about how slow the change and the movement, when I
14 think about that and back to the experiences, it is just
15 tremendously challenging to work with the different
16 stakeholders within the nursing facility area, and why, you
17 know, when we think of in terms of future work, does taking
18 this back into the broader perspective around integration
19 and duals, to be able push on the issue of nursing facility
20 and payment policy really needs to be connected to a
21 broader -- for states, where it's been impactful is where
22 it's brought up another level, where it's not just about

1 trying to work with that one specific group as well as
2 those who are associated with it on payment policies, but
3 how this is affecting both care overall, costs within the
4 broader delivery system, and the bigger outcomes.
5 I just don't think we're going to move it along
6 very fast if you set up rate recommendations about payment
7 policy just in this one discrete area.
8 CHAIR BELLA: Thank you, Toby.
9 Chuck and then Fred.
10 VICE CHAIR MILLIGAN: Rob, great work, as always,
11 and this is an area where I'm going to be interested in
12 seeing where the Commission's work goes.
13 I want to suggest that we identify and keep track
14 separately of for-profit and not-for-profit nursing
15 facilities in terms of a variety of the measures here.
16 Underneath that comment is the fact that this is a unique
17 service in that the for-profit world tends to serve more
18 people and tends to be willing to serve Medicaid more than
19 maybe some other service areas, whereas a lot of the
20 nonprofit nursing facilities are more predisposed to be a
21 little bit more reluctant to participate in Medicaid or
22 expect a long period of private pay spenddown before

1 somebody becomes eligible for Medicaid.

2 There's a lot of downstream implications to all
3 of that, that I will not elaborate now, but I just think
4 separately measuring and thinking about those two forms of
5 incorporation and all of that will, I think, be useful down
6 the road.

7 CHAIR BELLA: Thanks, Chuck.

8 Fred?

9 COMMISSIONER CERISE: Thanks, Rob.

10 You know I am going to talk about supplemental
11 payments because the nursing facilities are learning from
12 the hospitals, and I thought your comments are right on.

13 I would say two points. One is MFAR attempts to
14 get at this, but it's very vague. It's sort of, you know,
15 does it pass the eyeball test? Is it a real owner or not?
16 On the government ownership side, I think the thing to look
17 at, are they adding any value there to that relationship?

18 I know having some experience with this, with
19 small nursing facilities -- and the big change, they have a
20 lot of infrastructure. Some of the smaller ones, they
21 could benefit from a larger organization on things like
22 infection prevention, pharmacy, facilities. There's a lot

1 of pieces that we've been able to bring in some
2 relationships like this that actually provide some value
3 there, but there's also a lot of relationships where it's
4 just a paper transaction. And you can make some
5 distinction there.
6 The other point, apart from ownership, then, is
7 on the supplemental payment side and the opportunity to tie
8 those payments to quality, because as tough as it is to do
9 value-based payments for places that think they're being
10 underpaid and they don't have enough money to begin with
11 when you're adding payments as an opportunity to tie up to
12 quality measures, and the program in Texas has done a fair
13 amount. You can argue sort of how stringent they are in
14 terms of linking those to payments, but they are linked to
15 payments. And people do pay attention to them now, like
16 they didn't before.
17 One of them is as simple is how many RNs. What
18 is your RN ratio? And homes will pay attention and add RN
19 time if they know it's going to give them a payment bump.
20 CHAIR BELLA: Sheldon, did I see your hand?
21 [No response.]
22 CHAIR BELLA: No?

1 Well, Rob, I would just say that I would love to
2 see us doing more in this. I would be really interested in
3 what surprised you or what disappointed you as sort of an
4 indicator of where we might go, what any of the people you
5 found to be more forward thinking were sort of putting out
6 there.
7 I guess, in my mind, it does go a lot to what
8 actually Toby was saying about duals. CMS started work
9 several years ago, and it was around how to use payment
10 changes to improve the system writ large and drive better
11 outcomes and those kinds of things, and a lot of it came
12 down to, like Fred was saying, direct care and staffing
13 ratios. And these are workforce issues and payment issues,
14 and I think COVID has exposed a lot of that.
15 So I guess I feel like what can we take from what
16 COVID has really exposed that would help us understand how
17 do we end up in a better place as the result, and it's not
18 an overnight thing. A long way of saying it feels like
19 there's a lot to do here. I have no idea exactly what all
20 that entails, but I'm happy that we're looking at it.
21 What else would be helpful for you? I think
22 you're seeing strong interest from the Commission to keep

1 doing this. I do think when we're talking about this and
2 as we're thinking about value-based payment and as you're
3 getting comments from stakeholders about doing long-term
4 change, I assume some of those comments have to do with
5 driving more care to the community as well. So I don't
6 want to lose sight of this. We're doing this and we're
7 thinking about the community piece and the rebalancing and
8 all those pieces as well, particularly sort of thinking
9 about driving alternative payment models across a long-term
10 care system. So that would be all I would say. This is
11 not very coherent at all, but the only thing I can say is I
12 think you see a wide interest from the Commission here.
13 Are there any last comments?
14 [No response.]
15 CHAIR BELLA: Rob, any additional comments you
16 want to make to us? If not, we'll go to the public to see
17 if there are any comments.
18 [No response.]
19 CHAIR BELLA: Okay. We will now open it up to
20 public comment. In particular, if there are any comments
21 on the quality session or on this nursing facility session
22 or anything else that anyone wants to comment on that we've

1 discussed in the last couple of days. If you would like to
2 do that, please use your little hand button.
3 I can sit here and watch the little ticker thing.
4 I don't know if you guys all can see it, but the number of
5 people that are in here slowly declining as the day goes
6 on. No offense, Rob, at all to this subject. I chalk it
7 up to a Friday afternoon in December.
8 No? Yes, we do. Great. Nataki.
9 **### PUBLIC COMMENT**
10 * MS. MacMURRAY: Hello. So, yes, I've been
11 sticking with the crew for the last day and a half, and so
12 it's been a long time. But it's been great to listen to
13 the dialogue and the presentations. So thank you all for
14 your thoughts and your consideration and the discussion.
15 Just so I can go back to just kind of in general,
16 your thoughts as you're preparing for the letters for the
17 incoming administration as well as the new Congress, your
18 thoughts of kind of reading the tea leaves of where the
19 next administration will be leaning in to some of the areas
20 that we need to focus on, both in the short, intermediate,
21 and long-term arena, number one.
22 And then, number two, I'm very struck by the

1 whole idea if we can make more impact and raise the
2 awareness and create more of a need to invest in the needs
3 of youth and adolescents around so many of the health
4 indicators that we know that we can truly make a difference
5 going down the line, and so how we can do better, as we are
6 talking about so many different health priorities, how we
7 can really raise the level of awareness and investment in
8 addressing the issues for youth so that we're not where we
9 are now with the next generation and even worse going
10 forward.
11 So just those two questions or suggestions or
12 points of discussion.
13 CHAIR BELLA: Okay. We'll go in reverse order
14 and take your point on number two, and I think that,
15 hopefully, you saw from the session today about behavioral
16 health access and yesterday on postpartum coverage and the
17 relationship with getting kids off to a good start and
18 that's consistent with our thinking.
19 Number one, I'm not going to touch with a 10-foot
20 pole. I can't imagine to begin to speculate on that, but,
21 Anne, if you want to make any comments on her first
22 question, please feel free.

1 EXECUTIVE DIRECTOR SCHWARTZ: I mean, I don't
2 have anything more to add other than what I shared earlier.
3 I think we have a couple of issues that we are going to be
4 communicating early on, and then we will be in a continual
5 process of dialogue with both the Hill and with CMS in the
6 months ahead.
7 CHAIR BELLA: Any other Commissioners want to
8 respond to either of those questions or comments?
9 [No response.]
10 CHAIR BELLA: Nataki, you get the Steadfast
11 Award. So thank you for sticking in and making so many
12 comments.
13 Are there any other folks who would like to
14 comment?
15 [No response.]
16 CHAIR BELLA: All right. Are there any last
17 questions, concerns, comments, words of wisdom from the
18 Commissioners? Come on, Sheldon. It's Friday afternoon.
19 You've got to have something.
20 [No response.]
21 CHAIR BELLA: Okay. Anne, anything to say?
22 EXECUTIVE DIRECTOR SCHWARTZ: No. No more

1 meetings in 2020. Yay.

2 CHAIR BELLA: We're done with 2020.

3 All right. Well, let me say on behalf of the

4 Commissioners one more time, thank you to Anne and the

5 staff, thank you to Jim. Once again, we pulled this

6 technical thing off or so it seems, and you make it very

7 easy on us, and the work product is phenomenal.

8 We have no doubts we made tremendous progress the

9 past couple days. We came out with the three

10 recommendations or guidance that we needed on those three

11 pretty meaty areas with a lot of other work identified and

12 a full agenda for January.

13 So everybody rest up. Have a great holiday, and

14 we'll see you all in January. Thank you very much.

15 COMMISSIONER GEORGE: Merry Christmas, everyone.

16 * [Whereupon, at 4:14 p.m., the meeting was

17 concluded.]