PUBLIC MEETING

Via GoToWebinar

Thursday, October 29, 2020
10:32 a.m.

COMMISSIONERS PRESENT:

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

2 [10:32 a.m.]

3 CHAIR BELLA: All right. Good morning, everyone.
4 Thank you for joining us for our October MACPAC meeting.
5 We are going to start this morning hearing from a panel on
6 Medicaid eligibility redeterminations when the public
7 health emergency ends. Those of you that joined our
8 meeting last month know that when we have been talking
9 about the public health emergency and understanding what
10 gets turned on and what gets turned off, and what states
11 need, this was an area of great interest/concern as far as
12 what that process is going to look like and what amount of
13 time is going to be given and what guidance is going to be
14 coming from CMS. So we're very grateful to our panelists
15 this morning who have agreed to share their perspectives.
16 So we'll ask Joanne to kick it off, we will hear
17 from our panelists, we'll ask questions of our panelists,
18 and then following the panel the Commission will have some
19 time for discussion and then we will if there's any public
20 comments at the end of all of that.
21 So thank you again to our panelists. Thank you
22 to Joanne for putting this together, and I'll turn it over

1 to you.

2 ### PANEL: RESTARTING MEDICAID ELIGIBILITY
3 REDETERMINATIONS WHEN THE PUBLIC HEALTH EMERGENCY
4 ENDS

5 * MS. JEE: Great. Thanks, Melanie.
6 Commissioners, as you know, during the COVID-19 public
7 health emergency states have delayed conducting or acting
8 on findings from beneficiary eligibility determinations,
9 including renewals, and as Melanie mentioned, in the MACPAC
10 August letter to Secretary Azar and during the September
11 Commission meeting, Commissioners, you raised the need for
12 CMS guidance to states on timelines and expectations for
13 returning to routine operations, including for renewals.
14 And this was because of concerns with state capacity, the
15 ongoing effects of the pandemic on Medicaid programs, and
16 the potential for eligible individuals losing coverage.
17 So today we have a panel who will share the
18 perspectives of consumers as well as two state Medicaid
19 agencies on this topic. I think it's important to mention,
20 just off the top here, that literally overnight the context
21 for this discussion has changed a little bit. CMS issued
22 an interim final rule yesterday that would affect the

1 continuous coverage requirement from the coronavirus – now
2 I'm blanking on the name -- but the continuous coverage
3 requirement. Excuse me.
4 And it establishes a couple of new concepts. One
5 is the individuals who are validly enrolled in coverage,
6 and the second is the creation of three tiers of coverage
7 that would satisfy the coverage requirement for qualifying
8 for the temporary 6.2 percentage point increase to the
9 FMAP. So I just want everybody to keep that in mind.
10 So back to our panelists. Our first panelist is
11 Ms. Jennifer Wagner. She will present on the beneficiary
12 perspective. Jennifer is the Director of Medicaid
13 Eligibility and Enrollment at the Center on Budget and
14 Policy Priorities.
15 Then we'll hear from Ms. René Mollow, who will
16 share the experience and view from California. René is the
17 Deputy Director of Health Care Benefits and Eligibility in
18 the California Department of Health Care Services.
19 Our last panelist is Ms. Lee Guice. Lee is the
20 Director of Policy and Operations for the Department of
21 Medicaid Services at the Kentucky Cabinet for Health and
22 Family Services.

1 So that's all I'll say about their bios, which
2 you have a little bit more information on in your meeting
3 materials, and, Jennifer, I will pass the mic to you.
4 * MS. WAGNER: Great. Thank you so much and thank
5 you for the opportunity to be here today and to speak on
6 this important topic. This morning I'm going to talk about
7 what's at stake for Medicaid enrollees, as states look
8 ahead to restarting renewals and actions on changes at the
9 end of the public health emergency or PHE.
10 As a brief outline, the way state implementation
11 will impact eligible enrollees, I'll first talk about
12 actions states can take now to prepare for the end of the
13 PHE. I'll then discuss the way states can restart regular
14 operations at the end of the PHE, in the way that avoids
15 large-scale coverage loss and ensures that eligible people
16 stay enrolled.
17 The Families First continuous coverage provision
18 has protected Medicaid coverage for millions of people
19 during the current public health crisis. Many enrollees’
20 lives were disrupted by moves and job changes, and agencies
21 were forced to radically change their operations in a short
22 amount of time, transitioning to remote work and facing

1 staffing shortages. Without the continuous coverage
2 provision the number of eligible people losing coverage at
3 renewal or during their certification period would have
4 been astronomical, and the continuous coverage provision
5 substantially decreased the workload for state agencies,
6 allowing staff to focus on processing new applications so
7 newly eligible individuals could quickly gain coverage.
8 Unfortunately, all good things must come to an
9 end. When the PHE ends, states will have to resume acting
10 on renewals and changes. How they approach this could lead
11 to two starkly different outcomes for enrollees. On the
12 one hand, if a state terminates coverage based on outdated
13 information and initiates a large number of renewals
14 without staffing capacity to handle questions and
15 responses, eligible enrollees will lose coverage for care
16 and have to reapply for benefits.
17 On the other hand, if a state effectively
18 communicates with enrollees, conducts a full renewal of all
19 enrollees based on current information, ex parte when
20 possible, and spreads out renewals to ensure they have
21 staff capacity to respond to inquiries and process
22 paperwork, there will be minimal loss of coverage for

1 eligible enrollees.

2 As MACPAC has stated, states need lead time and
3 guidance from CMS to effectively plan for the resumption of
4 regular operations. While the very recent rule provides
5 some information, more is needed. And in the meantime,
6 states can act now to better situate themselves to restart
7 renewals, and they can establish a plan for the end of PHE
8 to minimize coverage loss.

9 First, let's look at what states can do now while
10 the PHE is still in effect to protect enrollees' coverage
11 in the future. For one thing, agencies should conduct ex
12 parte renewals now for current enrollees and push out their
13 certification 12 months, if successful. Some states are
14 doing this, reducing the number of cases in the backlog
15 that will be waiting at the end of the PHE.

16 Next, states should take time now to review and
17 improve the renewal process so more eligible enrollees
18 retain coverage when renewals start again. While federal
19 regulations lay out requirements for a streamlined renewal
20 process, there is tremendous variation in state
21 implementation, particularly around ex parte renewals.

22 To improve renewals, states should first obtain

1 and analyze renewal data. How many cases are successfully
2 renewed through the ex parte process? For those that
3 aren't, where do they fail? Agencies should then take that
4 information and analyze the design documents that control
5 the automated process within the eligibility system.
6 Equipped with the data on where cases are failing
7 the ex parte process, policymakers can identify areas in
8 the design documents that need to be modified. For
9 example, some systems kick a case out of the ex parte
10 process if the Medicaid file shows one employer but the
11 data source shows two. This rule could be modified to
12 allow renewal of a case if the income from the two current
13 employers combined is less than the eligibility threshold.
14 Also, some states have unnecessarily broad
15 exclusions from the ex parte process, such as not letting
16 the system even attempt renewals on Medicaid cases that
17 also have SNAP benefits. Rather than excluding cases with
18 SNAP, agencies should leverage current information from
19 other programs like SNAP for ex parte Medicaid renewals.
20 There are strategies to do that, that work in both
21 integrated and siloed eligibility systems, such as using
22 SNAP as a data source, using the fast-track state plan

1 option to adopt the income determination from SNAP, or
2 express lane eligibility for children. Any of these
3 approaches would allow states to renew Medicaid ex parte
4 based on information from other programs.
5 In addition to renewals, states should improve
6 communications with enrollees to ensure they get necessary
7 information. Many enrollees have experienced housing
8 changes or instability during this pandemic but may not
9 have reported address changes to the agency or the agency
10 may not have acted on change reports.
11 States should act now to update contact
12 information through interfaces with the Postal Service's
13 national change of address database, updating Medicaid
14 records with address changes reported to other programs or
15 managed care organizations. Agencies can also implement
16 systems now to more effectively communicate with enrollees,
17 such as through text messaging, improved notices, and
18 coordination with partners like CBOs and MCOs.
19 Now I'll turn to policies agencies should develop
20 for the end of the PHE to ensure eligible beneficiaries
21 stay enrolled, these include conducting renewals on the
22 full caseload using current information, staggering those

1 renewals over a 12-month period, and providing streamlined
2 transition of those no longer eligible for their current
3 category into other insurance.
4 Taking these one at a time, the continuous
5 coverage provision in Families First requires enrollees be
6 treated as eligible for such benefits through the end of
7 the PHE. After the PHE, states must make a fresh
8 determination of eligibility, based on current information.
9 Any supposed determination of ineligibility during the PHE,
10 from data matches or non-responses to requests for
11 information isn't valid. Each case must be reviewed anew.
12 And states must put these cases through the full
13 renewal process, including attempting to conduct an ex
14 parte renewal, sending a prepopulated renewal notice, and
15 allowing sufficient time for response. Conducting large-
16 scale data matches and sending requests for information
17 with 10 days to respond before cancellation is not adequate
18 to ensure that eligible people retain coverage. And as
19 mentioned earlier, getting a head start on ex parte
20 renewals now and improving the renewal process overall will
21 make this task much more manageable.
22 Next, states should stagger out their renewals,

1 preferably over 12 months. This will allow agencies to
2 handle the volume of calls and return paperwork, facilitate
3 MCOs and other community organizations in assisting
4 enrollees, and smooth out the workload for future years.
5 CMS guidance is particularly needed in this area to make it
6 clear the states have the flexibility that is allowed or
7 required.
8 Finally, some enrollees may no longer be eligible
9 for the category of coverage in which they are currently
10 enrolled, if, for example, they turned 65 or lost SSI.
11 Agencies must evaluate their circumstances to see if they
12 are eligible for other categories of coverage, request
13 information as needed such as on resources for a person
14 transitioning to non-MAGI coverage, and transition cases to
15 the marketplace, where appropriate. States should not
16 simply terminate coverage and direct the enrollee to
17 complete a new application for another program.
18 Even after the PHE officially ends, the effect of
19 this pandemic will be felt by people for years to come, as
20 they struggle to find work, deal with lingering health
21 conditions, and face the possible ongoing presence of this
22 virus. Agencies can take action now and establish policies

1 for the resumption of regular operations to protect the
2 coverage of millions of eligible enrollees when the PHE
3 ends, and into the future.
4 Thank you, and I look forward to your questions.
5 MS. JEE: So thanks, Jennifer. René, you're up.
6 * MS. MOLLOW: Thank you so much, and I appreciate
7 the opportunity today to represent the state of California
8 and our Department of Health Care Services. At the
9 Department of Health Care Services, we serve as the single
10 state agency for California's Medicaid program, and it's
11 known as Medi-Cal.
12 So I wanted to cover two things today. One was
13 our response to the public health emergency. So in
14 California, we serve approximately 13 million individuals
15 statewide. This represents 1 out of 3 Californians. We
16 are the largest payer of health care services in our state.
17 Our state, in terms of our Medicaid program, is state
18 managed but county operated for Medi-Cal eligibility
19 determination. We have 58 county Offices of Social
20 Services that conduct Medi-Cal eligibility determinations,
21 with approximately 40,000 county eligibility workers.
22 We leverage, here in the state of California, we

1 have four eligibility and enrollment systems that support
2 Medi-Cal eligibility determinations. Three of these
3 systems are used solely by our county social services
4 programs to also help support enrollment into our SNAP and
5 TANF programs that we operate in California. And we also
6 have a single portal for insurance affordability programs
7 that was required under the Affordable Care Act. So there
8 are multiple systems here in California that help to
9 support eligibility and enrollment into the Medi-Cal
10 program. We also have a state-managed and operated
11 eligibility data system which receives input from the four
12 eligibility and enrollment systems that are operated in our
13 state.
14 With the declaration of the public health
15 emergency, California swiftly put steps into place to
16 adhere to the new requirements, which included county
17 guidance on the requirements for allowable discontinuances.
18 I have to say that this was an unprecedented act here in
19 our state. California swiftly acted to implement over 50
20 flexibilities for the public health emergency, and in the
21 space of eligibility a few of those flexibilities are as
22 follows.

1 Again, as has been mentioned, we have done our
2 due diligence in terms of the maintenance of eligibility
3 for existing cases. We did, in California, maintain
4 renewal processing, leveraging ex parte processes.
5 However, our counties were instructed, through state
6 guidance, not to take negative actions for renewals or for
7 reported changes, again, at that time not knowing the
8 length at which the public health emergency would continue.
9 And again, provide a direction that these
10 discontinuances could only be for the allowable
11 circumstances, including the beneficiary requests, the
12 death of the individual, or movement out of state.
13 California also undertook the option to cover the
14 uninsured population for the provision of COVID-19 testing
15 and testing-related services, and in California we also
16 have made available treatment services for these
17 individuals. We also have waived cost-sharing for covered
18 populations that were subject to premiums, as a condition
19 of their eligibility into our programs.
20 We relaxed application timeline processing in
21 anticipation of increased caseloads, and then California
22 also took up the option, through a disaster state plan

1 amendment, to extend the number of presumptive eligibility
2 periods for populations that go through our presumptive
3 eligibility pathways. This extension of presumptive
4 eligibility also allowed for us to offer two periods of
5 presumptive eligibility, whereas in our program it's
6 normally one time period of eligibility per year.
7 And then we also added individuals over the age
8 of 65 as a new population for presumptive eligibility under
9 our hospital PE program.
10 The ceasing of renewals was unprecedented in
11 terms of the timing of the execution for when the public
12 health emergency was called, and it also required that our
13 counties had to interrupt the normal cadence that they were
14 under in terms of the renewal processing that was supported
15 by system automation.
16 In California, county operations were also
17 reduced, and there was also a reduction in capacity, again
18 given the status of the public health emergency. We still
19 have limited capacity that is occurring today in our county
20 offices. Many have limited or ceased in-person
21 applications, and that has historically been the major way
22 in which individuals have applied for coverage in our

1 programs, and instead they have turned to offering limited
2 appointments and the use of drop boxes.
3 We do have the ability for individuals to file
4 applications online as well as through phone, but when you
5 have reductions in county operations that becomes a
6 challenge for people trying to get into coverage at a time
7 when health care coverage is vital for individuals.
8 In terms of the unprecedented nature of halting
9 renewals in California, one of the things that we had to
10 take into consideration was looking at where there were
11 inadvertent discontinuances in our program, again due to
12 the timing. And so we have undertaken significant efforts
13 working with our county partners and our systems in terms
14 of looking at evaluating individuals who may have been
15 inadvertently discontinued from coverage.
16 In our program, historically, we see, on average,
17 anywhere between 100,000 to 200,000 individuals
18 discontinued on a monthly basis. As of October 1, we have,
19 through our efforts in looking at individuals that were
20 inappropriately discontinued, we have taken actions to
21 restore coverage for approximately 110,000 individuals
22 statewide. This has required an extensive amount of effort

1 and resources, both at the state level and at the county
2 level, in terms of analyzing the inappropriate
3 discontinuances and then taking the necessary steps to get
4 people back into coverage, to ensure that we are conforming
5 with CMS guidance on the maintenance of eligibility.
6 In terms of unwinding the public health emergency
7 specific to eligibility determinations, this will be a
8 significant undertaking, and I cannot impress upon the
9 Commission in terms of guidance and the timing of that
10 guidance that is needed.
11 In terms of our processing here in California,
12 and, you know, thinking through some of the comments from
13 Jennifer, we did have, as a continuation of the public
14 health emergency, our counties did continue to do renewal
15 processing, leveraging ex parte processes, but again, they
16 were required not to then take any type of negative actions
17 on individuals based upon the outcome of those processes
18 for conducting the renewals.
19 Our counties will need time in terms of turning
20 things back on in particular with our systems. Our systems
21 did have to make changes here in our State to cease the
22 undertaking of negative actions. And while they were able

1 to do this in a rather quick fashion, we did discover over
2 time that there are additional changes that had to be made
3 in the systems because we were not cognizant of some of
4 those downstream effects when the systems had to be turned
5 off from taking negative actions.
6 We also recognized that with the resumption of
7 the negative -- with the resumption of renewals, we really
8 need to have guidance from CMS in a timely manner and in an
9 advance manner. It's really important in terms of thinking
10 through the timing and just looking at the sheer volume of
11 cases, certainly from California's perspective, that that
12 will not be an easy undertaking. And we do recognize that
13 individuals have to be informed of their eligibility into
14 our program.
15 Again, we have three systems that we're working
16 through that help to support eligibility determinations,
17 and in California those systems are currently undergoing a
18 major system consolidation from three systems down to one.
19 So we still have to work within those time frames for
20 making those system changes to resume renewals.
21 We estimate that here in California it will take
22 us between 6 to 12 months to address the backlog. Ideally,

1 we would like to see federal guidance issued three to six
2 months in advance of the public health emergency ending and
3 would also like to -- because we also have to coordinate
4 the various sunset dates that are created by the federal
5 legislation providing the State flexibility.
6 We would also suggest that in the development of
7 the guidance, CMS also work with states to help further
8 inform that guidance, just because of the variations across
9 the state program in terms of how they do handle renewals
10 or their Medicaid programs. Also, the flexibility should,
11 to the extent possible -- and we have not heard this from
12 CMS yet -- in terms of our ability to roll forward with
13 renewal dates, and also relieving states of negative audit
14 findings, including those that may be related to PERM or to
15 MEQC. And the CMS guidance, we would also request that it
16 is very clear in terms of the expectations and then also
17 that CMS work with the states in advance of the release of
18 that guidance because, again, as states are taking on, you
19 know, the resumption of renewals, we want to make sure that
20 we have and are fully equipped with all the requirements
21 versus having the information coming out to us in a
22 piecemeal fashion.

1 Again, I thank you for the opportunity to present
2 before the Commission as these are unprecedented times, and
3 bottom line, the ability for us to resume normal operations
4 must be guided by maximum federal flexibility with clear
5 guidance that is provided in advance and developed in
6 collaboration with our state partners.
7 This does conclude my remarks, and I'd like to
8 now turn this over to my friend Lee. Thank you.
9 * MS. GUICE: Thank you, René, and thank you,
10 Jennifer, for your remarks as well.
11 As Joanne said, I'm with Kentucky Medicaid, and
12 I'd like to say, first of all, thank you for having me on
13 this panel. It's great to hear the other comments from
14 California that has a much larger population but a much
15 different structure than Kentucky has, and from Jennifer's
16 point of view, particularly. We continue to think about --
17 since the pandemic began, of course, we've been thinking
18 about how to emerge. Maybe we stopped thinking about
19 emerging from the pandemic about June, just to think, "Ah,
20 is it ever going to end?" But it was just a momentary stop
21 to think about it.
22 I think that in Kentucky we have an advantage

1 over perhaps some other structural Medicaid agencies in
2 that Medicaid is housed within the Cabinet for Health and
3 Family Services, and also in that cabinet is the Department
4 for Community-Based Services, which administers SNAP, TANF,
5 for us KTAP, child care assistance. So we're all under the
6 governance of the Secretary. The same Secretary of our
7 cabinet governs -- well, besides CMS and FNS, governs all
8 of the agencies that participate.
9 Our DCBS offices across the state, we have one in
10 every county. Unfortunately, or fortunately, we have 120
11 counties, not 58. But we do have a single integrated
12 eligibility system that makes all the determinations. DCBS
13 determines our eligibility. The system, which is once
14 again now called Kynect -- it was Kynect, then it was
15 Benefind, and now it's Kynect again. We're able to house
16 all of the information in there. We have access to it. It
17 was built by one vendor, so it's seamless, seamless across,
18 across all the programs.
19 I would say that the advantage of that was that
20 when the pandemic hit and when our governor took action
21 swiftly, we were able to make system changes immediately.
22 Now, we can't do that if we want some enhancement, you

1 know, just on a regular basis. But for the pandemic, we
2 were able to make system changes very, very quickly. We
3 were able to stop terminations, and we reinstate those that
4 were terminated, because March -- you know, it was the
5 13th, in that neighborhood -- things were already well
6 underway for the end of March and what has to happen with
7 all the programs.

8 So what we were able to do was get reports, have
9 reports, have everybody at the table, looking -- struggling
10 to determine what needs to be done, who needs to do it, and
11 how quickly they need to have it done. And that, I think,
12 was a great advantage for us to be able to have everybody
13 in the same -- well, I would say building, but we got out
14 of the building almost immediately. Our DCBS offices were
15 closed to foot traffic before the end of March, and I've
16 been working at home since the third week of March. And we
17 have been able to maintain and, in some cases, increase
18 productivity, so that's been great.

19 The close working relationship we have with our
20 technical teams has really helped a lot in being able to
21 run the reports, look at -- every month I have a meeting on
22 who might be terminated, who might not be terminated, so

1 that we can address how are we going to deal with these
2 folks. We have to do some manual intervention. Can the
3 reinstatement be systematic?
4 We have always -- for everyone else who has
5 talked about ex parte, we call that process "passive
6 renewal." We continued our passive renewal after March,
7 and so we renew everybody we can and renew them for a year,
8 and then the other folks, we just carry them forward. And
9 we carried them forward. And, of course, those numbers are
10 adding up.
11 But we have a plan for that. Our plan is to look
12 at downstream and look at what our usual case numbers were.
13 So let's say we had 10,000 renewals a month. That's not
14 the right number. That's just a fake number I pulled out
15 of the air. But let's say through summer -- our summer
16 months are actually the largest caseload months for
17 renewals, and that I think is because as people start to
18 come back into school, they start to think more about
19 perhaps their benefits or staying in place perhaps.
20 So we've looked forward now, and we have some
21 case numbers and some alignments that we intend to make to
22 spread out the anticipated number of renewals that we may

1 have if the public health emergency ends in January.
2 So that's one of the strategies that we're trying
3 to take to address are we going to have too big of a
4 caseload to maintain and staff for the renewals.
5 Now, we have a pretty good passive renewal rate.
6 It runs between 75 and 80 percent. So we feel that if
7 we're given time, we will be able to handle the renewals.
8 Now, the "if we're given time," I would go back to what
9 René had to say about CMS guidance. You know, it would be
10 great if we had that guidance and we had that guidance in
11 place three to six months before the end of any public
12 health. I realize it takes three to six months for CMS to
13 sometimes issue guidance given their heavy bureaucratic
14 structure. I understand that. I work inside of one
15 myself, so I understand how that works.
16 But the legislation requires us to end our
17 emergency actions the end of the month that the public
18 health emergency ends. That's not sustainable. There's no
19 way -- there's just simply no way for Kentucky to actually
20 end everything the month the public health emergency ends.
21 So that's the largest ask, is to say we must have
22 some lead time, we must have some grace period to revert.

1 We added PE periods. We elected the state to become a
2 qualified entity. We took PE applications only. For about
3 three months we didn't even take regular applications. We
4 added almost 200,000 individuals in PE only. We extended
5 to two periods as well, René. That's such a great option.
6 We tried to go for three, but we went for two, and we were
7 granted two.

8 So we have been -- Medicaid has been since we
9 expanded the largest single payer and coverer in Kentucky,
10 but now we have 1.6 million people on the rolls. We added
11 8,000 people to the enrollment a week for about six months,
12 and nobody dropped off. Nobody dropped off. So we have a
13 lot to clean up, and we would certainly appreciate the
14 opportunity to clean that up in a nice -- not nice -- in a
15 focused, caring, understanding realization that our
16 communities have changed completely and our cultural ideas
17 have changed completely. We need to be able to, as our
18 governor said a few times, "build it back better." Our
19 commissioner is very committed to that. But we are not
20 going to be able to do that if we have to end everything
21 the month that the public health emergency ends.

22 Okay. One more thing I left out while I was

1 talking. We have actually implemented -- we have self-
2 service portal, a web portal for people to apply. We've
3 implemented a new version of that, believe it or not, just
4 this month, and we're hoping that -- it's much more user-
5 friendly, it's mobile-friendly, so we're hoping that that
6 implementation will really assist with changes, renewals,
7 you know, you can take pictures of documents and upload
8 them on the phone. So we're really hoping and fingers
9 crossed. Too soon to say just yet, but we did have a lot
10 of increased usage of self-service portal when it wasn't
11 kind of clunky. But now it's much, much easier to use. So
12 we're hoping that's going to assist us as we roll back into
13 whatever the new world is going to actually look like.
14 I very much appreciate the time. I've always
15 appreciated the information from the MACPAC, and I've
16 always enjoyed hearing from you. Thank you. Joanne?
17 MS. JEE: I was on mute. Thank you to our
18 panelists, and, Commissioners, I will turn it over to you
19 all.
20 CHAIR BELLA: Yeah, let me also reiterate my
21 thanks to the three of you. You summarized well what needs
22 to happen, and then hearing from the states, we had -- you

1 know, our gut told us this was going to take quite a bit of
2 time. You said it very well, I think very clearly that you
3 have said to us you need flexibility and you need to be
4 involved in that guidance, and that's helpful for us to
5 hear.
6 So let me turn to the Commissioners to see who
7 has some questions for our panelists. Toby, then Martha.
8 COMMISSIONER DOUGLAS: First, Jennifer and Lee,
9 thanks for being on with us and presenting. I do have to
10 make a call-out to René, I think just for all the
11 commissioners, just how fortunate as -- René is just the
12 most amazing public official who's been in her position for
13 -- before I was even in service, and just has had such an
14 impact in many different ways on Medi-Cal, and we're really
15 just fortunate to have her in her role and really is the
16 face -- you know, when you think of the pressures of public
17 officials right now, and she's been through it many times
18 because this isn’t the first downturn in California and is
19 at it fighting for -- fighting really for the
20 beneficiaries. So thank you, René.
21 My question relates to just the financial, the
22 fiscal implications of once we turn off the PHE and what is

1 going to happen in terms of just the financial impacts if
2 it takes so long to work through the determination process,
3 and if you guys have -- either Lee or René, if you can talk
4 kind of the financial pressures on that front of losing the
5 FMAP, having higher enrollment, the pressures on the county
6 or state, if there's going to be a need to increase the
7 staffing, how that's being thought through and budgeted and
8 adding additional pressure, and then what the implications
9 are on the rest of the Medicaid budgets because of that.
10 MS. MOLLOW: So I can start. It's going to be
11 significant. I think that recognizing the timelines that
12 CMS put in place, to Lee's point and Jennifer's, about that
13 timing, because there's different time frames for -- like
14 if you took on the new population, you have to end their
15 coverage by the end of the month in which a public health
16 emergency was called, and then you have the end of the
17 quarter for the enhanced FMAP. But the reality is, to your
18 point, we're not going to be able to move forward people
19 that have come into our programs. It's going to create
20 additional fiscal pressures for states. And so one
21 consideration clearly would be that in giving that federal
22 guidance in terms of normal operations, giving

1 consideration to continuing that enhanced federal funding
2 until such time the state can get through those renewals,
3 and then make the appropriate adjudication for individuals.
4 Otherwise, the work that we have done to help maintain
5 people into coverage, the cost of that care in particular,
6 if you have people that are no longer eligible, but you
7 have to go through the process to get them out of coverage,
8 so you have to do the appropriate review of their case, the
9 appropriate notifications to them, they have to be timely,
10 but you're going to be carrying those cases in your
11 caseloads, and then there will be added cost pressures from
12 the state.
13 So it will be a cost that will now become borne
14 by states, actually during a time when the economy, there
15 is such a downturn because of the high numbers of
16 unemployment, and so state revenues are down. So it's
17 going to become a huge fiscal pressure, and then states are
18 going to have to make decisions about where they're going
19 to then prioritize their scarce fiscal dollars in terms of
20 coming out of this public health emergency.
21 DR. GUICE: Now, I cannot echo the comments
22 enough. Losing the FMAP at the end of the quarter will be

1 devastating, given the costs that all states have incurred
2 to move forward with dealing with the pandemic. So the
3 state coffer itself, the state budget, has been used to
4 supply testing, test supplies, PPE. We've increased
5 payments to various providers to try to, you know, keep
6 them whole and make them able to -- help them to stay in
7 business.

8 So ending that FMAP right away will be
9 devastating. We've had to cut administrative costs, and
10 when you cut administrative costs in Medicaid, that means
11 cutting staff. So you cut staff across the state budget,
12 and you cut staff in service programs. Then where do you -
13 - how do you go about making sure that the redeterminations
14 are made? Even with the best system, you have to have
15 somebody look at the document and make sure it's not a
16 picture of a cat. You have to have people to assist with
17 that, or else you're going to be paying millions of dollars
18 back to the federal government. Yes.

19 CHAIR BELLA: Thank you.

20 Martha?

21 COMMISSIONER CARTER: I wanted to bring up
22 something from the beneficiary perspective and it’s

1 something that Jennifer mentioned and jumped out at me when
2 I was reading our meeting materials, and that's about the
3 time that's considered reasonable for beneficiaries to
4 respond to requests for additional information, 10 days.
5 Considering the fact that people may have moved, as
6 Jennifer said, and may be displaced. And just in the
7 normal course of living, you know, I don't get mail at my
8 house. I have to go to the post office, or the woman who
9 brings it to us has to come to my rural mailbox, which is
10 two and a half miles from my house. So ten days is not a
11 reasonable amount of time, in my experience.
12 And then, of course, we've got really vulnerable
13 populations that would make that time frame even more
14 difficult. So I wanted to comment on that.
15 And also, this whole thing has affected the out-
16 stationed eligibility workers. I'm hearing as much in
17 person. I really applaud the efforts you all have made to
18 make the websites more user friendly, and I think that's
19 great. But there are still going to be people who need
20 that personal assistance and how you handle that, and is
21 there a possibility of increasing those outstation workers
22 as you reach redeterminations?

1 DR. GUICE: Well, in Kentucky, we have increased
2 our telephone and phone-in assistance. We have the kinds
3 of things that folks can do over the phone. Once
4 redeterminations and no determinations, then the end-person
5 traffic wasn't -- we didn't have a lot of calls. We didn't
6 have a lot of needed assistance for a couple of months, and
7 then that started to increase again because, of course,
8 people wanted to know about their eligibility.
9 I can't tell you if it's possible to have more
10 staff ready, I can say that we're cutting administrative
11 costs right now for this fiscal year. So I can't imagine
12 where we would get more staff. We're looking.
13 Oh, and we have increased our time to respond to
14 an RFI, the 30 days across the board, because MAGI, the
15 adult expansion group, required that, and we felt it made
16 it -- much more sense. So we have 30 days. It's a good
17 idea.
18 CHAIR BELLA: Thank you.
19 Chuck and then Tricia.
20 VICE CHAIR MILLIGAN: Thank you. Thanks,
21 panelists. Really appreciate it.
22 My question, Jennifer, is for you. When the

1 public health emergency was scheduled to end this week,
2 there were a couple of states that intended, I think, to
3 eliminate eligibility where people were ineligible
4 effective November 1st, so immediately, partly because of
5 the fiscal constraints. And the FMAP ends at the end of
6 the fiscal quarter, but the continuous coverage ends at the
7 end of the month of the PHE.
8 My question is, are you aware of whether anybody
9 is tracking? Are you all tracking kind of at a state level
10 what the plans are? I mean, has somebody kind of
11 identified the states that intend to start issuing the
12 process, issuing notices, issuing all of that, you know,
13 after the public health emergency ends and maybe kind of
14 trying to do it all in one fell swoop versus staggered, as
15 we've heard, and separately the states that might intend to
16 try to eliminate eligibility immediately in doing some of
17 the prep work, you know, at the tail end of the PHE?
18 And part of the reason I'm asking the question is
19 I can understand the state fiscal pressure to kind of try
20 to get back to normal operations and eliminate eligibility
21 for people who probably might not be eligible right now.
22 At the same time, trying to do any of the notice issuances,

1 any of the public-facing work while the PHE is still in
2 effect, not knowing whether the PHE is going to get
3 extended, is going to create massive amounts of
4 administrative waste, administrative resources confusion.
5 So my question ultimately is, are you aware of
6 whether anybody is tracking this at the state level, state
7 plans?
8 MS. WAGNER: So we work with advocates and state
9 officials wherever possible, and this has come up very
10 frequently. And sometimes the advocates have inklings, you
11 know, through proposed rulemaking or other things.
12 The challenge here is that it is not clear policy
13 that is being posted to a policy manual. It is not part of
14 the state plan or something where we can systematically go
15 through it, but we definitely share your concerns. We have
16 heard similar reports of efforts to terminate people
17 immediately, and believe, number one, that doesn't comply
18 with due process. I mean, there's no way you could legally
19 end coverage as of November if the PHE ends now without
20 proper notice.
21 But secondarily, we don't believe that's valid.
22 The Families First language says that people should be

1 treated as eligible, and so a determination of
2 ineligibility back in June is not valid. They've been
3 eligible up until this point -- or up until the end of the
4 PHE, and if at that time, you are going to see if they're
5 ineligible, that requires a full renewal. You can't base
6 it on stale info. There's a good chance that they didn't
7 get notices before, or maybe they replied to a request for
8 information and it's sitting at a closed office or the
9 agency hasn't been able to work it.
10 But the legality is important, but states are
11 going to do what states are going to do, especially with
12 the intense fiscal pressure on them. And so even if
13 they're sued and months later, it's found that that's
14 invalid, what does that do for people who need health care
15 in the next few months? And so that's why it's really
16 important that, number one, CMS comes out very clearly and
17 says what must be done.
18 The guidance that came out last night touches on
19 this, but, you know, there's a positive interpretation,
20 there's a negative interpretation within what they said
21 they said there, and there's not enough clarity. And
22 states need to know what's expected of them, and they need

1 to know that CMS has their back if they're going to do this
2 the right way.
3 The second thing that's needed is increased FMAP.
4 To allow states to do this in the future and overall
5 support them in the face of the crises that they are
6 facing, that Congress obviously needs to address, but to
7 give them the support to continue to do things the right
8 way.
9 CHAIR BELLA: Thank you.
10 VICE CHAIR MILLIGAN: Thank you.
11 CHAIR BELLA: Tricia?
12 [No response.]
13 CHAIR BELLA: You're on mute, Tricia.
14 COMMISSIONER BROOKS: Sorry about that.
15 That was a lot of what I really wanted to focus
16 on. We certainly know that Texas and Colorado have already
17 issued notices to individuals that they determined were
18 ineligible, telling them that they would lose eligibility
19 at the end of the month when the PHE ends.
20 And so going back to Jennifer's comment about due
21 process, if I were to get a letter today telling me that my
22 coverage is going to end at some point in the future, an

1 unknown date, and I'm thinking, wow, the country is in bad
2 shape, then I might not necessarily respond in that 10-day
3 period. And yet when you look at due process in terms of
4 fair hearing, the state must offer a reasonable amount of
5 time for someone to request a fair hearing, but it is not
6 to exceed a maximum of 90 days after the date of the
7 notice.
8 So if I get a notice today that I'm going to lose
9 coverage of that point in the future and that point in the
10 future is next June, then what's going to happen is my due
11 process, my fair hearing rights have already expired. So
12 it's another wrinkle on this.
13 The other thing I'll say is, I mean, clearly,
14 Lee, René, and Jen have all made this really clear. But
15 all we have to do is look at experience in states like
16 Tennessee and Missouri that had stopped doing renewals for
17 a long period of time and the chaos that that created when
18 they restarted those renewals, and lots of stories of
19 people inappropriately losing coverage. So I think this
20 really puts pressure on us.
21 We have as a commission opined on both extended
22 FMAP, more consistent with prior stimulus bills during

1 recessions. We've opined on needing guidance, but I think
2 we also need to make sure that the impact on the
3 beneficiary and on public health in general is part of the
4 contract that is made when that guidance actually is given.
5 CHAIR BELLA: Thank you, Tricia.
6 Comments from any other Commissioners?
7 [No response.]
8 CHAIR BELLA: It looks like we might have lost
9 Lee, but René, I would say -- I always like to say, like,
10 what else would you like this Commission to hear, and what
11 else could -- what other messages could we be sending on
12 behalf of states if we have an opportunity to do so?
13 I mean, you've made it pretty clear. You were
14 very clear, but if there's anything else, now is your
15 chance.
16 And then, Lee, I'm glad you're back. I'll ask
17 you the same thing and Jennifer as well. Any parting
18 thoughts on how we could be most helpful as you get these
19 efforts back in place?
20 MS. MOLLOW: Just to reemphasize the timing, the
21 engagement with the states, having clear guidance and clear
22 timelines to meet these requirements is really important.

1 And the advanced notice, I cannot reemphasize
2 that enough. We cannot do what we did with the calling of
3 the public health emergency and then ceasing those
4 operations. Recognizing the status of how things are in
5 this continuation of this public health emergency, we have
6 the time now to start being engaged and being thoughtful
7 about what those processes are. So to the extent that we
8 can work collaboratively with CMS and get that input from
9 the states to help because we are all 50, you know, plus
10 the territories, different Medicaid programs. So we do
11 have different needs, but that there are common needs
12 amongst all of us. And so I think it would be imperative
13 for CMS to work with us in terms of that guidance that is
14 needed.
15 And looking at reasonable timelines, I cannot
16 emphasize that enough in terms of how we're going to unwind
17 this public health emergency, because not only do we have
18 it in the space of eligibility, but you also have to then
19 think about the other flexibilities that states -- given
20 that states will equally have to unwind. So it's not we
21 can't -- I mean, eligibility is huge because we're talking
22 about people's lives and coverage for critical health care

1 services. So we have to think about that collectively in
2 terms of the different steps that states are going to have
3 to take, and it's not going to be easy, given the longevity
4 that we are seeing with this current public health
5 emergency.
6 Hopefully, we can use this as a path forward for
7 future public health emergencies and looking at ways in
8 which we can develop, whether you call it -- I'll take a
9 word from my Medicaid director -- like a playbook or a
10 toolkit that we can use and leverage future forward. But
11 now is the opportunity for us to be thoughtful about that
12 and not waiting until the very end to then come together to
13 think about what that guidance might look like.
14 CHAIR BELLA: Okay. Jennifer and Lee, I would
15 ask you the same thing. Any closing thoughts?
16 MS. WAGNER: Just to reiterate the clear guidance
17 and the time. People like René and Lee have done herculean
18 tasks to not only keep their head above water but to serve
19 people in their states effectively during this public
20 health crisis. And it was not easy to turn on a dime back
21 in March when guidances and flexibilities were suddenly
22 offered, but that was understandable. This public health

1 crisis hit us like a ton of bricks somewhat out of nowhere.
2 That had to be that way.
3 At the end of the PHE, we have time. We have
4 lead time now, and CMS and Congress can really take the
5 time to effectively listen to state officials like René and
6 Lee and do the right thing to support both them and their
7 efforts and their need for system changes and financing and
8 all the complexities that they deal with every day but
9 fundamentally to protect eligible beneficiaries.
10 Just remember eligible beneficiaries who lose
11 coverage don't go away and decide they don't need health
12 care after all. They're going to come back. They're going
13 to appeal. They're going to call. They're going to
14 reapply, and so there's not truly financial savings there.
15 There's a lot of headaches for eligible individuals and
16 state agencies.
17 CHAIR BELLA: Thank you.
18 Lee, any last words of wisdom or things you want
19 to make sure we keep in mind?
20 DR. GUICE: Keep in mind that we're all out here
21 struggling the same as you all are. We want to do the
22 right thing. We want to make sure that people have

1 coverage and that we're able to maintain what we can and do
2 what we can for the good of all of the citizens.
3 So thank you for your work, and thank you for
4 everybody's work. I appreciate hearing all of the
5 information today, and thank you for having me.
6 CHAIR BELLA: Yeah. Well, thank you for your
7 guys' work. I mean, you are in a thankless job many times,
8 and we're lucky to have you all working on behalf of the
9 Medicaid program. So thank you for joining us for this
10 panel.
11 We are now going to spend a few minutes with some
12 Commissioner discussion. The panelists are welcome to stay
13 and listen, or you're also free to go and deal with all of
14 the other things that you have on your plate today. So
15 thank you again very much for presenting this. You've
16 really given us a lot to work from here.
17 MS. MOLLOW: Thank you so much for the
18 opportunity. Greatly appreciate it.
19 **### FURTHER DISCUSSION BY COMMISSION**
20 * CHAIR BELLA: All right. Thank you.
21 Commissioners, I'm going to open it up to all of
22 us now to talk a little bit about sort of where your heads

1 are and what we've heard. We also should talk -- as has
2 been mentioned, there was an interim final rule released
3 last night. It covers two things -- well, actually, I'm
4 sure it may cover more than those things, but a couple
5 things, I think, most relevant to us are vaccine coverage
6 for Medicaid and also how the continuous coverage
7 requirements and how that's being applied and so all
8 applications which leads to that.

9 So we were able to confirm that there is a 60-day
10 comment period on what CMS released last night, and so as
11 part of what we're talking about here in this session, it
12 would be helpful to get a sense of where the Commission is
13 on what you might like to have for December, because we
14 have an opportunity in the December meeting to talk in more
15 detail about what a comment letter might look like should
16 we decide to comment. So just to be clear, we don't have
17 to make that decision today. We have some time. We will
18 bring that back for the December meeting, but you should
19 please highlight anything in particular that you want to go
20 into more detail on in December with regard to what was
21 released last night as well.

22 Fred, I saw your hand. You can kick us off.

1 COMMISSIONER CERISE: Yeah. Hey, Melanie, I have
2 a question. René hit on it. She talked about developing a
3 playbook for future public health emergencies. The history
4 of FMAP increases and conditions around that, we've never
5 dealt with this kind of situation before. Is there
6 anything to look back and say this is what the agency did
7 in the past?
8 CHAIR BELLA: Yeah, Joanne, do you want to
9 comment? Or Darin. We talked in the past about how CMS
10 gave states some flexibility. I don't know if that was
11 formal or informal in how that was provided.
12 COMMISSIONER CERISE: Economic downturns when
13 you've increased FMAP --
14 COMMISSIONER GORDON: We have. I mean, in each
15 of the times that they offered additional match rate in
16 downturns, there was guidance around maintenance of effort.
17 This one is being interpreted a bit more strongly than the
18 ones in the past, but they have given guidance.
19 Now, coming out of it, I think it's a bit of a
20 different scenario, because those were not public -- we
21 were having this conversation just yesterday, I think, with
22 some folks that the public health emergency dynamic here,

1 which is this stuff ends when they end the public health
2 emergency, and the uncertainty about when they're going to
3 do that is very different than what we've seen in the past
4 in downturns because there wasn't like once we declare this
5 moment over, it's an enhanced match rate for X period of
6 time, as opposed to not knowing when that's going to
7 happen, like -- which is the case here.
8 MS. JEE: And I think another distinction from
9 prior FMAP increases is with COVID the FMAP increase is
10 tied to the continuous coverage requirement, and that has
11 not been the case previously.
12 CHAIR BELLA: Yeah, I definitely think, Fred,
13 maybe there's been more certainty around a tail, if you
14 will, and there is no certainty around a tail here.
15 COMMISSIONER CERISE: Yeah.
16 CHAIR BELLA: And the agency doesn't have the
17 ability to give that tail, though. I mean, that's squarely
18 in Congress' purview, which I think is important for us to
19 remember.
20 Darin?
21 COMMISSIONER GORDON: You know, we had the
22 discussion, I think how we raised it, about the match, I

1 think about this, so you're told you have to keep everyone
2 on -- even with the clarification, you know, it was pretty
3 clear you keep everyone one. And when they say the public
4 health emergency ends and you still have this time that's
5 going to be required to get caught up, but it's the result
6 of you saying you have to keep everyone one. If they
7 extend -- you know, again, I would, I think -- I'm
8 assuming, and, Joanne, correct me if I'm wrong -- it would
9 require Congress to allow them to go beyond that public
10 health emergency, as Melanie was just saying, to have
11 additional funding. But I'm sure that the challenge is:
12 Does that -- you know, depending on how far they take that
13 out and allow for a tail for you to get caught up, you
14 know, would that cause states to be as diligent as far as
15 getting caught up? In other words, would they take longer
16 than they normally would if they had a longer or a shorter
17 -- it's just this old argument I'm having in my own head.
18 I'm trying to think about how that -- is this like yes,
19 this is the product of something you required the states to
20 do, so they should have the support until they can get
21 caught back up to a normal state? But then the counter-
22 balance there is, you know, does that then -- you know, do

1 some states maybe take a slower approach than they would
2 otherwise because -- and I don't have an answer for that,
3 but it's just something that I'm struggling with.
4 CHAIR BELLA: Yes, I share that point. As they
5 were rattling off the numbers of people in newly enrolled,
6 I'm trying to do in my head the math of how many you would
7 have to process on a given day and how long that would
8 take. It is -- the numbers are pretty overwhelming.
9 COMMISSIONER GORDON: We keep hearing, like, six
10 months, you know, as an example, and in my own head I think
11 about, well, when this ends, that would mean that you're
12 basically going to have to do twice as many reverifications
13 every month because you have to be doing the ones in that
14 month plus the six months, you know, that we've been
15 paused. And I just think about in a downturn your staffing
16 -- I mean, I just don't know how you really do that well in
17 six months, just because I don't think you're going to have
18 the bandwidth and the staffing to do that. But, again, I
19 don't know what the right answer there is, just this is
20 like you do need to support -- if you want the states to
21 get caught up, they need the support so they can get the
22 staffing to do it in a timely fashion and do it orderly,

1 but at the same time I don't know if there's an easy answer
2 to how long that will take.
3 CHAIR BELLA: Yes. Kisha, then Tricia.
4 COMMISSIONER DAVIS: Just following up on that
5 exact point, I wonder if we can make some recommendation
6 around saying, you know, whenever it ends that there will
7 be a grace period of 6 to 12 months, and I don't know what
8 the exact right time is, but so that that's baked in, so
9 there isn't this fear of, well, you know, when does it end,
10 here's the drop-dead date, you know, that there's a baked-
11 in grace period afterwards, and, you know, we'll be coming
12 up with some recommendations specifically around that
13 point.
14 Also, just, you know, highlighting the --
15 bringing it back to the patients, you know, who are in the
16 midst of coverage, and I think Jennifer at the end did a
17 really good job of, you know, highlighting just because
18 their coverage ends doesn't mean that their, you know,
19 problems go away, right? So patients are in the midst of
20 getting treated for whatever, and their coverage drops, and
21 those health problems that they, you know, have been being
22 treated for are still there. And so, you know, there's

1 still renewals and redeterminations and appeals processes
2 and trying to smooth-line that for folks while they're in
3 the midst of dealing with, you know, loss of jobs and loss
4 of families and a downturned economy.
5 And as that relates to, you know, some of the
6 most vulnerable folks and our racial and ethnic minorities
7 who have really experienced, you know, a worse COVID and a
8 worse economic crisis and how a kind of rapid removal of
9 the rolls might disproportionately affect some of those
10 minority folks. So just highlighting that as well.
11 CHAIR BELLA: Thank you, Kisha. Tricia and then
12 Kit and then Chuck.
13 COMMISSIONER BROOKS: If I get off mute here. So
14 going back to Darin's point and hearing Jennifer talk
15 about, you know, ideally stretching this out 12 months,
16 which is actually the only logical way we can avoid having
17 these uneven work flows in the future. If we do it all in
18 three months or six months, that's going to cycle around,
19 and it will take years to smooth that out. So I certainly
20 would hope that states are given the support that they need
21 to make that a full 12 months.
22 The one thing, I think, that would be helpful for

1 the Commission as we think about this and potentially
2 taking action -- I am sorry. I am in New Hampshire, and
3 they keep calling about the election. But what would be
4 really helpful is to have just a review of the various regs
5 that come into play and how they fit together. So you've
6 got your regs on timely notice, on review of eligibility
7 categories, your due process, the Families First language,
8 and you've got language in Medicaid statute about
9 administering the program in the best interest of the
10 beneficiary. So how do those all cobble together to have
11 the legal basis for guidance that really is in the best
12 interest of the beneficiary as well as in our country's
13 public health?
14 CHAIR BELLA: Thanks, Tricia. Kit, then Chuck.
15 COMMISSIONER GORTON: Thanks, Melanie. First, I
16 want to align myself with what Darin said. I agree with
17 everything that he said, and I too have struggled with what
18 is the right period of time. I'm not sure.
19 To Tricia's point, Massachusetts had to do a
20 reset of redeterminations while I was there because they
21 had for an extended period of time stopped doing them in as
22 disciplined a fashion as one might have expected. And it

1 was disruptive, but it was possible in the course of the
2 six-month period to get through it. I'm not going to say
3 there weren't individuals who were negatively impacted. I
4 know there were. But it is possible to work through that.
5 I don't know that that flies in a place as big as
6 California, but, you know, I think it needs to be worked
7 through.

8 I wanted to build on what Kisha said. One of the
9 things that people will still be doing with the end of the
10 public health emergency is, in fact, COVID. Not everybody
11 gets better in a week or two. And if we don't help those
12 people get taken care of, then it prolongs the tail of the
13 pandemic, which is not what we want. And I do think that
14 we need to think about not only the funding tail but the
15 clinical tail and how to balance those.

16 And then the last thing I just want to say
17 quickly with respect to this concept of the playbook, I
18 think the public health emergency fits pretty well as a
19 special case in our countercyclical work. And so I think
20 that we may want to, as we bring that forward and think
21 about recommendations to Congress, look at what we've
22 learned so far from the pandemic and, you know, we will

1 continue to learn from the pandemic in an extended period
2 of time, just as we learned in the aftermath of Katrina and
3 all of the other storms for an extended period of time.
4 And so it seems to me that we want to be able to lay out
5 some of the implications of a broader emergency for
6 Congress to consider in terms of sort of automatic
7 approaches to countercyclical events because, sadly, this
8 is not the last pandemic. And so we ought to make sure
9 that we think about being more ready the next time.
10 Jennifer said to us that, you know, it all
11 happened very quickly at the beginning, we weren't
12 prepared, and her view was it sort of had to happen that
13 way. I'm not sure I'm convinced of that. I think we could
14 have been more prepared. I think there could have been
15 desktop exercises and other things like we do in terms of
16 disaster preparedness and other things. And so I just --
17 there may be an opportunity for the Commission, in talking
18 about the countercyclical work, to talk about advanced
19 preparedness for the next one.
20 CHAIR BELLA: Thank you, Kit. Chuck and then
21 Toby.
22 VICE CHAIR MILLIGAN: Thanks. I want to separate

1 two things, and hopefully this will be helpful as we think
2 about maybe what to take up when we get back together, one
3 issue being the process by which and the timeline by which
4 redeterminations are done. And that timeline could be --
5 we could end up making a recommendation that states have,
6 you know, up to a year to manage the work flow and manage
7 the staffing demands and, you know, kind of a grace period
8 to do that. But to me that's separate from the FMAP,
9 enhanced FMAP issue. They're related but they're separate.
10 For example, you could say -- we could make a
11 recommendation that could say from a program integrity
12 point of view, from a disallowance point of view that
13 states have, should be given a grace period of up to a year
14 to get back to normal operations for eligibility and to
15 kind of go through the process of, you know, thoughtfully
16 doing redeterminations. We could make that recommendation
17 and delink it from the FMAP issue, and if a state chose to
18 do that, to manage their workload and work flow and
19 staffing resources, then they would be choosing to do it
20 with normal FMAP following the PHE.
21 The second part of it is should we be making a
22 recommendation about an extension of the FMAP because of

1 all of the issues that have been raised having to do with,
2 you know, high unemployment still, high eligibility still,
3 the fact states are going to be carrying a lot of people on
4 their eligibility rolls. I just think it would be helpful
5 for us to think through those in somewhat separate but
6 related ways, and, you know, kind of going back to Fred's
7 initial comments when we started this part of the meeting,
8 I think the challenge is the predictability piece for the
9 states. They need more certainty. State legislatures and
10 governor budget offices need more certainty about, you
11 know, FMAP issues and carrying caseload issues for purposes
12 of overall state budgeting. And the more we can, I think,
13 press on the development of certainty, the better.
14 And, again, the two buckets that I defined, the
15 first one, it seems to me, is within the agency's
16 discretion, it seems to me; and the second one is clearly
17 congressional in terms of FMAP. And I just think it would
18 be helpful to think of those as separate but related as
19 opposed to one thing together.
20 Thanks.
21 CHAIR BELLA: Thank you, Chuck. Stacey?
22 COMMISSIONER LAMPKIN: Thank you. I have what I

1 think is a question for the rest of you, because this is
2 definitely not my area where I have much personal
3 experience. But one of the things that Jennifer said in
4 her initial comments when she was talking about states need
5 to make plans and here are the things they need to do that
6 struck me was the plan to streamline transitions to other
7 coverage opportunities for individuals who are determined
8 ineligible, and then it doesn't seem like we talked about
9 that very much, but it connects to what Kisha was saying
10 and what others were saying about continuity of care or
11 continuity of treatment opportunities or some kind of
12 coverage for individuals who are receiving treatment.
13 Is there anything that we need to say or comment
14 about in terms of any kind of CMS guidance that would help
15 states, anything CMS could do differently that would help
16 states with the -- helping people transition to other
17 coverage sources?
18 CHAIR BELLA: Joanne, do you want to comment on
19 that?
20 MS. JEE: Yeah, I mean, I think one of the
21 questions that seemed to come up was -- well, maybe this is
22 another coverage source, but whether or not they needed to

1 do a brand-new redetermination, right? So if they've
2 already been redetermined once using information that was
3 current at the time, you know, when the PHE ends and that
4 information is no longer current, is there a new
5 redetermination? So I think that's a question. And,
6 Tricia, that's something that you raised before, so that's
7 sort of like maybe one piece of it. But my understanding
8 is always that they need to -- before terminating anybody
9 from coverage, need to sort of run them through and see if
10 they would be eligible for other coverage. So I think that
11 requirement is already there.
12 I'm not sure that any -- I'm not sure how that
13 changes if a person has sort of been in a holding pattern.
14 But I don't think that it would.
15 CHAIR BELLA: Bill, do you a comment on this?
16 Because, otherwise, I'm going to go to -- we're going to
17 finish this out. But do you have an answer to this?
18 You're on mute, Bill. Bill, sorry, you're on mute.
19 COMMISSIONER SCANLON: It is related, and I can
20 go a different path. It was the issue of equity between
21 people. The need for an extended period of redetermination
22 is a no-brainer, but there's the question of your luck. If

1 your redetermination is at the end of that period, you may
2 not -- you had eligibility for a much longer period than
3 someone who's redetermined at the very, very beginning.
4 And I think that part of this is that beneficiaries need to
5 have notice that redetermination is going to be happening
6 and that if there are alternative options for coverage, you
7 should take advantage of them. You do not want people, I
8 think, to be taking jobs as the economy improves, forgoing
9 coverage that they may no longer be eligible because they
10 didn't sign up at the beginning of their employment. So
11 it's this idea of that there's -- part of this is the
12 education of the beneficiary, yes, that's more effort, but
13 it may pay off sort of in the longer term.
14 CHAIR BELLA: Yeah, I'm going to see if Tricia
15 has any comment to what Stacey raised, and then we're going
16 to go to Toby, who's been waiting patiently.
17 COMMISSIONER BROOKS: It actually is -- you know,
18 the question that Joanne has, which is -- is it clear in
19 current law that we have to make that new current
20 determination, I think is the gist of this. But one point
21 I want to make that hasn't been made, and that is that I
22 don't think the Texases and Colorados that are already

1 issuing termination notices can be doing transfers to the
2 marketplace, which is required when someone loses Medicaid
3 eligibility if they've been screened for that. And,
4 therefore, you know, something has to happen at the end of
5 the public health emergency to make sure those account
6 transfers take place. So it's just another piece of the
7 pie.

8 CHAIR BELLA: Thank you, Tricia. Toby?

9 COMMISSIONER DOUGLAS: Chuck really addressed a
10 lot of what I wanted to talk about, but I would -- I think
11 the way you're framing it, Chuck, of two separate issues is
12 right, although there is significant tension from a state
13 between the two, and to make the right decisions about
14 length and not making perverse incentives, regardless of
15 what state, given the tension and the issues of the budget
16 pressures, it's just going to be enormous during these
17 times.

18 And so while we can advocate, or, you know,
19 provide guidance on more flexibility related to the
20 timelines, it doesn't separate this enormous budget
21 pressure, and can they actually go forward with it.

22 So I think we just need to keep them separate, as

1 you said, but then acknowledge the tension.

2 VICE CHAIR MILLIGAN: Yeah, if I can just respond
3 to that, Toby, I totally agree, and to me when I kind of
4 created those two buckets, I think if we get to the FMAP
5 discussion, and if the Commission wants to make a
6 recommendation about some kind of FMAP extension in a post
7 PHE, to kind of work through the eligibility roles, I think
8 we could, as a condition of making a recommendation for
9 FMAP extension, the enhanced FMAP, require states to take a
10 year, or whatever, take the period of time of the FMAP. I
11 just don't think we can mandate anything around, you know,
12 a 12-month or some sort of tail eligibility process if it's
13 the state dime that has to pay for it.

14 So that's, to me, the process piece, and the FMAP
15 piece I think are separate, but inside of that FMAP piece I
16 think, you know, then it becomes what are the conditions
17 associated with the enhanced FMAP.

18 CHAIR BELLA: I am going to turn to public
19 comment, and then attempt to summarize, and then we'll take
20 a break for lunch. So we're going to welcome anyone in the
21 public to comment. If you would like to do so there is a
22 little hand icon that you need to click, and then you will

1 be recognized and unmuted.

2 ### PUBLIC COMMENT

3 * [No response.]

4 CHAIR BELLA: So far now hands but we'll give it

5 just another minute.

6 [No response.]

7 CHAIR BELLA: Okay. It does not appear that we

8 have anyone who wants to make a comment. If, for some

9 reason, something is not functioning for you technically

10 you are able to submit comments to us, and Anne, maybe

11 we'll just remind everyone of that after each session, the

12 best way to do that.

13 EXECUTIVE DIRECTOR SCHWARTZ: macpac@macpac.gov.

14 CHAIR BELLA: So if people would like to submit

15 comments, please send them to macpac@macpac.gov.

16 I'm going to attempt to sort of frame what I

17 think -- what I've heard from you all and where we might be

18 going for December.

19 So I do like Chuck's framing, and I think it

20 sounds like others do as well. We'll think about the two

21 categories of the process and time for redetermination.

22 We'll think about the FMAP. With regard to the first one,

1 we have an opportunity to provide formal and informal
2 comment to the agency. I think when we come back in
3 December we should talk about if we would like to formally
4 be on record.
5 But in the meantime, Anne and Joanne, I don't
6 know with what regularity we're talking with CMS these
7 days, but there is no reason why, if they are amenable, we
8 shouldn't be talking to them about continuing to ask about
9 guidance, and when it's coming out, and reinforcing the
10 need to consult with states. So I don't know if you have
11 any comments on what the opportunity to do that is, but it
12 doesn't feel like we have to wait to do a letter. This is
13 like an important thing. I think CMS knows that everyone
14 is asking for guidance. I get they are working hard on
15 guidance. And so I would hate to lose another month, if we
16 have an opportunity to check in with them on that.
17 You're welcome to comment or not.
18 The other area is just to bring back in December
19 a discussion about do we want to say something to Congress
20 about FMAP and what that would look like. Would we be
21 commenting on an amount or would we be commenting on
22 duration or a tail? And obviously, like all of this will

1 be informed by the election and what we're looking at with
2 regard to Congress and any changes in any of those
3 dynamics.
4 So that is where I think I'm hearing the interest
5 in the Commission, in terms of what we want to look at,
6 what we want to talk about in December, and what we might
7 do with regard both to CMS and to Congress.
8 Does anyone have any -- do people agree with
9 that? Do you have any additional comments or modifications
10 to add to any of that? Or does that sound like the right
11 direction? Head nods are fine. Hands if you want to
12 comment.
13 I see some head nods.
14 All right, any last comments from Anne, Joanne,
15 or Commissioners?
16 [No response.]
17 CHAIR BELLA: Okay. Well, thank you for that.
18 Very timely. Very important. Great to hear from the
19 states directly.
20 We are going to take a break for an hour, so we
21 will reconvene at 1 p.m., and we will come back and get
22 into a session about dual eligibles. So I hope that you

1 are all able to rejoin us at 1:00, and Commissioners, we'll
2 see you then. Thank you all.
3 * [Whereupon, at 11:57 a.m., the Public Session was
4 recessed, to reconvene at 1:00 p.m. this same day.]
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1 AFTERNOON SESSION

2 [1:01 p.m.]

3 CHAIR BELLA: All right. Welcome, everybody.

4 Thank you all for reconvening, and welcome to our guests.

5 Super excited to have this panel on dual eligibles, and I'm

6 going to turn it over to Kirstin to introduce the panel.

7 And we'll take it from there.

8 **### PANEL: CREATING A NEW PROGRAM FOR DUALLY ELIGIBLE**

9 **BENEFICIARIES: KEY CONSIDERATIONS**

10 * MS. BLOM: Great. Thanks, Melanie.

11 So, everyone, today we're continuing our

12 discussion on ways to improve care for duals and reduce

13 costs. As you all know, the topic is of key interest for

14 the Commission and particularly now during the pandemic

15 since we know that the dually eligible population is

16 particularly vulnerable.

17 We've been focused on integrating care across

18 Medicaid and Medicare, but today we're turning to the

19 question of whether the future of coverage for this

20 population might require a new program, one that's uniquely

21 focused on the dually eligible beneficiaries.

22 In our June report, the Commission expressed

1 interest in analyzing proposals that would restructure
2 coverage into a single program. As many of you know, the
3 Bipartisan Policy Center released a proposal this past
4 summer outlining one essential pathway, and there are other
5 proposals under development, including work by Leavitt
6 Partners that has not yet been made public.
7 So our plan for today is to hear from a panel of
8 experts about key considerations in designing a unified
9 program of coverage for dually eligible beneficiaries.
10 Obviously, this is a very complicated topic, and so to help
11 us think through it, we have three great panelists here
12 today, each with a distinct perspective on integrating care
13 for this population.
14 So, first, we're going to hear from Kevin
15 Prindiville, executive director of Justice in Aging. Mr.
16 Prindiville is going to lead off the panel from the
17 perspective of beneficiaries, including what opportunities
18 and challenges a new program might present for people who
19 would actually be enrolling in it.
20 Mr. Prindiville is an expert in Medicare and
21 Medicaid policy and has served as counsel in several class-
22 action lawsuits protecting low-income seniors' access to

1 public benefits. Prior to joining Justice in Aging, Mr.
2 Prindiville worked as a staff attorney at the Pennsylvania
3 Health Law Project in Philadelphia, where he represented
4 low-income individuals having trouble obtaining health
5 care.
6 Next, we'll hear from Mark Miller, executive vice
7 president of Health Care at Arnold Ventures about the
8 short- and longer-term approaches to integrated care for
9 this population. Dr. Miller leads Arnold Ventures' work to
10 lower the cost and improve the value of health care. He
11 has more than 30 years of experience developing and
12 implementing health policy, including prior positions, as
13 you all know, as the executive director of MedPAC. Before
14 that, he was assistant director of Health and Human
15 Resources at the Congressional Budget Office, also spent
16 time at CMS as deputy director of Health Plans and at the
17 Office of Management and Budget as Health Financing Branch
18 chief.
19 And finally, we'll hear from Charlene Frizzera,
20 senior advisor at Leavitt Partners. Ms. Frizzera will
21 discuss the design features of a proposal being developed
22 by that group. Prior to joining Leavitt, Ms. Frizzera was

1 acting administrator of CMS, where she was responsible for
2 leading policy and operational aspects of that agency while
3 also executing the design and implementation of the
4 Affordable Care Act.
5 After we hear from the panelists, as is our usual
6 way, our usual approach, we're going to open it up to
7 discussion with the Commissioners.
8 So Mr. Prindiville will start, followed by Dr.
9 Miller, and then Ms. Frizzera. So, with that, I'm going to
10 turn it over to Mr. Prindiville.
11 * MR. PRINDIVILLE: Thank you, Kirstin, and thank
12 you, all of you, for continuing to work on this important
13 topic. It's nice to see many of you. I miss seeing many
14 of you in person, but thank you for continuing your work in
15 this challenging time and especially in issues as critical
16 as these that have only become more critical as we learn
17 every day through the COVID crisis.
18 I'm Kevin Prindiville. I'm the executive
19 director at Justice in Aging. If you're not familiar with
20 our work, we're a national nonprofit legal advocacy
21 organization that uses the power of law to fight senior
22 poverty. We have deep expertise in the Medicare and

1 Medicaid programs and a long track record of advocating for
2 dual eligibles at both the federal level and the state
3 level.
4 We at Justice in Aging have certainly worked on
5 ideas for various integrated models, but today I'm not here
6 to talk about one specific model or another but rather on
7 what we think the dual eligible beneficiaries most want and
8 need from any new integrated system that we build together.
9 Our ideas are based on information that we get
10 directly from beneficiaries and from advocates who work
11 with them every day from really people across the country
12 in a wide variety of states, and in our work, we really are
13 helping to solve access problems for duals, whether they're
14 in the fee-for-service system, a system that's actively
15 integrated in Medicare and Medicaid, or another type of
16 managed care product, whether it's Medicare Advantage or
17 Medicaid Managed Care. While all of these models are
18 different, many of the challenges dual eligibles face in
19 those models are the same, and I think as we think about
20 developing a new integrated model, we need to kind of be
21 solving for some of these common problems that are
22 existing, even as we've made progress on some integration.

1 I'm going to touch on four basic principles
2 today, and I think if we keep these principles at the front
3 of our minds in any program we develop, we're going to be
4 on the right track and in good shape. So those four
5 principles are: one, getting people more of what they
6 need; two, advancing equity and addressing health
7 disparities; three, expanding access to home- and
8 community-based services; and four, maintaining consumer
9 choice and other consumer protections.
10 So starting with that first principle, getting
11 people more of what they need, when I'm in meetings about
12 dual eligibles, state and federal agencies, program
13 administrators, providers, health plan executives, health
14 policy experts, there's a tendency to talk about
15 integration in terms of the experiences of those actors.
16 So talk about finances and complex program rules and
17 overlapping regulatory structures, these are real and
18 important problems that we need to fix to get to the
19 beneficiary experience, but those are not things that come
20 up when we talk to beneficiaries and their advocates.
21 When we're meeting directly with dual eligibles,
22 what we hear mostly is that people aren't able to get the

1 care and services they need. When beneficiaries report
2 satisfaction with an integrated model, conversely, they say
3 that, one, they finally have someone to call who can help
4 them get what they need and understand the steps they need
5 to take to get it, and two, they're now getting services
6 that they couldn't get before.
7 So the systems are difficult to navigate for
8 beneficiaries. That's certainly part of the problem.
9 People do better when they have someone helping them
10 navigate the system, but often, even when people
11 successfully navigate the system, there's not the services
12 that they need at the end of it. The services aren't
13 covered. The providers are not available.
14 So in many states, even when you put these two
15 programs together, the programs just are not robust enough
16 to meet the high needs of the population. So an integrated
17 model that's smoothing financing or program rules for
18 providers or payers will not necessarily lead to what duals
19 most need, which is that they just don't get all of the
20 care that they need today.
21 So a key principle of any integrated model must
22 be to ensure that, at a minimum, of course, current

1 benefits are maintained, but even better, that there's
2 explicit requirements to expand access to services in areas
3 where the gaps exist today. And some of those obvious gaps
4 would be continued gaps in LTSS, long-term services and
5 supports, especially in home- and community-based settings,
6 oral health care, quality provider networks. There's just
7 a lot of gaps that still exist for this population. So the
8 opportunity we see in integration is to fill those gaps,
9 not simply just to better organize the system that exists
10 today that has those gaps.
11 The second principle I identified was advancing
12 equity and addressing health disparities, and I appreciate
13 that this committee has had previous presentations and that
14 there's been previous meetings really understanding the
15 population. But just to review quickly with this
16 particular lens, nationwide, there's about 12 million older
17 adults and people with disabilities who are dually
18 eligible. All have limited income and wealth, and I'd like
19 just to remind everyone of this every time we're talking of
20 those policies because I think sometimes we forget that,
21 that we're designing for a population that by definition is
22 living in poverty. It's not a traditional Medicare

1 population. It's not a traditional Medicaid population
2 because of the level of need, but the poverty issues, we
3 really need to understand.
4 It's also a population that is predominantly
5 people of color. So nearly half of dual eligibles are
6 people of color compared to about 20 percent of the
7 Medicare population. About 20 percent of dual eligibles
8 are Black, 18 percent Latinx, 6 percent Asian American, and
9 1 percent Native American.
10 Duals are three times as likely as Medicare-only
11 enrollees to report being in poor health. Almost half
12 receive long-term services and supports. Sixty percent
13 have multiple chronic conditions. We really need to
14 understand the connections between these different
15 datapoints I just shared. The connections between race,
16 poverty, and health disparities are critical as we design
17 programs here, and COVID has only further spotlighted these
18 facts and the connection between them.
19 So that dual eligibles in relation to COVID have
20 at least two of the risk factors of COVID. They're older,
21 or they have a disability. And they are low income. For
22 many of them, you had a third risk factor, which is their

1 race and their experiences with racism really increase the
2 likelihood that they're going to suffer a negative
3 consequence related to COVID, and we see that in some of
4 the data that CMS has already shared. Black dual eligible
5 individuals are 1.25 times as likely to contract COVID and
6 2 times as likely to be hospitalized from COVID as white
7 dual eligible individuals. So there's really some
8 significant disparities even within the dually eligible
9 population based on race.

10 So it's critical that any integrated model is
11 clear about who the model is being designed for and include
12 specific strategies and requirements for remedying racial
13 inequities and disparities and addressing social
14 determinants of health.

15 Some ideas in this area include being sure that
16 there's robust reporting requirements that disaggregate
17 important metrics across race and ethnicity and also
18 thinking about outreach and education programs as
19 culturally competent and not applying one-size-fits-all
20 approaches for the entire dual population.

21 So the third principle is around expanding access
22 to home- and community-based services. This must be a

1 clear and explicit goal of any integrated program, that we
2 must be shifting more long-term care into home- and
3 community-based settings for both people with disabilities
4 and older adults. We still have considerable room for
5 growth, we think, in providing more home- and community-
6 based care for older adults at home, and the integrated
7 models really -- this is probably the thing we find most
8 exciting about integrated models, the ability for the
9 integration of great new ways to shift those services.
10 It's a clear preference for the vast majority of
11 people who need LTSS, and there's evidence that there is
12 potential for cost savings in this area, not only in
13 reduced reliance on more expensive skilled nursing
14 facilities, but also reduced hospitalizations when you
15 provide more of this care at home and in the community.
16 COVID has increased our sense of urgency around
17 this, as we have seen that nursing facilities are
18 particularly a dangerous place for older adults to be.
19 We just saw some data from Kaiser Family
20 Foundation this week that showed Black and Latinx older
21 adults in nursing facilities are particularly at risk of
22 negative outcomes from COVID, including death, and we can

1 assume that that's many dual eligibles that are being
2 affected by their experiences living in skilled nursing
3 facilities today. So this needs to be a clear priority for
4 any integrated model.
5 I think that's in the integrated models to date.
6 It's been talked about as a clear priority with an
7 assumption that if we get the incentives right, more care
8 will be provided at home and in the community. We haven't
9 seen great evidence that that's actually occurred across
10 the board in those models. So we think we need to be even
11 more explicit in new models about the intent to provide
12 more access to these services.
13 So finally, my fourth principle around
14 maintaining consumer choice and other consumer protections,
15 based on our experiences talking directly to beneficiaries
16 and their families and their advocates, we believe that it
17 should be a choice for dual eligibles whether to enroll in
18 new integrated models. We think that if the integrated
19 model is doing the other things I talked about that people
20 will want to enroll, but that really should be their
21 choice. Being a dual eligible, being a low-income Medicare
22 beneficiary should not fundamentally alter the basic right

1 to choose whether you receive your services through the
2 traditional Medicare program or through some type of
3 managed model, so we really do think it's a choice.
4 We do support, however, limiting the managed
5 choices that duals have to only those options that are
6 truly integrated. The current approach today, which in
7 most states includes a plethora of choices for dual
8 eligibles, some, you know, a traditional Medicare choice,
9 some managed options that are really integrated care, some
10 managed options that are only managed on the Medicare side
11 or the Medicaid side. We do not think that array of
12 choices is helpful. We think it's confusing for
13 beneficiaries. They often end up enrolled in a program
14 that doesn't match their expectations. They think they're
15 enrolling in something that's managing all of their care
16 when it's not. So we support an integrated model that
17 would provide one truly integrated model to choose from and
18 not have other models competing with that one in ways that
19 both confuse the consumer and weaken the ability of the
20 integrated model to do its job.
21 Other consumer protections are also really key,
22 and we've seen that in the integrated models to date, where

1 they've been successful. They've included protections like
2 robust stakeholder involvement in designing, implementing,
3 and overseeing the program; strong and integrated appeals
4 processes, expansive provider network requirements;
5 benefits counseling to decide whether to join the model;
6 and then, importantly, a dedicated consumer ombudsman to
7 help consumers navigate any issues they have once enrolled
8 in the program.
9 So those are the four principles that we think
10 about as really opportunities. In an integrated model,
11 that if these things are included, we can really help dual
12 eligibles get what they're not getting today and leave our
13 system, including the individuals it's meant to serve in a
14 better place.
15 I thank you again for your time and attention on
16 this issue and look forward to the discussion.
17 MS. BLOM: Thank you, Kevin.
18 Dr. Miller?
19 * DR. MILLER: So I'd like to formally thank the
20 Chair and the Vice Chair, Melanie and Charles, for inviting
21 me, and thank you to the rest of the Commissioners and the
22 staff.

1 I'm Mark Miller. I'm the executive president of
2 Health Care at Arnold Ventures. I'll take a minute to tell
3 you who we are since I don't expect everybody knows, and
4 then I'll get into the comments here.
5 We're a philanthropy. We're dedicated to
6 exploring a range of social problems. We fund independent
7 grantees to assemble evidence. We develop policy, try and
8 drive change through the federal and state levels. We work
9 on a lot of different areas: education; criminal justice;
10 pension reform; and of course, health care.
11 My portfolio, in particular, looks at cost
12 containment, cost containment for the three actors who pay
13 for health care, taxpayers, employers, and then the
14 families and patients who pay premiums and copayments.
15 We have work going looking at the prices of
16 drugs. We have work going where we're looking at the
17 prices of hospital and physician services in the commercial
18 sector. We also look at identifying and avoiding
19 unnecessary care; and then finally, we look at managing the
20 care for complex populations, the populations with
21 disproportionate health care needs and disproportionate
22 health care costs. And it's this last one where the dual

1 eligibles enter our workstream.

2 We believe that there are three things -- and
3 there's a lot of consistency, I think, you'll hear in our
4 thinking and our policy direction with Kevin's comments.
5 We believe there are three changes that are required to
6 improve care and contain cost for the dual eligibles:
7 increase financial and delivery system integration between
8 Medicare and Medicaid, increased enrollment in integrated
9 coverage options, and then flexibility within those options
10 to design a package of services around the various dual
11 eligible population.

12 I know all of you or most of you are aware that
13 there have been attempts to improve integration between
14 Medicare and Medicaid, the dual eligibles for a long time.
15 Disproportionate spending, poor outcomes, cost shifting
16 between the states and governments, all of that has been
17 well documented; and yet despite that at this point, we
18 don't have very much enrollment in what I think most of us
19 would prefer to or think of as truly integrated plans.

20 So what I'm going to outline for you is some key
21 problems and then in turn a set of policy principles and
22 directions that we're using to guide our work and sort of

1 represents our current thinking.

2 While my comments generally apply to all dual
3 eligibles, most of the policy stuff is probably most
4 relevant to the fully dual population.

5 In both our research and in our work interviewing
6 dual eligibles as well as consumer advocates, very clear,
7 just as people say, there's not a lot of integrated plan
8 choices, and also, when people are in what they think might
9 is an integrated plan, it's not truly an integrated one.

10 There was a recent piece by ATI Advisory that
11 went through 43 different combinations for Medicare and
12 Medicaid beneficiaries to get their Medicare and Medicaid
13 services. You can find yourself in a Medicare D-SNP plan
14 that is not truly integrated with the Medicaid benefit.
15 You can find yourself in a Medicaid managed care plan
16 that's not truly integrated with your Medicare benefit.

17 It's not uncommon for services to be carved out,
18 services like behavioral health and long-term services and
19 supports.

20 There is not a single entity responsible for
21 delivering quality of care, for the financial outcomes, or
22 for administrative processes like enrollment or grievances

1 and appeals.

2 Integrated models are only available where states
3 make them available. The federal government has little
4 control, despite the fact that it has a significant share
5 of pay, for a significant share of the cost associated with
6 serving this population. We believe it's in the best
7 interest of the beneficiaries to have an integrated option
8 available for their Medicare and Medicaid coverage.

9 But we also understand that implementing these
10 programs is extremely difficult, and it largely falls on an
11 underfunded and thinly stretched state staff.

12 The dual-eligible population is not homogenous
13 and the state has to take into account a diverse set of
14 needs and perspectives as they try and develop these
15 programs, and it's not surprising that they may opt not to
16 make these plans available, or in doing so, to limit the
17 scope, either based on the population that it reaches, or
18 limit the services, or limit the geographic area that it's
19 available.

20 Another problem is that when a beneficiary is
21 making a choice, that choice set can be overwhelming, which
22 I think Kevin has already referred to, and it's not always

1 clear where to get advice. It has also been true that
2 beneficiaries have often turned to their providers. We
3 know that providers sometimes have financial interests in
4 where that beneficiary seeks care.
5 There are some instances when beneficiaries are,
6 in fact, automatically enrolled, but they are not likely to
7 be enrolled into a truly integrated option. And then this
8 is a point that Kevin made and I'm sorry that some of this
9 is redundant, states often permit integrated models that
10 are largely intended to serve the same purpose, to compete
11 side-by-side. And that just makes the market more
12 fragmented and confusing, not just for the beneficiary but
13 even for the providers and the plans trying to enter the
14 market.
15 And then there has been a lack of benefit design.
16 If you are an entity and you have some desire to do this,
17 there is a lack of benefit design flexibility and
18 flexibility to use Medicare and Medicaid dollars to fund
19 different mixes of services around the population. So in
20 all likelihood, you knew at least some of that, and in all
21 likelihood you may even know all of it.
22 So let me talk to you a little bit about how

1 we're thinking about things, and I just want to be clear
2 here. Where we are in our thinking is that we are
3 accumulating evidence and accumulating ideas, not in the
4 business now of projecting. This is our current thinking,
5 this is the current pathway, but we are still evolving.
6 We think integration is essential. The dually
7 eligible should have a fully integrated health care plan
8 available to them. The plan should include a broad range
9 of services that any dually eligible might need -- medical
10 physical benefits, behavioral health, long-term services
11 and supports. We generally view at-risk entities as the
12 vehicle to provide the integrated care for the dually
13 eligible. The at-risk entities should be held to the
14 financial outcomes that matter to the state and to the
15 federal taxpayer and to the beneficiary who does, in some
16 instances, pay premiums.
17 The plan should be held responsible for the care
18 outcomes that matter to the dual eligible and to their
19 family, which are things like reducing hospitalizations,
20 reducing emergency room use, reduced institutional long-
21 term and post-acute care, reduced mortality, and
22 maintaining function and functional status as long as

1 possible.

2 Alongside these responsibilities, the plan should
3 be given flexibility to use the dollars that they receive,
4 that they and their providers believe will lead to better
5 outcomes. Within the context of the capitated payment,
6 this can include providing services beyond the basic
7 Medicare and Medicaid services that I mentioned, and
8 include services that address social needs, like food,
9 transportation, or home-based long-term services and
10 supports, as long as it is viewed that that would improve
11 their outcome or reduce cost in the delivery of the care.

12 The implicit contract between state and federal
13 payers is that these at-risk entities should be subject to
14 fiscal pressure, but they also should be paid appropriately
15 for the level of risk that they are taking on with these
16 populations.

17 As mentioned, states decide whether to pursue
18 integrated models. At a minimum, they would need
19 incentives, both positive and negative incentives, to move
20 them to integration, but it may very well be that in the
21 end the states have to be required to take on and offer a
22 truly integrated model.

1 If the state is not able to or unwilling, we
2 think that a federal fallback should be contemplated to
3 assure that the dual-eligible beneficiary has an integrated
4 plan available to them, either because the state has
5 stepped up and taken it or the federal government has come
6 behind the state and taken the task on.
7 This is a point Kevin made. In moving the states
8 to offer integrated plans, we believe that the number of
9 different kinds of plans should be narrowed, and to be
10 clear -- and I think Kevin already said this -- we're not
11 trying to limit the choice for the beneficiary but the
12 different platforms and different models that are running
13 side by side in the state. That probably leads you to a
14 truly integrated DNSP model or a truly integrated MMP model
15 as the most likely outcome.
16 We do think that more needs to be done to support
17 the beneficiary's decision-making process, both their
18 first-time decision and subsequent decisions, and we also
19 think that from a policy perspective we should consider
20 automatic enrollment into an integrated plan with the
21 ability to opt out.
22 And then, as we have said repeatedly -- and this

1 is very difficult to overcome with two different programs -
2 - alignment on eligibility, enrollment, marketing,
3 grievance, and appeals processes just complicates. Without
4 alignment it just complicates the beneficiary's life.
5 I'm going to wrap up here, but I do want to make
6 another point about evidence. We argue that the existing
7 system falls short of what the dual eligibles need for
8 their care, and it needs to be improved. At the same time,
9 we believe that the evidence that is available is
10 directional but not necessarily definitive.
11 The best evidence today comes from the financial
12 alignment demonstrations, and it is incomplete because it
13 uses Medicare data but does not have access to Medicaid
14 data. We absolutely believe that that demonstration and
15 other integrated models continue and need to be studied.
16 But in order to better serve Medicare and
17 Medicaid beneficiaries, this is the environment that we're
18 trying to create. We wanted integrated plans that provide
19 basic Medicare and Medicaid benefits. In the capitated
20 environment, give those plans flexibility to design the
21 service package and to add other social services. Hold the
22 plans to measurable outcomes, which I've named earlier, and

1 then objectively study the outcomes in terms of cost and
2 quality and disseminate the positive results.
3 We know that the state, CMS, plans, providers,
4 and beneficiaries all need this evidence to move forward.
5 At Arnold Ventures we're actively supporting the
6 accumulation of the evidence on integrated MMP models, and
7 we are actively supporting technical assistance to the
8 states in order to help them redesign those.
9 We are working with organizations like Community
10 Catalyst, Urban Institute, Bipartisan Policy Center, and
11 the Center for Health Care Strategies. We hope that the
12 work we produce will be a resource to the Congress, to CMS,
13 and to organizations like MACPAC and MedPAC. Our website
14 has a bunch of information. If you'd really like to
15 discuss this, the person to get in touch with is Arielle
16 Mir, who is the vice president at Arnold Ventures, who
17 handles this portfolio of work for us.
18 I really would like to thank you for asking me to
19 speak at this, and I look forward to your questions.
20 MS. BLOM: Great. Thank you, Dr. Miller.
21 Charlene?
22 * MS. FRIZZERA: Well, thanks again for the

1 invitation. Just like Mark and Kevin, I'm super happy to
2 be here today to talk about the work we've been doing at
3 Leavitt Partners on the dual coalition. You know, in my 30
4 years at CMS, dual eligible was an issue for 30 years. We
5 always knew it was a problem. We didn't do a lot of work
6 on integrating duals until Melanie's group was formed -- I
7 call it Melanie's group because it's the easiest to
8 identify by. So Melanie's group was formed and she did a
9 lot to bring some of the issues for dual eligibles forward.
10 When Melanie left CMS, she and I were at
11 breakfast and we were just talking about what it was like
12 to be leaving, and we thought, well, it would really be
13 nice if we could continue to do some work on the dual
14 eligibility issues that have been longstanding. And while
15 there was some improvement made, as Mark and Kevin have
16 both identified, there are still issues to be addressed.
17 So we approached Leavitt Partners to see if they
18 would be interested in putting together a coalition with us
19 to talk about how to re-engineer the dual eligible health
20 care delivery system in this country. Our idea was pretty
21 bold. It's really to create a totally new, integrated,
22 health care delivery system that builds off of some of the

1 lessons that we've already learned in some of the programs
2 that already exist.
3 So we started in 2017, and we put together a
4 group of multisector stakeholders, and we have a wide range
5 of members. We have beneficiary advocates, managed care
6 plans, provider system, state advisors, and behavioral
7 health and social support services organizations. The idea
8 was to develop a fully integrated system that combined
9 Medicare and Medicaid services, currently separated into
10 two programs, into one fully integrated program.
11 So we developed a framework on how we were going
12 to do that, and in developing the framework we came up with
13 six principles that we thought were really important to
14 remind ourselves of as we continued to develop some of the
15 details out around the program. One was supporting
16 beneficiaries to live as fully as possible; ensuring
17 comprehensive integration, which you heard both Mark and
18 Kevin speak of; promoting state-federal partnerships;
19 ensuring robust reporting accountability and continuous
20 quality improvement; aligning incentives for value-based
21 care; and promoting consumer engagement.
22 So we took our principles and we put together a

1 framework, and we've started talking to not only obviously
2 the coalition members, who their input and expertise is
3 helping us develop the model, but we've had conservations
4 with over 40 different stakeholders across the country --
5 health care community, including health experts, providers,
6 advocates, associations, foundations, Medicaid programs.
7 So we've really tried to reach out to as many diverse
8 stakeholders as we can to get a lot of their views,
9 opinions, and information on how we can put together a
10 program that we think can actually work.
11 Our program really does build on the learnings of
12 the current efforts, and we are trying to advance the goals
13 of truly integrating care for the duals by creating this
14 new program that we called "Title 18.5." So it's not
15 Medicare. It's not Medicaid. It's really a totally new
16 title.
17 One of the things that we needed to address in
18 the program is, you know, fragmentation that still exists.
19 So in our model we want to make sure that we address the
20 fragmented beneficiary experience that exists today,
21 limited state incentives, as Mark mentioned. You know, you
22 do need incentives in here so that the federal-state

1 partnership actually works, and we have the right
2 incentives to make it work the right way for the dual
3 eligible population.
4 Today there's still the two-contract
5 fragmentation that we obviously would not have under this
6 model. Siloed funding, you know, Medicare and Medicaid
7 funding pools. What our model tries to do is to combine
8 that into one integrated funding source, so it's no longer
9 two separate ones. We would have to address the separate
10 marketing materials that exist today and the separate
11 enrollment that exists today.
12 So those are all some of the current
13 fragmentations that we used in determining how to develop
14 this model.
15 We have five areas that we've bucketed our
16 program into: program administration, eligibility,
17 benefits, beneficiary protections, and financing. And I'm
18 going to talk briefly about some of the principles under
19 each of those areas.
20 In program administration, we had a lot of
21 discussion about various models, and the model we landed on
22 was that this would be an option of the state, so the state

1 would have to select to participate in Title 18.5. It's
2 different than a demo, though, in the sense that once you
3 pick Title 18.5 you can't go back. So you don't really get
4 to say, "Well, I'll do Title 18.5 for a few years, but then
5 if I don't like it, I'll revert." Once a state picks Title
6 18.5, it becomes the permanent program for the dual
7 eligible population.

8 We see this working through -- obviously it would
9 be by the Secretary, but through the current Federal
10 Coordinated Health Care Office. They would be the CMS
11 component that would manage and be the federal oversight
12 authority for the program.

13 We would have a minimum set of federal standards.
14 So what we want to make sure, in this program, is that no
15 beneficiary is harmed in terms of care or delivery services
16 that they need. So this program will be operated, what we
17 feel meets a minimum set of federal standards, including
18 things like ensuring there is access to care, quality of
19 care, beneficiary protections, marketing and enrollment
20 standards, grievance and appeals, procurement. So we want
21 to continue all of those important standards that exist
22 today to protect beneficiaries in this program. However,

1 they would be obviously administered different in a state-
2 federal partnership program.
3 We acknowledge that we do need enhanced funding
4 in the beginning for states, to assist them with staff if
5 they need it, IT planning, evaluating the program, even
6 launching the options. So we would include some provisions
7 for some enhanced funding for those services to continue.
8 And the program would be delivered at the state level
9 through capitated managed care plans or at-risk value-based
10 alternatives, but they have to be a fully integrated
11 delivery system.
12 On eligibility standards, so we propose that this
13 model would be for full-benefit duals only. We wouldn't
14 have any partial duals in this program. And there would be
15 no carve-outs of the population, so all full-benefit duals
16 in a state would participate in this program, and that we
17 would have a standard floor for income and assets, since in
18 eligibility that's a pretty important issue in terms of who
19 is eligible and who isn't. So we would design a standard
20 floor for income and assets.
21 The one thing I do want to mention is that in
22 this program we do believe it's important for beneficiaries

1 to still have the choice to opt out of this program if they
2 don't want to use it. However, the choice is to opt out
3 into Medicare fee-for-service, and they would have to do a
4 Medicaid-only program in a state. So a beneficiary would
5 either be in this fully integrated program or they would be
6 in a fee-for-service Medicare program and a Medicaid-only
7 program in a state.

8 The next area we tackled were benefit standards.
9 As I said earlier, we want to make sure that we protect the
10 core benefit package that exists today. So the core
11 benefit package would address all medical, behavioral,
12 long-term care, and social needs. The core package would
13 include everything that exists today in Medicare A, B, and
14 D services, all mandatory Medicaid services, and any
15 additional behavioral health, social supportive services
16 that are provided in lieu of current services, to make sure
17 that we have the flexibility that Kevin mentioned in order
18 to achieve person-centered outcomes in what we hope will be
19 the most cost-effective settings.

20 There will be a maintenance of effort for states
21 to exist at current beneficiary level services, and there
22 will be no benefit or services carve-outs. So again, in

1 order to make it fully integrated there are no carve-outs
2 of services. Everything is included in this program.
3 The next bucket is beneficiary protections. We
4 are proposing that each state would have to have an
5 independent enrollment broker to assist beneficiaries in
6 understanding this program and helping them make good
7 choices. States will be permitted to use existing
8 enrollment flexibilities that exist today, for example,
9 default enrollment. Each state will have to have a
10 dedicated 18.5 ombudsman program, they will have to have a
11 beneficiary advisory council, and we are proposing that
12 there would be a continuity of care provision for the first
13 six months of the individual's enrollment in Title 18.5,
14 again, trying to make sure that the benefits that they
15 receive today are still available.
16 However, the one thing that's important about the
17 benefits in this program, we are proposing that states
18 really do need the flexibility to work with the
19 administering entity to make sure that, to Kevin's point,
20 beneficiaries get what they need. Core benefits exist, but
21 we want a lot of flexibility to be in this program so that
22 there can be specific plans of care developed for

1 beneficiaries that provide the services they need in order
2 to get quality care from the health care delivery system.
3 And then the last program is financing. You
4 know, the current program, separate funding comes from
5 Medicare and Medicaid. In Title 18, we would create a
6 Title 18.5 funding allocation, and it would combine the
7 expenditures that are currently made from Medicare and Part
8 A, B, and D side, the federal share of the Medicaid
9 expenditures, the state share of the Medicaid expenditures
10 including the Part D. We will take all of these
11 expenditures and put them into one single funding stream.
12 There no longer will be a Medicare or a Medicaid federal
13 contribution, a state and federal contribution. It will be
14 one contribution from a pool of money.
15 The difference is going to be how that money gets
16 disbursed and divided between the state and the federal
17 government. So we evaluated a ton of models, trying to
18 figure out what model we thought would work best in this
19 new fully integrated system, and we came up with what we're
20 calling the expenditure-based model.
21 And basically what this model does, in lieu of a
22 federal matching assistance percentage that exists today,

1 we would have -- expenditures would go into -- so a state
2 would identify what their expenditures are for this
3 program. The federal government would contribute what
4 we're calling their weighted contribution in expenditures,
5 and the state would contribute their weighted
6 contributions. The weighted contributions are calculated
7 by taking the total expenditures paid by the federal
8 government, which is their Medicare expenditures and the
9 federal share of Medicaid expenditures. We determine what
10 that percentage is of the total. We determine what the
11 state Medicaid expenditures are, and then those are the
12 weighted contributions.

13 So an easy example is if we had $100 in
14 expenditures and when we add the federal Medicare and the
15 federal Medicaid together, that's $80. The federal
16 government would pay 80 percent of the expenditures, and
17 the state would pay 20 percent of the expenditures. And we
18 feel that the weighted contribution model allows the
19 federal government and the state government to really
20 contribute what they have been contributing in the past in
21 terms of total dollars to the program.

22 What's interesting to note about the financing is

1 it is based on actual expenditures. So the state would
2 report the actual expenditures, and the federal government
3 would send their contribution based on those actual
4 expenditures.
5 We do have some incentives in the program, so
6 we're working on some adjustments to the expenditures for
7 the increases and decreases in expenditures to ensure that
8 those are appropriate increases and appropriate decreases
9 and some incentives to not increase above what we were
10 calling "inappropriate increases." And then to the degree
11 there were decreases, there are some incentives for the
12 state to get a higher federal match. However, we believe
13 that if the expenditures decrease below a certain
14 percentage, we do want some of those savings to be
15 reinvested back into the program.
16 So the federal and state government get to keep
17 some of the savings, but if it reaches a threshold that's
18 higher than what we believe is the appropriate savings that
19 the budgets can keep, we will require some reinvestment
20 back into the program. And we're working on some
21 principles of what we think that reinvestment should be,
22 how they should spend those reinvestment dollars.

1 So we're continuing to work to build out the 18 ½
2 program. You know, we still have a lot of details to work
3 out, but these are our proposed overall framework for the
4 program, and looking forward to any questions or comments
5 you may have about what we're trying to do. So thank you
6 for listening today. I appreciate it.
7 CHAIR BELLA: Thank you all very much. Kirstin,
8 did you have anything to add before we go to Commissioner
9 comments?
10 MS. BLOM: No. Thanks, Melanie.
11 CHAIR BELLA: Okay. Wonderful. I want to thank
12 the three of you. I also want to just instill
13 transparency, as Charlene mentioned, I've had the privilege
14 to work on the duals coalition as well. The hat I'm
15 wearing today is lover of dual-eligible issues and MACPAC
16 Chair. It's not as a participant in the Leavitt group, but
17 I did want to be transparent about my involvement in that
18 process.
19 With that, we are going to open it up for
20 Commissioner comments. Brian, you can kick us off. Thank
21 you. You're on mute, Brian.
22 COMMISSIONER BURWELL: Thank you, Mark, Charlene,

1 and Kevin. Those were great presentations. We really
2 appreciate your time.
3 I feel like this issue is moving more into a
4 solution stage than just an identification of current
5 problems and demonstration, so I'm really glad to see that
6 people are starting to talk about real design issues for a
7 unified program. I have a two-part -- I have design
8 questions. Originally, I had four, but I've combined them
9 into two, and I just -- those representing organizations
10 like Mark and Charlene may not be comfortable with giving
11 their answers as personal opinions.
12 The first one is: Do you think this new program
13 should be voluntary or mandatory to the states? There are
14 those who think that every dual eligible should be
15 automatically enrolled in this program when they become a
16 dual. But there's also the recognition that some states
17 are way further ahead in terms of developing integrated
18 care models than others, and it's only those states that
19 have prior experience and knowledge that should move
20 forward with this new program. And other states, for a
21 variety of reasons, could opt out.
22 The second is: If states do elect to move ahead

1 with this program -- and some of you have touched on this -
2 - should enrollment in this program be mandatory for all
3 duals or voluntary? A number of you have said there should
4 be an opt-out provision where people go back to Medicare
5 fee-for-service? Why do we think that Medicare fee-for-
6 service should be retained as an option, if you so believe?
7 If we maintain, if we develop standards that are strong
8 enough and enforced enough to only have participating plans
9 that really provide quality services, and the existing
10 system is not providing the kind of care that duals need,
11 why should there still be a fee-for-service option? So
12 that's kind of the two-part first question.

13 The second question has to do with who drives the
14 -- I call it the "Who drives the bus?" question. The
15 current models that are out there between Medicare and
16 Medicaid have a two-part management and administration
17 infrastructure that's part of the responsibility for
18 running these programs, and obviously the states do, too.
19 Charlene was talking about a financing model in which the
20 balance of financing would be more heavily through the
21 federal government given its role in financing Medicaid.
22 If it's 80-20 federal, obviously CMS would want to take the

1 lead role in program oversight. However, among the dual
2 population and those who have served this population for a
3 long time, many prefer that the states drive the bus just
4 because they have the experience -- states have the
5 experience with managing long-term services and supports,
6 which is a major component of any dual-eligible program,
7 and a fear that if it stays within the Medicaid -- the
8 federal Medicare framework, this will be an overly
9 medicalized model as opposed to more of a social model that
10 duals need.
11 So if you can answer, give quick answers to those
12 two-part questions -- they're kind of hard questions, but I
13 think they're important ones.
14 MS. FRIZZERA: Okay. Well, yeah, I'll start. So
15 there's a lot of questions, so I hope I can answer them
16 all. Let me start with the last one first, though, because
17 I think that's really very important, who drives the bus.
18 So in the model that we're proposing, the states drive the
19 bus, and the idea behind that is what you were sort of
20 mentioning, Brian, and it is the idea that the states
21 really know these populations, right? They do more of the
22 long-term support services. They do more of the community

1 services. And the concept that states have told us over
2 the years and time and time again that if you let us manage
3 that Medicare population, we can do a better job because we
4 believe that we can -- we are, in fact, spending more on
5 long-term support services; we are, in fact, decreasing
6 hospitalizations and Medicare expenditures.
7 So our model is really based on that premise that
8 the states should drive the bus. However, having said
9 that, the federal government obviously would be a partner,
10 and there would be federal oversight, and I didn't mention,
11 which I should have, a federal government and a state
12 partnership readiness review. So to one of your other
13 questions, you know, states just don't come in and apply
14 and the federal government says okay. There would be a
15 readiness review to ensure that, in fact, the state is
16 ready and does have all the tools necessary to manage the
17 program.
18 So we don't see every state in the country taking
19 this program. We do feel that the states who feel that
20 they can really make a difference in managing those dual
21 eligibles, to both Mark and Kevin's point, in a fully
22 integrated system. And part of your question was, so why

1 would -- you know, if duals like it, why do you need a
2 fallback or, you know, why would you make them participate
3 in the program? We believe that if we design this program
4 the right way, this will be the fully integrated system
5 that both Mark and Kevin talked about, and we feel that
6 this program then would be the choice of duals. That's
7 why, while we're not making it mandatory -- we're making it
8 mandatory that you have to be in this integrated program
9 because we don't want a bunch of integrated programs in a
10 state that aren't integrated, number one. Right? We don't
11 have a lot of choices that are integrated. And there will
12 be choice in the state for which integrated program you
13 pick. But we feel like we're giving them the choice of
14 integration or fee-for-service. There will be choices
15 within that integration of plans and entities for
16 administering it. So we feel like we're not really
17 mandating -- we're not forcing them into a program they
18 don't want. We're changing to benefit the dual-eligible
19 beneficiaries for a fully integrated model that will
20 provide better care for them, which we, of course, hope
21 everybody will want to be in.
22 On the voluntary versus mandatory for the state

1 and federal government, we talked a lot about that in the
2 beginning of the coalition, and we just felt that given
3 some of the things I've been saying that, you know, we do
4 think that the state probably is a good way -- in a good
5 place to be the driver of this program because of, you
6 know, their experience, their interaction. And, again, you
7 know, we feel they can administer the entities more
8 locally. They know their beneficiaries better and, you
9 know, even though Medicare -- we talk about Medicare being
10 a national program, it's not really, right? Medicare is
11 administered differently across the country depending on
12 the geography in which you live, the providers that are
13 there, the services that even exist. So for those reasons,
14 we really thought that having this drive the train and not
15 making it a federal mandatory program was the best option
16 for us to go forward within the model that we've designed.
17 I think that answered -- most of your questions?
18 COMMISSIONER BURWELL: Good. Thank you.
19 MR. PRINDIVILLE: I thought that was great,
20 Charlene, and I guess I was talking a little bit on the
21 question, Brian, that you had specifically about choice for
22 the beneficiary. We certainly believe it's important that

1 this continues to be a beneficiary choice whether to be in
2 these programs or not, our experiences to date on a wide
3 variety of health care issues, so that beneficiaries really
4 want to be in control of that choice. Not having control
5 of that choice creates bad feelings about the program
6 generally.

7 I think if you think about what the goals are
8 around enrollment, I see two. One is to make sure people
9 are in a good program, and we think the beneficiary's in
10 the best position to make that choice; and that if they're
11 the ones that make that choice, their investment in the
12 program will be real. They'll be empowered; they'll be
13 committed to the program.

14 Frankly, many people have a system that's working
15 for them, and so introducing disruption into what they have
16 today is a disruption. It's a significant transition. We
17 can be convinced broadly that the new system is a better
18 one. But for each person it's a significant transition,
19 and so we think it's critical that they have ownership of
20 that choice and own that.

21 Another goal of enrollment is to build a program
22 that's sustainable, and we think you can build a

1 sustainable program while also having choice for the
2 beneficiary. Forty percent of duals are in some form of
3 Medicare Advantage today, and so it's not as if duals are
4 allergic to managed choices. And to Charlene's point, if
5 you build a strong program, then you can have sufficient
6 enrollment to get them in. The biggest impediment we've
7 seen to -- not enrollment -- to build strong integrated
8 programs is the issue of competition with other managed
9 models that are going and actively recruiting duals into
10 models that aren't integrated. So if we solve that
11 problem, we think we can have a robust enough enrollment
12 that's led by consumer choice to have a sustainable
13 program, and then also the choice meets the other goal of
14 really having the beneficiary be in control of their own
15 choices and carrier as we all would want to be.
16 DR. MILLER: So I'll take a shot at it. So I
17 think, just to make sure I follow, do states and does the
18 beneficiary have to be in, who's driving the bus is sort of
19 the road map here. And, also, I should say to your point,
20 like, you know, comfort in responding to this, I'm speaking
21 for myself. We're a philanthropy. I don't know that we're
22 taking positions here, but I will answer your question

1 pretty directly from my own point of view.

2 What we're trying to do is kind of recognize on
3 the ground that there is a split system here. There are
4 arguments on both sides of the street of like, you know,
5 the level of financial involvement on the side of the
6 federal government, you know, the states arguing the
7 expertise on the LTSS side of things, but there's also
8 significant variation across the states in how they
9 approach, you know, Medicaid in general and these
10 populations specifically.

11 So we want to create a situation where the state
12 can choose to offer an integrated plan. So when I was
13 going through my comments, which may have been too quick
14 and I apologize, is to say you probably have to get -- you
15 can incent, and we can talk about incentive. But you
16 probably have to get to where there's a requirement to
17 offer an integrated plan, but the requirement works like
18 this: It's to the state. You can step up, and you can do
19 it. These are the conditions that have to be in -- you
20 know, the key things that we've gone through here, an
21 integrated plan that fully pulls the two benefits together
22 through the managed care plan. Or if as a state you don't

1 want to do it, then the federal government will do it.
2 And so one of the reasons in doing that is there
3 are some states who do want to push out into this
4 population if you do want to construct programs. There are
5 other states who are looking at this as a gigantic risk and
6 complication and cost and may not want to. And so our
7 point is if the population picks an option in any state
8 they happen to live in, that they have -- I'm sorry -- that
9 they have an option in any state that they live in.
10 So the notion in trying to answer Brian's plan is
11 I guess no, the state doesn't have to come in, but the idea
12 is there's a requirement; you can make that requirement by
13 coming in or asking the federal government to take it off
14 your hands.
15 Second point on the beneficiaries, and I think
16 this is mostly what everybody is saying, but I'm going to
17 give it a little bit more of a fine tune, that the
18 beneficiary is automatically enrolled in an integrated
19 plan. The beneficiary can opt out. They can opt out into
20 another plan, which will give you some competition among
21 plans, and/or fee-for-service. I think probably, if we're
22 thinking about it, the notion of getting access to the

1 social wrap-around services, which at least in our model
2 would come from a capitated way in which the provider has
3 decided if I offer this social service, this is a better
4 outcome for the beneficiary, that those services are
5 available there and would not be as readily available in
6 the fee-for-service setting. How you administer them and
7 how you control them becomes more complex.
8 But the answer is that the beneficiary
9 automatically goes in, can opt out. We would probably --
10 again, Mark would probably think that they can go to a plan
11 or they can go to fee-for-service.
12 Driving the bus, in some ways, you know, part of
13 my answer has already addressed this. In our idea, you
14 know, just talking here, Mark's opinion, that type of
15 thing, you know, there's one situation where the state
16 says, "I want to step up and do this," and there's another
17 situation where the federal -- they default to the federal
18 government. It may be a topic for a different
19 conversation, but I'm also happy to comment, but I don't
20 want to monopolize a lot more time here. I think if you
21 think in terms of who is positioned to respond in a
22 countercyclical way, what often happens in a state

1 situation where Medicaid needs arise just at the time when
2 the revenues might not be there for the state, the federal
3 government in theory should be in a position to better
4 counteract that, the COVID pandemic being a really obvious
5 example.

6 Now, the federal government probably should have
7 entered the COVID crisis not as deeply as it was to begin
8 with, but the notion that the federal government steps up
9 when something is out of kilter, I think the federal
10 government is better positioned to do that than a lot of
11 states are. And to the extent, you know, the Medicaid
12 costs are kind of countercyclical to, you know, the
13 economics of a given state, there's something to be argued
14 for a federal backstop.

15 CHAIR BELLA: Thank you all.

16 COMMISSIONER BURWELL: Thank you.

17 CHAIR BELLA: Very helpful to get those comments
18 out.

19 Darin, then Toby, then Chuck -- and, Mike, did I
20 see your hand? -- and Kit. Wonderful. Darin?

21 COMMISSIONER GORDON: Thank you for all of your
22 presentations, very, very helpful.

1 I was glad to see a great deal of alignment,
2 which is always encouraging, given some of the diverse
3 perspectives.
4 Charlene, something you brought up made me
5 wonder, as we think about integration. You were talking
6 about potential one-time investments in this Title 18.5 to
7 help get this program launched, but I'm even backing up a
8 little bit, short of something that robust, which I always
9 like folks thinking about the larger substantial steps to
10 fix these problems, though not discounting that.
11 But this is one of those subjects that I find
12 that states struggle on mightily because they don't fully
13 appreciate and understand the Medicare side of the
14 business, and so Mark had made a comment about states
15 talking about how complicated it is. I mean, they
16 typically don't have Medicare experts in the house trying
17 to understand the variety of different options on the
18 Medicare side. It isn't overly simplified, by no means.
19 I would like to hear the perspective of the group
20 of things that you think could work or might be helpful and
21 at least enabling states to have some resources to be able
22 to even evaluate these different choices, whether it's

1 Title 18.5 or some kind of alignment model or an MMP,
2 whatever the case may be. I'd like to hear the group's
3 perspective on that. I think that's a big hurdle that
4 we're all stuck on right now to really get this moving in
5 this country.
6 MS. FRIZZERA: Yeah. So I'll start on the
7 integrated model.
8 So what's interesting, I think, when we put this
9 all into one bucket, right into one pot of money and one
10 program, the federal government has as much incentive as
11 this state government does to make this work. I mean, it's
12 the majority of the federal dollars are actually going into
13 the program.
14 So our conversations with states, Darin, have
15 been exactly what you've been saying. They don't know. We
16 said, "Well, where did you get the information?" and they
17 don't know.
18 So one of the details that we're still trying to
19 work on is how did we get what the cost is, the Medicare
20 program's cost in administering their program for duals
21 would be.
22 So if I just talk about administrative claiming,

1 right, I'll just use that as an example. So administrative
2 claiming, if you look at all of the administrative claiming
3 provisions that existed for Medicaid, they are not
4 appropriate administrative claiming for this integrated
5 model. So we're going to have to take a look at that and
6 talk to the Medicare program and say, "So what are your
7 administrative costs that now need to be subsumed by this
8 program which the state is going to administer?"
9 So you did hit on one of the issues we're still
10 trying to figure out, that we're having conversations with
11 states, and we will have them with Medicare. Where do we
12 get that information? What does it look like so that we
13 can figure out what those dollars need to be? And to your
14 point, so that the states understand what it means to
15 administer the program for those Medicare beneficiaries.
16 And I'll take it one step further to say that we
17 also are working on what information the states need to
18 even know what the care is on the Medicare side for these
19 populations, because this model really works on this
20 concept that I mentioned earlier where states say, "We
21 spend a lot of money on long-term support services, and we
22 can save Medicare a lot of money. We don't have budgets to

1 increase those services. If you gave us money to increase
2 those services, we could save Medicare services." So
3 there's a whole collection of issues that we're addressing
4 around Medicare data, not just on how to administer the
5 program, but even the Medicare data on what kinds of
6 services do Medicare beneficiaries get today in your
7 states, so that they can design a program where they make
8 sure they can take advantage of both of those programs and
9 create the efficiencies that are needed to provide better
10 care and make it more cost effective.

11 COMMISSIONER GORDON: I think that's a key
12 component.

13 CHAIR BELLA: Mark, did you want to comment on
14 that?

15 DR. MILLER: I almost heard your question -- and
16 I may have missed it, and if I did, I'll just back off and
17 be done. I almost heard your question of how do the states
18 get resources so that they can come up to speed, even kind
19 of thinking about how to approach this. My main answer,
20 now that Melanie gave me the opportunity, is I don't know.

21 One thing that we are trying to do as a
22 philanthropy is actually fund organizations to be available

1 to the states, so that they can think through the designs
2 of these programs and then also be able to take something
3 forward if they're going to approach the CMS in order to
4 put some other operation in place.

5 My mind goes to things, to certain organizations
6 where you could try and build expertise into them, where
7 Medicaid directors come together, that type of thing, if
8 that was your question.

9 To the other comments on the administrative cost
10 of this, I mean, part of the other reason that I think our
11 thinking gets driven to a federal fallback is, at this
12 point, you also have 50 different administrative costs that
13 you're kind of replicating from state to state, and so
14 there's also a question of whether that is the best way to
15 be thinking about how to spend a dollar, even if you end up
16 understanding how Medicare and Medicaid work separately as
17 administrative operations.

18 CHAIR BELLA: Kevin, did you want to comment?

19 MR. PRINDIVILLE: Yeah. I think it's a really
20 critical point. It's certainly something we've seen in our
21 advocacy, that these programs are completely silent in
22 every possible way. Even in the advocacy world, there's

1 expertise in Medicaid and experts in Medicare and few that
2 exist together at the intersection, and that's certainly
3 true in states too. And often we see that Medicare
4 expertise missing entirely, and so they end up pretty
5 reliant on health plans to inform them. And I think that's
6 not the ideal situation. Ideally, you'd have state
7 programs that have more internal expertise.
8 I think you could build that. I remember at one
9 point in the Leavitt conversation, we were talking about
10 some states that have developed that internal capacity, at
11 least a little bit, and you could create special funding
12 opportunities for states to develop that internal
13 expertise.
14 The savings that we're talking about in these
15 models would also justify some state expense, to add a
16 couple staff and develop expertise. The savings here are
17 significant enough, hopefully, that that is a minimal
18 investment to get to a better program in savings for the
19 states.
20 This is also an issue that's comes up. I'm
21 working in California where the governor is working to
22 create a master plan for aging, and I was part of a

1 stakeholder advisory committee. And this concept came up a
2 lot as well, even thinking beyond the dual population, but
3 to the Medicare-only population in a state and how the
4 rising numbers of Medicare-only beneficiaries in states
5 connect to broader health system and long-term care
6 problems and the challenges that states are going to
7 experience.
8 So having Medicare expertise somewhere in state
9 government is going to be increasingly important. So I
10 think that there's an additional benefit of adding this
11 expertise for a state as the state is thinking about
12 solving long-term care challenges. If nobody in the state
13 really has a handle or understanding of what Medicare does
14 and doesn't do, that's an impediment to designing of the
15 state solution.
16 So I think state investment in this area, even if
17 it's their own dollars, is going to hopefully be beneficial
18 for duals and for the broader aging and disability
19 population in the state.
20 CHAIR BELLA: Well, as Darin knows, but just so
21 Kevin and Charlene and Mark know, the Commission made a
22 recommendation to Congress in its June report to provide

1 funding to states to build capacity, particularly on the
2 Medicare side, as we had heard from states that have been
3 more successful in this realm if they do have dedicated
4 resources on that front. So that is something, I think,
5 we'll continue to reinforce as we hear back.
6 Let me ask the panel. We are supposed to be done
7 with this panel in five minutes. We have four people who
8 I'm guessing will have longer questions than five minutes.
9 Do you guys have any flexibility to stay a few minutes
10 over?
11 MS. FRIZZERA: Yeah, I can stay.
12 CHAIR BELLA: Okay. Well, even though they are
13 generous enough to stay, I will ask us all to be sort of
14 succinct with our questions.
15 So Toby, then Chuck, then Martha, then Kit.
16 COMMISSIONER DOUGLAS: Great to see you all, and
17 thanks for presenting.
18 My question is really around the siloed nature.
19 When you talk about siloes, there's also on the Medicaid
20 all the carveouts, and as we think about integration,
21 whether it's in Title 18.5 or just in the current state,
22 how we work on bringing that integration for those carved-

1 out benefits, they vary state by state.
2 CHAIR BELLA: Kevin, do you want to start on that
3 one?
4 MR. PRINDIVILLE: Well, I think the intent is to
5 get away from the carveouts, and then it always gets much
6 more tricky, as you know, Toby, when you start thinking
7 about a particular program and how each state is so
8 different, and both how that impacts the beneficiary,
9 there's certain things that beneficiaries don't want carved
10 out because they like programs the way they're operating
11 today and worry about when you integrate them that it
12 changes who's making decisions about care and coverage and
13 what networks are providing the care, so there's risk for
14 the beneficiary.
15 And we've also seen reluctance from the
16 integrated entities that they're comfortable integrating
17 three or four parts of the benefit package, but they have
18 no experience or desire to get into trickier ones.
19 Usually, it's behavioral health or oral health, or for
20 consumers, it's concern about integrating pieces of the
21 LTSS system that are maybe more consumer-directed.
22 So I think the goal is to get to fewer carveouts.

1 The reality is difficult, and so I think for us, it's a
2 little bit of, you know, don't let perfect be the enemy of
3 the good. How can we move towards fewer carveouts, but
4 also make progress and not try to jump too far ahead in
5 ways that create either disincentives for people to
6 participate, whether beneficiaries or providers in the
7 plans?
8 CHAIR BELLA: Mark or Charlene, do you have a
9 comment on this one?
10 DR. MILLER: In the interest of time, no.
11 MS. FRIZZERA: Yeah, just a quick comment. I
12 would say, Toby, obviously, for our program, we're thinking
13 big. So in order for us to really get a person-centered
14 and a specific plan of care for each beneficiary, the way
15 the program really works most efficiently is to have
16 everything carved in.
17 The politics of states, obviously, are going to
18 be an issue to be addressed, but if we're just designing
19 the model, when you look at the model, we feel like it's
20 pretty important that everything needs to be integrated
21 into that model in order for it to work the way the Title
22 18.5 is designed.

1 CHAIR BELLA: Toby is thinking, "Thank God, I
2 don't have to do that in California."
3 Okay. Chuck and then Martha and then Kit.
4 VICE CHAIR MILLIGAN: Thank you all.
5 I'm in a similar boat of having a lot of
6 questions, and I'll try to constrain in the interest of
7 time. I appreciate the provocative thoughts about this.
8 One of the questions I want to start with is
9 around comments, Kevin, that you and Mark both made about
10 honoring choice but somewhat limiting choice to more
11 integrated models. Part of what I heard in that is maybe
12 one model per county, per region, so that there isn't as
13 much confusion. I'm curious about what that means for two
14 things. One is we haven't talked about PACE in this
15 conversation. PACE is another model. Would there be a
16 problem from your perspectives of having PACE in the same
17 region as a FIDE SNP model or an MMP model?
18 And then the second element of that is, is it
19 correct to interpret those comments to mean that, from your
20 point of view, dual eligibles should not be enrolled in
21 MAPD, period? Like way beyond kind of the look-alike
22 prohibitions that CMS is moving toward, but that

1 integration doesn't get achieved if a dual eligible is in
2 an MA-PD or I-SNP or C-SNP, all of those models.
3 So I'm trying to frame it as almost like a yes or
4 no to kind of help move the time along here, but is it like
5 one model per area and that duals would not have those
6 options available to them?
7 CHAIR BELLA: All right. Charlene touched on
8 that too. Let's go Mark, then Kevin, then Charlene,
9 please.
10 DR. MILLER: Okay. So what I would say is it may
11 mean that there is a single model available, but it doesn't
12 mean that there's single choice available. So it might be
13 that a state says -- and there are some states that we've
14 talked to that said, "I want a D-SNP-based platform. I
15 want to make sure that the Medicaid is integrated into
16 that," and another state may work off of an MMP platform
17 and integrate Medicare into that. But there could be
18 competing plans in a county which the beneficiary could
19 choose from. So depending what you meant by one model
20 versus one plan, I just wanted to make that distinction.
21 I think the issue we have is you have a D-SNP.
22 Then you have an MMP. Then you have an I-SNP. And then it

1 becomes difficult.

2 I think PACE is kind of different. I don't know

3 that we would say no to that, but that's kind of a

4 different animal out there. And that's my best shot at it

5 in the time limit that we have.

6 CHAIR BELLA: Thank you.

7 MR. PRINDIVILLE: That's our view as well,

8 including that PACE -- the way we've been thinking about it

9 is that PACE would somehow fit into the model that the

10 state has fixed as a special part of integrated care.

11 But to your question about whether other MA-PDs

12 would be enrolled in options for duals, our view is no.

13 MS. FRIZZERA: Yeah. And 18.5 is built the same

14 way, to Mark's point. It's one model, multiple plans, and

15 PACE is allowed to continue under our model.

16 VICE CHAIR MILLIGAN: Thanks.

17 So just one more question, in the interest of

18 time, and it's really kind of the federal fallback and

19 state, 18.5, kind of. So this, I think, is really mainly,

20 I think, Charlene and Mark, directed to you all, although,

21 Kevin, if you have something to say.

22 So if a state elects -- the first part of this

1 really is, I think, Charlene, the 18.5. If a state takes
2 on the option and in your framework the beneficiary has
3 choice of Medicare fee-for-service still, would the state
4 be operating the Medicare fee-for-service model if it took
5 the state option, but the beneficiary chose to be in
6 Medicare fee-for-service in terms of paying Medicare rates,
7 Medicare network, Medicare FI, all of that stuff?
8 And the second part of this, kind of the flip
9 side, Mark, to you, if there is a federal fallback, that
10 you want some version of this in every state, and if a
11 state declines, you want there to be a federal fallback.
12 Do you think the federal government could effectively take
13 on what states deliver for duals, including not just -- it
14 can be health centers, attendant care, homemaker services,
15 HCBS, setting custodial nursing home rates, and we haven't
16 also in this conversation really talked about ID/DD
17 waivers, the intellectual and developmental disability
18 waivers? There are a lot of duals who are in those waiver
19 programs.
20 So, on the one hand, does 18.5 contemplate,
21 Charlene, from your point of view, states stepping into the
22 role of Medicare fee-for-service administration for

1 beneficiaries who choose that model in that state; and
2 then, second, if there is a federal fallback to have some
3 integrated approach for duals and the federal government is
4 administering it for a state that declines, is the federal
5 government, Mark, from your point of view really up to the
6 job of or could it get up to the job? And what would it
7 need to get up to the job of managing those kinds of
8 Medicaid benefits that are very foreign to Medicare?
9 MS. FRIZZERA: Yeah. So, in our model, the state
10 would not administer the Medicare fee-for-service. If a
11 beneficiary elected not to be in this integrated program,
12 they would go back to Medicare, and Medicare would
13 administer their Medicare services. And Medicaid would be
14 a Medicaid-only plan.
15 DR. MILLER: Charlene, you're done?
16 MS. FRIZZERA: Yep, I'm done.
17 DR. MILLER: So what I would say is yes because
18 that would be consistent with the position I'm taking.
19 The thing I would say, just to build that out, I
20 mean, first of all, there's not a zero-knowledge base on
21 Medicaid in CMS, and so I believe that there is a Medicaid
22 knowledge base at CMS. It's not zero. I do understand

1 your question and not dismiss it.

2 The other thing that I would say, remember it's
3 not necessarily the federal government administering this -
4 - I mean, it is, but the actors are going to be state
5 actors, a managed care plan that has roots in that state,
6 and the partners that they're going to be pulling in are
7 people who are from that state. And so I tend to think of
8 it that way, that the managed care -- like if it became a
9 D-SNP platform that bolts on the Medicaid, they would have
10 to be working with partners in the states in order to put
11 that benefit together on the ground.

12 And then, like I said, I don't think CMS comes at
13 this with a complete deficit in knowledge, but I do
14 understand your point about the precision for a given state
15 in a given population, and that's something that they would
16 just have to grow into.

17 VICE CHAIR MILLIGAN: Mark, I agree with you. I
18 mean, there's a lot of expertise at CMS about Medicaid, but
19 it doesn't mean enrolling providers, paying claims. I
20 mean, it's an oversight role more than a program
21 administration role. But thank you very much.

22 DR. MILLER: But remember, they are enrolling

1 providers and overseeing providers now, on the Medicare
2 side. I get it. It's different beneficiaries. But even
3 from that platform they're not starting with zero.
4 CHAIR BELLA: Kevin, did you want to add anything
5 here?
6 MR. PRINDIVILLE: No.
7 CHAIR BELLA: Okay. And I do want to remind all
8 of us, Kevin and Mark and Charlene aren't going to
9 disappear after this. Like I'm sure that they would be
10 willing to share opinions, even if we can't get them in in
11 this speed round today. So Martha and then Kit.
12 COMMISSIONER CARTER: Thank you. I really
13 appreciate the amount of thought you all put into this
14 design process. I think it's actually really
15 extraordinary.
16 My question is about the role of the federally
17 qualified health centers in these new models. A breakdown
18 in program for duals, you know, as was already stated,
19 health and quality of life repercussions for the
20 beneficiaries but also has an increased cost down the road
21 in terms of nursing home care, hospital care. So we need
22 to get this right.

1 As I stated in our last meeting, the community
2 health centers right now care for about 1 million people
3 who are dually eligible, and that number is expected to
4 increase as people who are currently in Medicaid age into
5 Medicare. So right now the health centers are required to
6 accept patients who are Medicaid and Medicare eligible, and
7 to protect them financially they get a PPS rate. And one
8 of the goals of the PPS rate is so that the health centers
9 don't have to use their federal grant dollars to cover
10 Medicare and Medicaid shortfall.
11 So in your thinking about these new programs,
12 what would be the role of the health centers? Would they
13 be required to take these patients, like they currently
14 are, from Medicaid and Medicare beneficiaries, or is this a
15 whole new category, and how will they be paid, and then how
16 will that federal grant, that purpose of the PPS rate, be
17 maintained? Or are you considering that that would maybe
18 go away?
19 Just as a point, right now I think that some
20 states are not paying the PPS rate for some of the dual
21 programs. There's already a problem. We already know that
22 these are high-cost, high-need patients. So what's the

1 role of the health centers?

2 MS. FRIZZERA: So I can start on 18 ½. So I

3 don't have an answer to your question. It is on the list

4 of issues that we have to address. So that is one of the

5 issues, in addition to many others, which is when we pull

6 the duals out of other programs that exist, what impact

7 does that have on that program? I don't have an answer for

8 you but it's definitely one of the issues that are on the

9 table for us to talk about with the states.

10 CHAIR BELLA: Mark, and then Kevin.

11 DR. MILLER: Yeah. I am more in the same boat

12 that I will acknowledge that we have not directly

13 contemplated it. It seems to me you're starting points are

14 whether you're looking for these to come into the network

15 of the provider, in which case then that would be built

16 into the capitation rate and they would be paid that way,

17 or whether there's an eligibility distinction that they

18 continue to exist under the current system, and that person

19 is not the person that is defaulted into the situation that

20 we're discussing.

21 MR. PRINDIVILLE: And I don't have a view on the

22 financial piece. From a services piece, we certainly want

1 -- that's one of the concerns we have around transitions
2 here is we want dual eligibles to remain connected to
3 trusted, quality providers that they rely on today. And
4 certainly in places with robust FQHCs that's part of the
5 system that supports duals today, so we want to find ways
6 to keep them connected.
7 CHAIR BELLA: Thank you. Kit, for the last
8 question.
9 COMMISSIONER GORTON: So I'll keep this on
10 beneficiaries, just where we started and where we probably
11 should end, I mean, always. My question is for Kevin. You
12 were talking about health equity at the beginning of the
13 session, and we often arc to race with health equity. But
14 in terms of the duals, as you mentioned, it's not a
15 homogeneous population.
16 And when you talked about what beneficiaries and
17 their families and advocates identify as need that are not
18 being met, the gaps in care that they currently receive,
19 can you identify for us, are there common challenges across
20 seniors and under-65s, rural and urban, Black and ethnic
21 minorities? And are there specific things? Because it
22 always concerns me most, when we talk about heterogeneous

1 populations, that we come up with this sort of vanilla,
2 peanut butter layer approach that ends up not filling the
3 gaps for anybody because we missed the specific needs of
4 specific subpopulations, and if you can't get to the
5 subpopulations you really can't drill down to the
6 individual beneficiary.
7 MR. PRINDIVILLE: Yeah. Thanks for taking us
8 back to the beneficiaries. I say that there are common
9 gaps in the services that are covered, that are gaps in the
10 Medicare program, gaps in the Medicaid program, and because
11 dual eligibles are low-income and low wealth they can't
12 fill those gaps like the other Medicare beneficiaries
13 might. So those are somewhat obvious around long-term care
14 coverage, around oral health coverage, other services that
15 just aren't covered by Medicare and are only optionally
16 covered in Medicaid, and many states don't pick up those
17 options.
18 And we also see common problems around certain
19 phases of care. And so transitions between settings or
20 between the hospital and home, or SNFs and hospital. That
21 seems to be pretty common across the population and across
22 states. And then you get into different types of problems

1 with access to providers, depending on rural versus urban,
2 depending on what Medicaid rates look like and Medicaid
3 networks look like in different states, or even different
4 parts of states.

5 So those are some pretty common and consistent
6 issues we hear about across the population. And when you
7 dig deeper, I think one thing we need to do, as a
8 community, is dig deeper on how those disparities show up,
9 particularly by race, and I think a lot of the data will
10 confirm things you might suspect, so that duals are more
11 likely to be in lower-performing nursing homes, and that
12 those are also nursing homes with higher rates of COVID
13 infection, COVID death right now. Really digging into that
14 might reveal some new policy levers or new requirements we
15 might want to put in place that are targeted to the
16 experiences of those parts of the community, recognizing
17 that it's not a homogeneous group.

18 CHAIR BELLA: Thank you, Kevin. As I'm sure you
19 could imagine, I could spend hours talking to the three of
20 you and asking you questions but I will not. I will
21 instead say it would be wonderful if we could seek your
22 counsel as we move forward in this area, because it is a

1 priority area and you are laying the groundwork for many
2 discussions to come, as we try to bite off something as big
3 as what a new program would look like.
4 So thank you for getting us started down this
5 road. I really appreciate, and I especially appreciate you
6 spending more time than you had originally committed.
7 We are going to have a few more minutes of
8 Commissioner discussion. The three of you are welcome to
9 stay, but you are also welcome to be relieved of duty with
10 a sincere thank you.
11 MS. FRIZZERA: Thanks, everybody. Great
12 conversation.
13 **### FURTHER DISCUSSION BY COMMISSION**
14 * CHAIR BELLA: Okay. We have 15 minutes left, and
15 we know we're going to be spending a lot of time on this
16 issue area going forward, so I'm going to suggest a couple
17 of things. One is -- and Anne flagged this morning, like
18 we're gearing up for being able to do a chapter on this in
19 the March report. Obviously we're not anywhere close to a
20 recommendation stage, but I think what today did was
21 illustrate how you might think about a thought piece that
22 talks about principles and starts to lay out some of the

1 different kind of design considerations, whether that's who
2 drives the bus or how do you handle mandatory and
3 voluntary, or how do you handle carve-out, and how do you
4 think about financing and oversight.
5 There are a lot of things that this teed up, and
6 so in that vein, my guess -- and Kirstin can confirm --
7 what is going to be most helpful at this point is for not
8 necessarily us to debate the pros and cons of these things
9 but to go around to the Commissioners and ask what burning
10 questions do you have and what things are unanswered or
11 most important to you that we can get to Kirstin so that
12 the team can go back and do some of this legwork, and then
13 bring it back to us and we continue to iterate on this
14 subject.
15 So I'd like to ask that we not sort of advocate
16 for or against certain things but we instead tee up, what
17 questions did this raise for you that we can ask folks to
18 continue to explore and bring back to us. Kirstin, would
19 that be helpful to you, and does that work for the
20 Commissioners?
21 MS. BLOM: Yeah, that would be great, from my
22 perspective.

1 CHAIR BELLA: Okay. I see no hands. Sheldon,
2 thank you, and then Kit, and then Stacey, then Bill.
3 COMMISSIONER RETCHIN: Is my mic on?
4 CHAIR BELLA: Yeah. You're good.
5 COMMISSIONER RETCHIN: Yeah, hi. Well, thanks.
6 I'm pleased to sort of kick this off in an area where it
7 will probably not surprise anyone, and that is, you know,
8 when we've been talking about integrated models we've done
9 a great job, albeit there are complications, barriers, and
10 hurdles to jump. But we've done a great job talking about
11 integrated payment, and solving the integration of payment
12 across the scenes that Medicaid and Medicare present.
13 But we really haven't spent a lot of time on
14 integrated models and delivery of care, and maybe that's
15 because -- and this is a question that I think we ought to
16 be a little careful about resolving -- we assume integrated
17 models will provide superior results, but so far, and at
18 least in terms of the FAI and others that I've seen, there
19 have been mixed results, with one exception.
20 And that's why when I thought Chuck was going
21 there, I thought he was going to go where I wanted to go,
22 which is there was one model that is built on integrated

1 delivery of care, and then the payment is on top of that,
2 and that's PACE. PACE has had tremendous results, and what
3 I was hoping somebody would suggest would be not that PACE
4 is a competitor, but is PACE the expert model of delivery
5 of care that could subcontract, like an ACO would, for
6 duals? And by the way, PACE takes care of the dual
7 population that is the most expensive, on average $80,000
8 per beneficiary, whereas the dual population is about
9 $30,000 total, in terms a median.
10 So I'm getting back to integrated models of care
11 on a delivery basis. Where's the beef? And we should be
12 able to present that.
13 CHAIR BELLA: Okay. Thank you. Kit?
14 COMMISSIONER GORTON: So I'll go back to where I
15 ended with Kevin. I would us to be able, in a more
16 complete way, to describe the problem, to describe the
17 gaps, from the perspective of beneficiaries, and what
18 they're not getting now. So it's the access issues because
19 of, as Kevin talked about, not having access to a full
20 array of high-quality providers. We're going to talk about
21 NEMT and transportation is a big deal. It's a bigger deal
22 in some communities than it is in other communities, right.

1 Transportation in rural communities is very, very
2 challenging, not that it's not in urban communities.
3 And so I would like us to ground this in the
4 principle what it's about, which is where I think Kevin
5 said last session, which is doing a better job for
6 beneficiaries and family caregivers. And so what are the
7 gaps? Yeah, they want administrative simplification, but
8 that's not where they start. Where they start is, as Kevin
9 said, they can't get what they need, and I think we need to
10 give a little more color, and perhaps even get a little
11 more of their voices into a descriptive piece, into what
12 they think they're not getting now, so that people have a
13 sense of what we're trying to solve and it's not just
14 administrative simplification and unified rates.
15 CHAIR BELLA: Thank you, Kit. Stacey?
16 COMMISSIONER LAMPKIN: Thanks. My comments are
17 related to the concept of the new title, or what have you.
18 It's really fascinating to hear about, that it made me
19 start thinking about things like transition of eligibility
20 and kind of the enrollee experience and things like that.
21 And then I started wondering, what would be the benefit of
22 a new title, since I think Medicaid covers almost

1 everything, if not everything, that Medicare covers, of
2 just having a different financing model and saying these
3 individuals are in Medicaid for all of their services, and
4 there's a comprehensive set of care there.
5 And so, you know, obviously there is provider
6 payment differences and other things that would need to be
7 aligned. But like if we go forward and we talk about the
8 new title model, like where are the advantages of that over
9 just bringing those folks into Medicaid and updating the
10 financing in some way?
11 CHAIR BELLA: Great. Thank you. Bill and then
12 Darin.
13 COMMISSIONER SCANLON: Yeah. Two things. One is
14 with respect to long-term services and supports, one of the
15 things that constantly bothers me is the geographic
16 variations in the provision of services. And to me it
17 reflects, for people in some areas, that there's a lot of
18 unmet need. And I think that this question of, if you have
19 a new program, how would it try and reduce that variation?
20 Right now it's primarily budget-driven. It's what states
21 have chosen to spend. And I think it really is a choice on
22 states' parts.

1 I was in a state which probably spent some of the
2 lowest amount of money per person of any state in the
3 country, where the Medicaid director was talking about how
4 they spent too much. So I think that there is this issue
5 of state preferences that are driving some of these
6 budgets. So that's one issue that I think I would like to
7 see, how we can maybe ameliorate that situation.
8 The other thing about sort of this in general is
9 that a tremendous amount of what we're assuming is going to
10 happen is driven by the ability to specify outcomes.
11 Outcomes are going to determine the accountability of these
12 entities that are going to be participants, and for me it's
13 always been problematic, how do you define outcomes for the
14 segment of the population whose natural outcome is
15 deterioration and death? And that is very true of these
16 very old dual eligibles.
17 And this is something that came up in Medicare's
18 context, in terms of discussion of should we have value-
19 based payment for home health, and it went nowhere, because
20 it's really hard to think about what are going to be sort
21 of good outcomes measure. And they have to worry about it.
22 In Medicaid home health, what we discovered is that the

1 agencies that make the most money are the ones that are
2 serving, in their terms, the sickest population, but they
3 do it by visiting them less.
4 So there's this question of, is that good care,
5 and I think that's the issue we have to face here. We've
6 got to have accountability, and if the accountability is
7 going to depend on outcome measures, are we going to have
8 adequate outcome measures?
9 CHAIR BELLA: Thanks, Bill. Darin and then
10 Brian.
11 COMMISSIONER GORDON: Yeah. I just wanted to go
12 back to something Sheldon had brought up about focusing on
13 the financing. I just think back -- and we see this on the
14 behavioral and physical health integration discussion. You
15 know, a lot of folks talk about how they would like to see
16 more integration at the clinical level, but a lot of the
17 evidence, back when we looked at this back in, you know,
18 I'd say the early 2000s, was that you had to simplify the
19 payer dynamic if you ever wanted to hope that providers
20 could navigate or where they were integrating at the
21 service level.
22 And I think that same dynamic is true here. I

1 also believe that because the benefits are so segregated in
2 how it's administered on the Medicare-Medicaid side of
3 things, and that there's certain tools in the Medicaid side
4 of the house that are not available to the Medicare side of
5 the house that it's also yet another reason why you have to
6 at least attempt to try to simplify that side of the house
7 in hopes to have other models that the service delivery
8 level flourish and progress.

9 So I don't think you just skip straight to the
10 delivery of service level side and not address this
11 dysfunction we have at the payer side. I think you have to
12 do the financing side first to better enable the delivery
13 system evolution.

14 That's my two cents based on my experience.

15 CHAIR BELLA: Okay. Brian, with a focus on
16 additional questions. Sheldon, did you want to make a
17 comment? Remember, guys, we're not arguing for what's
18 right or wrong here. We're trying to just identify future
19 areas. I don't mean to cut you off, but, Sheldon, do you
20 want to go back to that? Are you sure? Okay. Brian, with
21 any additional areas you would like to be explored.

22 COMMISSIONER BURWELL: Well, my area has to do

1 with kind of processes. I'd like for us as a group to have
2 a discussion at some point about what our objectives are in
3 this cycle regarding this issue. Particularly if we are
4 going to move forward with this idea of a new program,
5 that's obviously something larger than MACPAC has ever
6 undertaken in terms of policy change. And, Melanie, you
7 talked about, you know, we're going to do -- we're moving
8 towards a chapter in March, but it kind of may be a soft
9 chapter with principles in it. Is there a possibility of
10 doing a hard chapter in June with, you know, something --
11 recommendations, further recommendations about what a new
12 program should look like? Or do we want to just comment
13 on, you know, there's these two other proposals coming out,
14 be commenters on those ideas? I think there's a large --
15 you know, are we going to continue not going after the big
16 fish but, you know, think more about incremental changes?
17 I just think that we should have some kind of overall
18 strategy for how we want to move this issue forward in this
19 year's cycle.
20 CHAIR BELLA: Yeah, I mean, we can certainly say
21 some more about that. I think Kirstin and Kristal have
22 presented us with a work plan that lays out a mix of sort

1 of current issues around things like MIPPA and enrollment
2 brokers and seamless enrollment and defaults, right? And
3 then we said at the same time we want to be looking bigger
4 thinking about what does the future look like. And so,
5 Brian, I think we're just working both of those in
6 parallel, and so the purpose of today is to tee up thinking
7 for doing some descriptive work to make sure that everybody
8 is on solid ground about what gaps are there, particularly
9 from the beneficiary point of view, and do we want to try
10 to tackle this, right?

11 I don't think anybody is necessarily satisfied
12 thinking that in perpetuity we're just going to always be
13 trying to band-aid these two programs together, but I don't
14 know that we can do something hard in June. This is a
15 pretty big issue to tackle, and there's a lot of different
16 views to have, and it feels like what we're trying to do
17 now is narrow the sets of information and decisions that we
18 would need to make to be able to feel comfortable making a
19 recommendation in that regard.

20 And so, Anne, I would invite you to sort of add
21 your two cents to that.

22 EXECUTIVE DIRECTOR SCHWARTZ: I think the point

1 of today's session -- and I think there's probably many
2 more sessions of this type that we could have, maybe even
3 biting off different pieces of it, because there's the
4 30,000-foot notion of putting the programs together, but
5 then there's dozens of choices around that. And the
6 choices, you all have different views on; you all have
7 different views about the possibility of doing things, of
8 how much of a stretch or a reach those different things
9 are. There's political dynamics. There's geographic
10 issues.

11 So I think the idea was just to talk about this
12 and analyze this in a more systematic way, but not
13 necessarily push ourselves to make a recommendation. Nobody
14 is demanding that we solve this problem by June. We can
15 take some of these different proposals and try and unpack
16 them a little bit. That's the reason really to ask for more
17 questions about this, because I think we could spend easily
18 an hour and a half just around an issue of unmet need or an
19 issue of how do the different providers fit in or the issue
20 around, say, state-federal dynamics. So that was really
21 the goal of it.

22 CHAIR BELLA: I mean, to be clear, it would be

1 wonderful to solve the problem by June, right? But today
2 should have like surfaced why that would be pretty hard to
3 do. As Anne said, I mean, we could spend an entire meeting
4 debating state versus federal and who's going to run it and
5 how we even do that, not to mention some of the financing
6 and provider issues. And so I think, Kirstin, I'm hoping
7 we come out of this, again, understanding like what are we
8 solving for, you know, what are the gaps and problems we
9 see today, and what are the design features we need to
10 think about, and then we can decide as a Commission how we
11 want to start tackling those. Maybe we chunk it out into
12 sessions about various areas. I think there's any number
13 of ways we could go here. It's a good push, Brian, and
14 maybe what we say to ourselves is, "When do we want to be
15 ready to try to have something harder to say about this?"
16 The good news is this is not a one party or the
17 other party issue, so, you know, folks on the Hill are
18 pretty distracted with COVID, so we have a little bit of
19 time, I think, to tee this up. But you're right, we
20 shouldn't not move quickly, but we should be really
21 thoughtful in how we move.
22 COMMISSIONER BURWELL: Well, one area for Kirstin

1 -- I mean, other people may have thought of this, and it
2 did come up today -- is the multiplicity of models that are
3 currently out there and the opportunity to do
4 simplification, that if there was going to be a movement
5 towards, you know, a new program, there would probably be a
6 lot fewer models, maybe only one model. And so something,
7 you know, along the lines of how many different flavors
8 there are of integrated care models out there and, you
9 know, why and, you know, what the opportunities might be
10 for consolidation.
11 CHAIR BELLA: Chuck.
12 VICE CHAIR MILLIGAN: Thanks, Melanie. In the
13 interest of time, I'll just hold my thoughts for later.
14 CHAIR BELLA: Okay. In the interest of time, I
15 will do the same except to say the only thing I didn't hear
16 come from this last little round robin is just reminding us
17 to be talking about the states and the incentives for the
18 states and the capacity of states and all the dynamics that
19 go into what it's going to take to make this work at the
20 state level.
21 We are schedule to take a break, but I actually
22 would like to take two minutes and just see if we have

1 public comment on this issue because it is very separate
2 from the other issues we have after break, and I would like
3 to do it that way if that's okay with folks. So I would
4 like to invite anyone in the public who would like to
5 comment on the session we just had speaking about a new
6 program for duals.
7 Just as a reminder, if you do want to comment,
8 hit your little hand icon, and you will be called on and
9 unmuted. And also to remind people, if you would like to
10 provide a comment and would prefer not to do so
11 technologically, you can email us at Macpac@macpac.gov.
12 [Pause.]
13 CHAIR BELLA: Well, I can't imagine why everyone
14 isn't flooding the little hand icon to comment on this
15 issue, but we don't seem to have any commenters. So with
16 that, we will -- oh, we do. It's Camille. I was wondering
17 where your hand was, Camille. So we just need to -- can we
18 unmute Camille?
19 **### PUBLIC COMMENT**
20 * MS. DOBSON: Oh, there we go. Really there's so
21 much to say about this topic that there's not -- I don't
22 know what to say, I guess. Just that we have talked with

1 the folks from the Leavitt Project about this, giving them
2 feedback from the state perspective on eligibility and
3 financing. You know, I would agree -- somebody said, I
4 don't know if it was a Commissioner, one of the
5 Commissioners. It's been a while -- that there are some
6 states who are very anxious to take on the Medicare benefit
7 and manage it themselves, and so, you know, short of a new
8 title, which would be great -- back to Brian's point, I
9 think there are a number of states that would be ready to
10 do that. I think there are a lot of states that are not
11 ready, and we'd have the sort of mix -- I think about it
12 like the exchange -- right? -- where some states are
13 managing their own and others defer to the federal
14 government.
15 Could MMCO be more flexible now about allowing
16 states to try and manage the Medicare benefit now as a
17 precursor to see how it could work before, you know, we go
18 through the legislative process? I know that at least one
19 state has proposed that, and we haven't heard -- it's been,
20 I think, radio silence, or at least public radio silence
21 from MMCO about whether that's doable as a model, as one of
22 the other options that are out there. So I guess I would

1 urge that flexibility today while all of the multitude of
2 issues around -- that the panel raised today about a new
3 title work themselves out.
4 CHAIR BELLA: Thank you, Camille.
5 Kirstin, do you have what you need to sort of
6 organize the start of teeing up this in a descriptive
7 chapter and then being able to come back to us and fit this
8 into the sequence of how we might begin to attack this and
9 a sense of timing on that alongside the other issues we're
10 looking at in this area?
11 MS. BLOM: Yeah, I think this has been really
12 helpful in setting -- like putting some structure around
13 the conversation, thinking about like buckets and key
14 topics. So that was great. I think we're good to go.
15 CHAIR BELLA: Okay, and we'll spend some time in
16 December, Brian, to your point. We can sort of make it a
17 little more concrete about where this work fits and what
18 sort of time frame we might be on in being able to continue
19 to address it.
20 Okay. Thank you, everyone. We're going to take
21 now a ten-minute break. I would ask you to be back at 3
22 o'clock, and Chuck is going to lead us in the NEMT session.

1 So see you back here in about ten minutes. Thank you.

2 * [Recess.]

3 VICE CHAIR MILLIGAN: I think it's okay to get

4 started.

5 Nice to see you, Kacey and Aaron. Look forward

6 to the presentation and then kind of leading us through the

7 discussion and comments afterwards about the mandated

8 report on non-emergency medical transportation.

9 So, Kacey, I will turn it over to you to kind of

10 walk us through this.

11 **### MANDATED REPORT ON NON-EMERGENCY MEDICAL**

12 **TRANSPORTATION: PRELIMINARY FINDINGS**

13 * MS. BUDERI: Great. Thank you, Chuck.

14 Federal Medicaid regulations require that states

15 ensure transportation to and from providers, a benefit

16 known as non-emergency medical transportation, or NEMT.

17 In recent years, policymakers at the state and

18 federal levels have begun to reexamine the necessity of the

19 NEMT benefit, and the Senate Appropriations Committee has

20 asked MACPAC to conduct a study on NEMT.

21 So, in this presentation, I'll review the

22 committee request and provide some background information.

1 I'll then discuss the policy questions we're examining in
2 our plan for analysis, and I'll spend the bulk of my time
3 talking about the findings from our work to date. I'll
4 finish it off with our next steps.
5 So here we have the language of the congressional
6 request. As I mentioned, the Senate Appropriations
7 Committee directed MACPAC to conduct a study on the
8 benefits of NEMT, including for certain populations, and
9 examine the benefits of coordinating NEMT with other
10 federally assisted transportation programs. The report
11 language also directs the U.S. Department of Health and
12 Human Services to take no regulatory action on availability
13 of NEMT until the MACPAC study is complete. The request
14 has no due date and does not require recommendations, but
15 staff anticipate that the results from the study and any
16 recommendations could be published in MACPAC's June 2021
17 report to Congress.
18 Great. So to provide an overview of NEMT, states
19 are required to provide NEMT and use the most appropriate
20 form of transportation. They are also required to provide
21 NEMT as part of early and periodic screening, diagnostic,
22 and treatment services for children.

1 NEMT is a mandatory Medicaid benefit, but unlike
2 other mandatory benefits, it is not required by statute.
3 Rather, it was created as a regulatory requirement for
4 states to ensure access to other mandatory services.
5 The scope of the benefit varies by state but
6 generally covers a broad range of transportation services,
7 including trips in taxis, buses, vans, public
8 transportation, personal vehicles belonging to
9 beneficiaries and their friends or family, and in some
10 cases, transportation network companies including Uber and
11 Lyft.
12 In FY 2018, states and the federal government
13 spent over $2.2 billion on Medicaid NEMT services provided
14 through fee-for-service. I'll note that this does not
15 include spending for services provided through managed care
16 or brokerage models. So it's just a portion of total
17 spending on NEMT.
18 States may claim federal Medicaid match for NEMT
19 as either administrative or medical assistance
20 expenditures.
21 States and federal policymakers have considered
22 making changes to the NEMT benefit. Specifically, a number

1 of states have sought and received Section 1115
2 demonstration authority to exclude NEMT for certain
3 populations, specifically low-income adults not eligible
4 for Medicaid on the basis of disability.
5 The current administration has considered making
6 NEMT an optional benefit through a revised regulation.
7 Most recently, in fall 2019, CMS announced plans to issue
8 an RFI, request for information, seeking input on whether
9 the requirement to provide NEMT is necessary and for which
10 populations. However, this RFI has not yet been issued.
11 At the same time, Congress has largely been
12 skeptical or opposed to these efforts and has considered on
13 a bipartisan basis codifying NEMT regulations into statute
14 so that the benefit could not be made optional via
15 regulation.
16 So now I'll talk about the MACPAC study in
17 greater detail. Our study has three primary components:
18 first, to better understand state approaches and challenges
19 to administering and delivering NEMT; and more closely,
20 examine current issues and trends, MACPAC contracted with
21 Health Management Associates, or HMA. HMA conducted both
22 an environmental scan of state NEMT policies in all 50

1 states and the District of Columbia and structured
2 interviews with stakeholders in six states and at the
3 federal level. Our study states are Arizona, Connecticut,
4 Georgia, Indiana, Massachusetts, and Texas.
5 Second, to better understand the beneficiary
6 perspective on NEMT, we contracted with PerryUndem to hold
7 virtual focus groups with beneficiaries who have used NEMT,
8 and these are ongoing.
9 The third component involves analysis of
10 administrative data on NEMT utilization and spending.
11 Specifically, staff are analyzing 2018 Transformed Medicaid
12 Statistical Information System data, or T-MSIS data. Our
13 goal is to provide data on NEMT utilization and spending by
14 state and other factors, including destination,
15 transportation type, basis of eligibility, dually eligible
16 status, urban versus rural, and diagnosis. And our hope is
17 that these data are more complete than the limited data
18 that have been available up until this point.
19 I'll note that the NEMT project is MACPAC's first
20 attempt to leverage T-MSIS data to review service-level
21 utilization, and it is among the first attempts among T-
22 MSIS users to review service-level utilization. So we do

1 expect data challenges to arise over the course of this
2 work.
3 In your materials, you have a detailed list of
4 analytic questions and which study component or components
5 we're using to answer each question.
6 So now we'll talk a little bit about our findings
7 from our work to date. The findings I'll be talking about
8 today are primarily from our work with HMA, and we hope to
9 expand on and refine these findings in the coming months as
10 we complete the other components of the project.
11 I'll start by discussing our findings on
12 utilization. Interviewees did not uniformly point to the
13 same populations as frequent NEMT users. Some identified
14 groups using services frequently, such as those undergoing
15 dialysis or using medications for opioid use disorder.
16 Others identified individuals over age 65 and those with
17 intellectual or developmental disabilities and those
18 undergoing cancer treatment.
19 Utilization, after increasing over the last
20 several years, as more states expanded Medicaid, declined
21 sharply with the onset of COVID-19 but has now started to
22 creep back up again.

1 We found that prior authorization requirements
2 are the most common utilization control, and other policies
3 like copayments and mileage limits are used less
4 frequently.
5 A wide variety of transportation modalities are
6 used for NEMT. The mode of transportation chosen for any
7 given trip varies based on availability within the
8 geographic area and the beneficiary’s needs. In urban
9 areas, beneficiaries tend to rely more heavily on public
10 transportation. Regions with limited or no public transit
11 options tend to rely more heavily on taxis or mileage
12 reimbursement for personal vehicles.
13 As I noted, states are required to use the most
14 appropriate form of transportation for the beneficiary.
15 States and brokers try to match the transportation modality
16 to the beneficiary's needs or preferences while balancing
17 cost and other factors, such as vehicle availability.
18 Still, ill-suited vehicles are a common reason for
19 beneficiary complaints, which I'll discuss more in a
20 moment.
21 States choose how to deliver NEMT, and they may
22 use more than one approach to accommodate varying

1 beneficiary needs, delivery systems, and geographic areas.
2 NEMT delivery models include in-house management in which
3 the state manages NEMT directly and pays for rides on a
4 fee-for-service basis, a broker model in which states
5 contract with a third-party transportation broker to manage
6 all or some aspects of NEMT on the state's behalf, and this
7 arrangement can be on a capitated or a fee-for-service
8 basis. And Medicaid managed care, meaning Medicaid managed
9 care organizations, MCOs, are responsible for delivering
10 NEMT along with other Medicaid benefits. And MCOs
11 frequently contract with a third-party transportation
12 broker.
13 According to our environmental scan, 35 states
14 are using a broker for some portion of their program, 25
15 use managed care, and at least 12 manage the benefit in-
16 house for some portion of the program. Each approach has
17 various advantages and disadvantages, and choices about
18 which delivery model to adopt or whether to change
19 approaches are influenced by a variety of factors,
20 including the state's available financial and staff
21 resources, its broader Medicaid delivery system, and other
22 state-specific factors.

1 There was no consensus among interviewees about
2 the delivery model most likely to lead to improved
3 beneficiary satisfaction, efficiency, or value. Some
4 interviewees noted that the quality of the state's NEMT
5 program depends more on factors other than the model, such
6 as strength of oversight and stakeholder engagement
7 processes.
8 Turning to issues of coordination, Medicaid NEMT
9 is the largest source of federal financing for human
10 services transportation; however, there are over 100 other
11 federal programs that provide funding for these services.
12 Federal policy encourages coordination across services.
13 Coordination can help reduce costs, for example, by
14 clustering passengers to reduce the number of trips and
15 sharing equipment, personnel, and other resources, and
16 improve services, for example, by reducing wait times.
17 However, delivery of transportation services has
18 historically been fragmented among these programs, which
19 can result in overlap and duplication.
20 Three of our study states cited coordination as a
21 policy priority, particularly Massachusetts, which has one
22 state office that manages transportation for six different

1 state agencies, including MassHealth as a Medicaid agency.
2 Our other states reported lesser degrees of coordination or
3 no coordination.
4 Interviewees talked about the challenges to
5 coordination. First, beneficiary needs differ across
6 federally assisted programs, making it more challenging to
7 arrange shared rides. For example, many Medicaid
8 beneficiaries need to use a specific type of transportation
9 like a wheelchair or a stretcher van. Other federally
10 assisted transportation programs often have greater or
11 different constraints, such as limited geographic
12 footprints or limited hours of operation. Additionally,
13 the requirement that Medicaid can only pay for transporting
14 a Medicaid-eligible beneficiary to a medically necessary
15 service can make it difficult and administratively
16 burdensome to calculate the Medicaid-eligible portion of
17 any shared ride. Some interviewees reported that Medicaid
18 entities are reluctant to have Medicaid beneficiaries share
19 rides with beneficiaries of other programs because of these
20 challenges. Administrators may be incentivized to choose a
21 single-passenger on-demand trip instead of assigning a
22 beneficiary to a shared ride option.

1 Interviewees also noted that administrators of
2 different federally assisted transportation programs,
3 including Medicaid, are often not engaged in coordination
4 efforts, perhaps because of these difficulties.
5 Interviewees had mixed views on the extent to
6 which state NEMT programs meet the needs of beneficiaries
7 and on program performance more generally. Most state
8 officials described their NEMT programs as functioning well
9 or improving but acknowledged problems that have led to
10 beneficiary complaints. Advocates believe the quality of
11 state NEMT programs varies widely by state, noting that
12 some states have strong programs, while others have serious
13 issues that regularly lead to unsafe conditions for
14 beneficiaries, missed appointments, or distrust of the
15 program.
16 The primary reasons for beneficiary
17 dissatisfaction or complaints are late pickups and drive
18 no-shows. Other common issues involve vehicles that are
19 unsafe or ill-equipped, long call center wait times, and
20 other customer service issues, including insensitive
21 drivers or drivers who are not trained to dealing with
22 beneficiaries with high needs.

1 Interviewees described a wide array of factors
2 that cause performance issues, including strained provider
3 networks, traffic and weather conditions, and scheduling
4 and dispatching issues.
5 They also described a wide array of strategies
6 they used to address these issues, including process
7 improvements for scheduling, such as building in more time
8 between appointments and implementing training programs for
9 drivers.
10 Some states and MCOs include performance
11 incentives for brokers that meet quality metrics, and
12 brokers may include performance incentives for well-
13 performing drivers.
14 Interviewees talked about the importance of
15 strong contracts and oversight mechanisms. State contracts
16 with brokers and MCOs often contain requirements around
17 data and reporting call center wait times, on-time
18 performance, vehicle standards, driver training criteria,
19 and more. However, these sometimes lack enforcement
20 mechanisms, and state agency staff may lack the necessary
21 capacity, expertise, or tools needed to monitor and conduct
22 oversight of the program's performance.

1 Advocates noted that states with formal sustained
2 consumer engagement processes tend to have better-
3 performing programs.
4 One of the biggest challenges that interviewees
5 talked about in terms of administering NEMT is maintaining
6 an adequate provider network. Provider network challenges
7 are common, especially in rural areas. They are also
8 common with respect to the supply of specialty vehicles
9 such as wheelchair and stretcher vans. To alleviate these
10 challenges, states and brokers use strategies like
11 promoting mileage reimbursement for people living in rural
12 areas, providing incentives to drivers willing to operate
13 in remote areas, as well as leveraging public
14 transportation and country transit programs.
15 They have also increasingly used TNCs like Uber
16 and Lyft. TNCs are increasingly being included in NEMT
17 provider networks. At least a dozen states have
18 specifically authorized their use, and they are being used,
19 to some extent, in as many as 25 states. TNCs are helpful
20 for reducing strain on provider networks, and they can also
21 provide greater flexibility to respond to last-minute
22 requests or requests that come in at certain times of the

1 day; for example, a late-night hospital discharge. They
2 also provide an opportunity to enhance customer
3 satisfaction, especially for beneficiaries who are used to
4 using Uber and Lyft in other settings and appreciate their
5 ability to track drivers' locations in real time.
6 Some interviewees cited the potential for cost
7 savings, although there are few data on that. However,
8 there are some concerns about using TNCs in Medicaid, as
9 drivers in vehicles are not trained or equipped to meet the
10 needs of Medicaid beneficiaries, particularly those in need
11 of extra assistance or with special health needs. Using
12 TNCs also often requires a smartphone, which many
13 beneficiaries do not have.
14 Some states, including Arizona and Texas, chose
15 not to apply the same regulations and requirements around
16 driver training, vehicle safety, and insurance that apply
17 to other NEMT providers, raising safety and fairness
18 concerns. TNCs have made efforts to adapt to the needs of
19 the Medicaid population, but still some interviewees felt
20 that they can only be helpful for a relatively small
21 portion of the Medicare beneficiaries.
22 Along with TNCs, new technologies are

1 increasingly being used in NEMT. They are viewed as
2 important tools for strengthening program integrity,
3 improving on-time performance, and by extension, customer
4 satisfaction. For example, GPS data, usually collected
5 through an application on a device in the vehicle, can
6 document the date, time, and location for each NEMT pickup
7 and drop-off to ensure that trips to places authorized.
8 They're also necessary for reliably tracking and providing
9 on-time performance.
10 Increasing GPS capability among drivers is a high
11 priority for stakeholders. Barriers to greater adoption
12 include reluctance among NEMT providers due to cost,
13 Smartphone or tablet literacy on the part of drivers and
14 beneficiaries, and to internet and data bandwidth
15 challenges.
16 One thing we heard from brokers is that it's
17 easier to get NEMT providers to adopt these new
18 technologies when they are required by the state.
19 So federal oversight authorities have identified
20 NEMT as high risk for fraud and abuse, noting concerns
21 related to enrolling providers, program inefficiencies, and
22 verified eligibility. This has come up in past GAO and HHS

1 Office of the Inspector General reports. However, Medicaid
2 officials and other interviewees did not cite fraud or
3 abuse as major concerns, noting that instances occur
4 relatively infrequently.
5 Some interviewees attributed stronger program
6 integrity in recent years to the shift in NEMT
7 administration from Medicaid agencies to brokers and MCOs
8 who typically have greater oversight capacity, as well as
9 the increasing use of GPS and other technologies that are
10 helpful for program integrity, as I talked about.
11 When it comes to the role of NEMT in Medicaid and
12 its value, interviewees agree that NEMT is an important and
13 even essential tool for promoting access to care, managing
14 health conditions, and improving health outcomes,
15 particularly for people with chronic conditions. Most
16 interviewees expressed the belief based on their own
17 observations or internal data that NEMT yields savings for
18 states and the federal government in the long run.
19 It's unclear whether or not states would reduce
20 or eliminate the NEMT benefit if it became optional. While
21 state Medicaid officials generally thought they would keep
22 the benefit, they noted that state legislatures or

1 governors might choose a different approach. Advocates
2 actually felt that many states, including those not
3 normally inclined to reduce Medicaid programs -- reduce
4 Medicaid benefits, excuse me, might do so given declining
5 revenues and pressure to reduce spending in the short term.
6 There was a great deal of concern about this
7 process. Interviewees noted that reducing the benefit
8 would reduce access, exacerbate racial and geographic
9 disparities, and harm transportation systems in rural
10 areas.
11 Interviewees suggested a number of opportunities
12 for federal government action that could help improve NEMT
13 quality and performance. These include that CMS could more
14 proactively facilitate sharing of best practices and
15 strategies for NEMT administration, and CMS does this
16 already on an ad hoc basis. CMS could issue guidance on
17 use of TNCs in Medicaid, and according to CMS officials,
18 this is under discussion and development. Congress or CMS
19 could create mechanisms to provide federal incentives to
20 address provider shortages in rural areas. And, finally,
21 Congress could codify NEMT requirements in statute as a way
22 to ensure the benefit cannot be made optional through

1 regulation and to signal NEMT's value in Medicaid.

2 In terms of our next steps, staff will continue

3 to carry out the other components of our project, including

4 our focus groups and analysis of administrative data. We

5 will present the findings of our work at future meetings

6 this winter. And, with that, I will stop and I will turn

7 it over to you, Commissioners, for discussion and any

8 questions you might have for me.

9 VICE CHAIR MILLIGAN: Thank you very much, Kacey.

10 Let's open it for discussion, and maybe to frame

11 it initially, the report is required, as Kacey mentioned,

12 in terms of the Senate looking for this from MACPAC. We're

13 not obligated to make any recommendations or take any

14 further action, so if people are inclined to have an

15 opinion about that one way or the other, it would be

16 helpful to hear. But, again, we're not required to take

17 any action other than deliver the mandated report.

18 Anybody want to kick us off?

19 [No response.]

20 VICE CHAIR MILLIGAN: Okay. Seeing none, Fred

21 and then Martha.

22 COMMISSIONER CERISE: Yeah, I'll start. I'm

1 looking at the direction to us and examining the benefits
2 and -- I think you've done a good job of describing -- you
3 know, a good approach in just sort of looking at the
4 importance of this to the Medicaid population. It's hard
5 to imagine this is really controversial in terms of does it
6 provide a benefit in terms of improving access, and so, you
7 know, I think you've done a great job of laying out some of
8 that information here.

9 One point I would make, and I know this is not
10 what they asked us, but I think it is related, because, you
11 know, you end up by what you pay for, that's the behavior
12 you incentivize. You've mentioned that the two top
13 conditions for using NEMT is behavioral health and end-
14 stage renal disease, both of which are very amenable to
15 other approaches to care at home. You know, telehealth, if
16 COVID has taught us anything, behavioral health conditions
17 or -- the patients like it a lot, and it's been effective
18 if you talk to the providers who've been involved in that.
19 And I would suspect that would sort of carry over to
20 substance use disorder and the follow-up and things like
21 that in terms of investing in ways you could manage that
22 care without having to make people go back and forth to the

1 provider.

2 The same thing with end-stage renal disease, you
3 know, we make people go to a dialysis center three days a
4 week when there is -- peritoneal dialysis can be done at
5 home. It's safer. Patients like it. And so I think at
6 least a comment to say as you look at those conditions that
7 we're transporting people around for, you know, we should
8 take a look to see if we might want to, you know, provide
9 some other incentives or mechanisms to get people to look
10 at behavior change instead of just driving people back and
11 forth to providers.

12 VICE CHAIR MILLIGAN: Thank you, Fred. I see
13 Sheldon, so Martha and then Sheldon.

14 COMMISSIONER CARTER: I agree, Fred. I think,
15 first of all, I like the layout that you've got here. I
16 would pay real close attention to people in MAT programs,
17 substance use disorder programs. Although I agree that a
18 lot of that care can be now delivered through telehealth,
19 there are some bandwidth problems in terms of telehealth in
20 rural areas, especially if you try to do group therapy.
21 And I'm actually doing a little research project on factors
22 that help people get into and stay in MAT programs.

1 You know, people have to go and get their
2 medication usually, sometimes once a week, and so they
3 really do rely on NEMT. So I would maybe, you know, have
4 that group particularly weighted in your focus groups.
5 COMMISSIONER CERISE: I would just comment that I
6 would look at investing in things like access to broadband
7 technology. You could do things like that instead of
8 transportation. You could look at ways to get medications
9 to patients instead of moving the patients back and forth.
10 COMMISSIONER CARTER: People have been
11 uncomfortable mailing those drugs. You're right. You're
12 right. But there are some...
13 VICE CHAIR MILLIGAN: Okay. I have Sheldon, then
14 I have Leanna after that.
15 COMMISSIONER RETCHIN: Thanks. Kacey, this is a
16 great -- first of all, it's an area that's very
17 interesting. I always -- I never really knew the -- I
18 mean, I knew NEMT was important, but when I was running an
19 HMO, we actually bought our own vans. I wonder where
20 they're at today.
21 So I went back -- it's kind of interesting. I
22 went back and looked at whether there were previous studies

1 on NEMT, and I'm sure you ran across them, but there was a
2 very comprehensive study in 2014 by Texas A&M that looked
3 at NEMT state by state showing the state differences, which
4 were interesting.
5 Then I found another one by Kaiser in 2016. The
6 fascinating part about that was that neither one addressed
7 the transportation network company, Uber and Lyft. It
8 shows you how fast this space is changing. So I'll just
9 point out that the TNCs have in common with telehealth,
10 different in terms of bandwidth, but they do have in common
11 with telehealth, they're both technology that can be very
12 confusing, not easy to navigate.
13 I have problems, we all have problems getting to
14 the right corner, finding the Uber. Imagine -- I tried to
15 teach my 97-year-old Dad, who still scores in the stock
16 market, knows how to short a stock and makes a ton of money
17 off of that, and still can't get an Uber.
18 But it was pointed out in your memorandum that
19 those technological issues could be solved by software
20 where the frail elderly who are stranded in urban areas,
21 much less rural, that that should be solved. There ought
22 to be an easier way for those people who need different

1 icons or different ways to be able to get that. But I
2 thought it was a very important presentation, and I thank
3 you for it.
4 VICE CHAIR MILLIGAN: Thank you. I have Leanna.
5 COMMISSIONER GEORGE: I'd be interested -- I'm
6 sorry.
7 VICE CHAIR MILLIGAN: No, I'm sorry.
8 COMMISSIONER GEORGE: I'd be interested in --
9 why, the folks who are on dialysis, center-based dialysis,
10 are requiring center-based versus in-home dialysis? We're
11 going through this right now, my husband being in stage 5
12 kidney disease himself. And usually center-based dialysis
13 is like the least recommended because it's not as many
14 visits, it's not as frequent as what your nephrologist
15 would like you to have, generally speaking. So what are
16 the reasons why it's being chosen over home-based dialysis?
17 If we can address those reasons, then maybe we can get more
18 people on home-basis dialysis and reduce the need for these
19 centers and reduce the need for NEMT. So that's my
20 suggestion.
21 VICE CHAIR MILLIGAN: Thank you, Leanna. Tricia
22 and then Toby.

1 COMMISSIONER BROOKS: Yeah, just a quickie.
2 Great work. It was really helpful. I didn't actually know
3 that there were other programs that required
4 transportation, so that Massachusetts model that was
5 mentioned for having a central office to coordinate across
6 agencies sounded very interesting.
7 I just wanted to put something on your radar
8 screen that I don't know if it came up at all in your
9 interviews, but when you look at the regs on NEMT, they are
10 different for EPSDT than they are for others. In EPSDT, it
11 says to provide the child and the family with
12 transportation. And what we have heard from the pediatric
13 community is that many of the services that are available
14 to them refuse to allow them to bring their other children.
15 And if they have small children at home and don't have
16 child care, that becomes a barrier. I get the fact that
17 this is really complicated, and it's even more complicated
18 in various geographic areas. But I do think it's an
19 important benefit, and I'd like to see it working better
20 than it does.
21 VICE CHAIR MILLIGAN: Thank you. Toby? I think
22 you might be on mute, Toby.

1 COMMISSIONER DOUGLAS: Yeah, I'm on mute. Sorry.
2 Great presentation. So the one thing I just wanted to say,
3 and it gets to this issue of optional versus mandatory
4 benefit, and what Fred was saying, immediate for this
5 report, just thinking through going forward, a point that
6 really got focused on the outcomes with so much changing in
7 the way delivery of care and the ability, whether it's
8 virtual or bringing care home, creating these optional and
9 mandatory categories for benefits may not be the right
10 approach rather than focusing on the outcomes, and what
11 we're trying to achieve here in this, and transportation is
12 one way to get to the outcomes, but there's other
13 modalities, and so how we balance really driving, you know,
14 the way a state or a plan would need to achieve that
15 outcome.
16 VICE CHAIR MILLIGAN: Thank you. Have I missed
17 anybody? Seeing no hands, I had a question and a comment
18 myself, Kacey and Aaron. The question first. You
19 mentioned some 1115 waivers that have been approved
20 regarding NEMT. Do we have any outcomes or evaluations or
21 information coming out of those 1115 waivers that would be
22 relevant to this work?

1 MS. BUDERI: Yeah, so it's very limited. There
2 are evaluations for the waivers in Indiana and Iowa. Both
3 of those evaluations, when they looked at NEMT, there were
4 some pretty significant methodological issues that would
5 put like a big asterisk on their findings, you know, for
6 example, the lack of a comparison group.
7 I can follow up with you for more details, but,
8 for example, one of the findings from Iowa was that the
9 group that had access to NEMT was more likely to have a
10 transportation barrier than the populations that didn't
11 have access to it. However, the comparison group was a
12 completely different Medicaid population versus the new
13 adult group. So I think it's hard to read findings from
14 those evaluations.
15 VICE CHAIR MILLIGAN: Yeah, that makes sense in
16 terms of just trying to extrapolate that to kind of
17 relevance in other areas.
18 I think I had two kind of comments to make. One
19 is around dual eligibles and integration. You know, we
20 heard in the panel in the discussion right before this
21 that, you know, a lot of suggestions about the importance
22 of integration. I think one of the challenges with NEMT

1 with respect to dual eligibles is if one entity is
2 delivering the coverage of the rides, so the Medicaid side,
3 but a separate entity is the service that's being received
4 on the end of that ride, so if a Medicare physician visit
5 or a D-SNP or Medicare Advantage physician visit. And I
6 think it raises the specter of fraud, waste, and abuse.
7 You know, are those rides really resulting in a visit? Is
8 access provided? Is the Medicaid side fulfilling the NEMT
9 access needs to receive the Medicare-covered benefit? All
10 of those things kind of if it's not a single entity, a
11 single integrated entity delivering both of those benefits.
12 So I think as you kind of go through some of the
13 upcoming focus groups, I think I'd like to learn more about
14 what's going on with dual eligibles and kind of one payer
15 delivering the ride and the other payer delivering the
16 visit at the end of the ride.
17 And, second, and somewhat related, is about LTSS
18 and rebalancing. If somebody's in a nursing facility, it's
19 in some ways easier to organize care. They're in the
20 nursing facility. The physicians can round and all of
21 that. Successfully rebalancing into community-based
22 settings is dependent on people being able to get access to

1 covered services from their homes, you know, as we've heard
2 in this conversation among the Commissioners. That could
3 be telehealth. It could be home-delivered services in
4 terms of some dialysis and other things that were
5 mentioned. But it could mean needing to get a ride to a
6 physician or a specialist. And so I think there is a
7 dependency on successful rebalancing about making sure
8 there's access to especially physician services, but other
9 medical services where, you know, that's easier in a
10 facility setting and NEMT might be a constraint to
11 successful rebalancing. So hopefully we can kind of tee
12 some of that stuff out in the focus group work to come.
13 So let me pause before following Melanie's
14 template here of trying to summarize. Are there any
15 comments -- Melanie, go ahead. Did you want to jump in,
16 Melanie?
17 CHAIR BELLA: Yeah, I appreciate the conversation
18 about other modes of delivery, and I think all of those
19 things are important and they can go alongside NEMT. I
20 guess I'm wondering if we -- I expected we would more
21 directly tackle the issue of do we want this to be
22 exclusively in statute as a mandatory benefit even if they

1 have discretion about how they administer the benefit. We
2 haven't really talked about that. And so I'm wondering if
3 we should be talking about that, and I guess I'm kind of
4 surprised it didn't come up, because to me that doesn't
5 take away from the other issues that were raised about
6 telehealth and about things we would need to do to make --
7 what are we calling Lyft and Uber? TRNs, or whatever the
8 acronym --
9 MS. BUDERI: TNCs.
10 CHAIR BELLA: Sorry. Whatever we would need to
11 do to make those more acceptable. I still think there is
12 like the core -- one of the core things I took out of the
13 chapter was this is supposed to be a mandatory benefit that
14 isn't in statute like other mandatory benefits are, and the
15 administration may exercise discretion to make it voluntary
16 or maybe has granted that. And is that something that we
17 want to worry about? And I guess I just raise that as a
18 question for us and see if anybody has any thoughts on
19 that.
20 CHAIR BELLA: Or Kacey, maybe you can say it. Is
21 that something you expected to hear from us on, or did I
22 just take something different from the chapter than

1 everyone else did, which is highly possible?

2 VICE CHAIR MILLIGAN: Yep.

3 MS. BUDERI: I think that's definitely one of the

4 issues, yeah.

5 VICE CHAIR MILLIGAN: Martha, were you jumping

6 in? And I think, Melanie, thank you for kind of raising

7 this. It would be good to just take the temperature of the

8 Commission about that. Martha?

9 COMMISSIONER CARTER: I think we should wrestle

10 with whether this should be a mandatory or optional

11 benefit. I think we need to wrestle with that. I have an

12 opinion on that because I live in such a rural area that

13 people really rely on this. And despite other potential

14 solutions, they are not there yet. And so it would be a

15 huge problem if NEMT wasn't available in my area. So I

16 think we do need to wrestle with this. I would come down

17 on the side of making it mandatory, but I'd be interested

18 in hearing the discussion.

19 VICE CHAIR MILLIGAN: Anne, can I check with you

20 about if we were to try to be prepared to have a discussion

21 about whether to make a recommendation here about a

22 mandatory benefit, in terms of how that fits into the work

1 plan at these upcoming focus groups and fits into the work
2 plan in terms of kind of the cycle of meetings, to get to a
3 vote, if we were inclined to go that direction?
4 EXECUTIVE DIRECTOR SCHWARTZ: So that's a great
5 question, but I think we have a fair amount of time. We
6 have December, January, March, April. We have four more
7 meetings. And knowing that there's interest in that is
8 useful, because then we can start to take some of the
9 findings that you've already seen, and that we'll be
10 getting from these other components, about think about how
11 they line up against a recommendation.
12 I also just want to mention that when we get
13 draft studies that the Hill staff shares with us, the staff
14 often tries to make sure that there isn't a requirement
15 that the Commission make a recommendation. That’s because
16 it seems inappropriate to require the Commission to make a
17 recommendation where there's just not enough evidence to
18 make one, or the Commission is sufficiently all over the
19 place and a study could still be helpful. But that doesn't
20 mean that you can't make a recommendation if you feel it
21 would be useful. So I think probably they would value a
22 recommendation if you think that you can get there, and if

1 you think we have the information to support a
2 recommendation.
3 VICE CHAIR MILLIGAN: Do we have a sense, Kacey
4 and Anne, when the findings on the slide that's on the
5 screen right now will be presented to the Commission, in
6 terms of how to stage the work if we want to get to a
7 recommendation? Like is this going to be coming back in
8 December or January? Do we have a sense of that?
9 MS. BUDERI: I think right now we're hoping both
10 can go in January.
11 VICE CHAIR MILLIGAN: Okay. So if we receive
12 that information and if we prepare the Commissioners to
13 have a discussion at the January meeting about taking a
14 temperature for a potential recommendation and then kind of
15 going from there, Melanie, would that timeline and process
16 kind of address your interest in getting a sense of the
17 Commission and how far we want to go with a recommendation?
18 And I see Kit.
19 So, Melanie, why don't you answer my question and
20 then Kit, I'll come to you.
21 CHAIR BELLA: Yes. I mean, my interest in
22 raising this was to figure out where the Commission is on

1 this, right, because it is something that we should have a
2 position on.
3 VICE CHAIR MILLIGAN: Thanks. Kit?
4 COMMISSIONER GORTON: So this was education to me
5 because I didn't know about all these regulations. It was
6 a regulation not in statute until we started addressing
7 this. So that was an "aha" for me. And, you know, for 30
8 years, or however long it’s been around, you know, it's
9 mandatory to have to do that.
10 So if we're now talking about assessing whether
11 it should be mandatory or not, then I think we have to
12 assemble some base of information. And you have
13 beneficiary focus groups and you're doing some
14 administrative work, but what happens if it goes away?
15 What do people see -- generations of regulators thought
16 that it was important enough to put in regulation and leave
17 in regulation. What were the original rationales, which I
18 don't know? Do those rationales test out, right? When the
19 regulation was proposed, who testified in favor and who
20 against? And did the hypothesis test out?
21 So we ought to figure out whether it should be
22 mandatory or not. My gut says, having dealt with many of

1 the issues that other people talked about, that this is
2 really, really important for an awful lot of people in an
3 awful lot of settings. And so if we're going to make a
4 recommendation then we need to support that recommendation
5 with evidence, and I think that's what goes into the
6 process, Chuck, that you're talking about, to get us to a
7 place where we can vote on a recommendation. And that's
8 what I would want to know, and Anne is perking up so she
9 may actually have answers to some of my questions.
10 But that would be what I would want to know.
11 This is sort of a new question for me, maybe because I've
12 been under a rock somewhere. And so when we start talking
13 about making something mandatory in the statute, I think we
14 have a high bar that we need to get over.
15 VICE CHAIR MILLIGAN: Anne, did you want to jump
16 in?
17 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just
18 wanted to clarify, and I hope that Kacey will correct me if
19 I get this wrong. It is mandatory now. It's just in the
20 reg, not in the statute. And the question that is being
21 posed to policymakers, you know, this administration has
22 had a focus - although maybe not as aggressive as they

1 might have been due to COVID, to change that to be an
2 optional benefit. And Congress, through this action, has
3 sort of said, "Hey, wait. Whoa, wait a minute."
4 So I think your point is well taken, Kit, to
5 answer the question about, you know, should it stay the
6 same or would it be better for it to be in the statute, or
7 could we get rid of it. This is exactly what we're trying
8 to get at. But I just wanted to clarify that it isn't like
9 should it be mandatory or optional. It is mandatory. It's
10 just in reg, which makes it vulnerable, easier to remove.
11 If it were statutory that would be a lot harder but not
12 impossible. I mean, you can change it, but it would be a
13 heavier lift with more actors needed to do it.
14 COMMISSIONER GORTON: It sounds like this
15 administration is actually waiving it.
16 VICE CHAIR MILLIGAN: If I could maybe just jump
17 in and try to kind of respond, Kit, to your question but
18 also kind of wrap it up, because we're at time. The
19 administration has signaled that they were going to issue a
20 proposed reg about the future of NEMT, and that proposed
21 reg has been kind of on the docket for a while and hasn't
22 been released. So it's not clear.

1 And, by the way, just contextually, the HEROES
2 Act that the House passed, and the Senate didn't take up,
3 did include requirements about making NEMT a mandatory
4 benefit, by statute.
5 So some of this is in play in the context of
6 COVID, but I think in terms of maybe next steps for us,
7 Kacey and Anne, I think it would be helpful -- let me just
8 try to summarize -- it would be helpful to come back, when
9 you present the rest of these findings and focus group
10 work, in January, it would be helpful to come back with
11 some options for the Commission, including a potential
12 recommendation to make a statutory change. But I think in
13 framing that up, what I think I heard the Commissioners say
14 that would be helpful is to really be as sharp as we can be
15 around when and how NEMT is necessary for access to care.
16 You know, picking up on some comments from Fred
17 and others around, maybe telehealth has picked up some of
18 the need that previously would have been rides. Maybe
19 services can be more home delivered. And yet there's the
20 technology issues that Sheldon and Martha raised around
21 bandwidth, around, you know, areas in rural communities
22 where you can't get telehealth easily, you can't get -- you

1 know, it's not easy to use apps like Uber and Lyft.

2 So I think framing it from an access perspective

3 and what is known in terms of impact on access if NEMT were

4 to be changed in a regulatory framework I think would be

5 helpful. And, Sheldon, I'll give you the last word and

6 then we need to move on to the next agenda item, I think.

7 COMMISSIONER RETCHIN: Yeah, Chuck, just to

8 double down on what you just said, and that is that

9 documenting what telehealth may have done in terms of

10 reducing the need for trips links the two, since the issue

11 of telehealth is not mandatory. And I think linking the

12 two, personally, it makes sense to me, in the way that

13 there have been some cost savings, and that's one area

14 where telehealth may show a return on investment.

15 VICE CHAIR MILLIGAN: And I do, I think -- and

16 I'm not sure, Anne, if you're getting my attention, and

17 Kacey, I want to make sure that you've got what you need

18 for now or if you have any questions. I should probably

19 give you guys the last word and then give it back to

20 Melanie to go to the next agenda item.

21 Anne? Kacey?

22 EXECUTIVE DIRECTOR SCHWARTZ: I think we will do

1 what we can do in terms of data, both on the T-MSIS front -
2 - you know, Aaron is here and he is doing a lot of that
3 analysis -- but also on the telehealth front. I think that
4 the supposition may be right, but our ability to be able to
5 actually show the data for that may be limited.
6 VICE CHAIR MILLIGAN: Thank you. Melanie, it's
7 all yours.
8 CHAIR BELLA: Thanks, Kacey. Thank you, Chuck.
9 All right. We're in the home stretch. We have
10 our final session right now with Rob, who is going to talk
11 to us about nursing facility acuity adjustment. So please
12 try and make that as exciting as possible, Rob, as we have
13 our last session of the day.
14 But this is more -- there's no action necessary
15 by the Commission on this one. This is going to be
16 educational for us. And then once Rob is finished and
17 we're finished with our discussion we'll ask if there's any
18 public comment on either the NEMT or on what Rob presents
19 now.
20 So take it away, Rob.
21 **### CHANGES IN NURSING FACILITY ACUITY ADJUSTMENT**
22 **METHODS**

1 * MR. NELB: Thanks, Melanie. Yeah, so we're going
2 to finish today's meeting with everyone's favorite topic,
3 the nursing facility acuity adjustment methods.
4 This work emerged out of the Commission's
5 discussion last fall about nursing facility payment
6 methods, and it's the first in a series of analyses around
7 nursing facilities that we plan to present during this
8 report cycle.
9 I'll begin today by just providing some
10 background about nursing facility payment in general, and
11 then focus in on how acuity adjustment is currently used in
12 state Medicaid programs. Then I'll present the results of
13 our analyses, comparing resource utilization groups, or
14 RUGs, which is the system that most Medicaid programs
15 currently use, and comparing that to the patient-driven
16 payment model, or PDPM, which is the new model that
17 Medicare began using in October of this past year.
18 Overall, our analyses find that PDPM isn't a very
19 accurate measure of the therapy needs for long-stay
20 Medicaid patients, and so we'll conclude today's
21 presentation by thinking about some of the implications of
22 these findings for state Medicaid programs and for our

1 future work on nursing facility payment more generally.

2 So first just some background. Medicaid programs
3 are statutorily required to cover nursing facility care,
4 which includes both skilled nursing care following a
5 hospital stay as well as long-term custodial care in a
6 nursing facility for individuals who need help with
7 activities of daily living.

8 In 2019, approximately 84 percent of Medicaid-
9 covered nursing facility residents were dually eligible for
10 Medicare and Medicaid. Because Medicare, though, only
11 covers up to 100 days of skilled nursing facility care, for
12 these dually eligible patients Medicare typically covers
13 the first portion of their stay and then Medicaid picks up
14 to cover subsequent days of nursing facility care once the
15 Medicare benefit is exhausted.

16 As with other types of Medicaid payments, states
17 have broad flexibility to design their nursing facility
18 payment methods. In general, there are two categories:
19 base payments are tied to particular services and
20 supplemental payments, which are lump-sum payments,
21 typically made for a fixed period of time. Together, base
22 and supplemental payments cannot exceed a reasonable

1 estimate of what Medicare would have paid, which is known
2 as the upper payment limit, or UPL.
3 In this presentation I'll be focusing on Medicaid
4 fee-for-service payment policies, but it's important to
5 note that these findings are relevant to managed care as
6 well, since most states require managed care plans to pay
7 according to fee-for-service methods for nursing facility
8 care.
9 Moving on to acuity adjustment, in general acuity
10 adjustment is a method for adjusting payment rates to
11 account for the fact that patients with different care
12 needs have different costs of care. Compared a purely
13 cost-based system, a price-based acuity adjusted system
14 provides an incentive for facilities to treat sicker
15 patients while also controlling costs.
16 In 1998, Medicare switched from a cost-based
17 system to a prospective payment system for nursing facility
18 care, and developed a method known as RUGs, to help adjust
19 for patient acuity.
20 According to MACPAC's review of state fee-for-
21 service payment policies, as of July of last year, 33
22 states and the District of Columbia currently use RUGs to

1 adjust their base payment rates for nursing facilities.
2 However, states are not required to use a specific method,
3 and in our review we found that eight states used a state-
4 developed method and that nine states didn't appear to use
5 any acuity adjustment method, since their payments are
6 largely based on costs.

7 Because RUGs has been the method that Medicare
8 has used to pay nursing facilities, most states use RUGs to
9 calculate the UPL, based on estimates of what Medicare
10 would have paid for the same service, which CMS refers to
11 as a price-based UPL method.

12 States also have the option of demonstrating the
13 UPL through a cost-based method, but in general, because
14 Medicare payments to nursing facilities typically exceed
15 costs, the price-based method typically results in higher
16 UPL limit than the cost-based method, that is allowing
17 states to make more payments to nursing facilities.

18 So beginning in October of last year, Medicare
19 changed its acuity adjustment method from RUGs to PDPM.
20 The main difference between these two methods is that the
21 RUG method varies payment based on the amount of therapy
22 that a patient uses, while PDPM predicts the patient's care

1 needs, based on their initial diagnosis.

2 States are allowed to continue using RUGs, but

3 CMS is currently planning to phase out support for RUGs by

4 removing some of the RUG-related questions on the standard

5 federal assessment of nursing facility residents, known as

6 the Minimum Data Set, or MDS. CMS was initially planning

7 to phase out the RUG-related questions in October of this

8 year, but they have since delayed this transition to a

9 later, unspecified date.

10 Nevertheless, this pending transition is causing

11 some states to reconsider how they measure patient acuity

12 for Medicaid, and so we thought it would be helpful to take

13 a closer looks at how these two acuity adjustment methods

14 compare.

15 In this study we contracted with Abt Associates

16 to calculate patient acuity using MDS assessments from

17 2019, which is before the PDPM transition. Because full

18 PDPM data aren't available for 2019, we developed a

19 crosswalk to estimate PDPM patient acuity using some of the

20 crosswalks that CMS had used when they were initially

21 developing the model.

22 However, it is important to note that these

1 crosswalks are imperfect, and that because of the different
2 data elements involved in each system there isn't a very
3 easy way to convert acuity from one method to another.
4 So with those caveats, let's look at the results.
5 This figure shows our findings for average case-
6 mix weights for Medicaid-covered nursing facility residents
7 for each component of RUGs and PDPM, and the findings are
8 standardized as a ratio to the average acuity levels for
9 Medicare-covered nursing facility residents.
10 Under RUGs there were two components to acuity, a
11 nursing and therapy component, whereas in PDPM there are
12 five different components. PDPM also has a nursing
13 component, which is pretty similar to the RUG nursing
14 component, but it breaks out the therapy components into
15 different parts, to physical therapy and occupational
16 therapy.
17 PDPM was designed to be budget neutral for
18 Medicare patients, and so there's no change in the average
19 acuity levels for Medicare patients. But in our analysis,
20 we do find that there's a big change in average acuity
21 levels for Medicaid patients. And we observed the largest
22 difference for the therapy components.

1 For example, under RUGs the average therapy index
2 for Medicaid residents was about 13 percent of the average
3 RUGs therapy index for Medicare patients. However, under
4 PDPM the average physical and occupational therapy indices
5 are nearly identical to those of Medicare residents.
6 We observed less of a difference between the
7 nursing components of RUGs and PDPM, but PDPM still
8 resulted in a slightly higher case mix rate.
9 So the main reason for the differences between
10 RUGs and PDPM is that PDPM case mix weights are largely
11 based on a patient's initial diagnosis at admission and
12 doesn't reassess care needs during a longer nursing
13 facility stay, such as those that are covered by Medicaid.
14 Although our patient's initial diagnosis is often
15 a good measure of the care that they need during a short
16 skilled nursing stay that's covered by Medicare, it's not a
17 particularly good measure of the care that they need
18 throughout a longer Medicaid-covered stay.
19 So to better understand how nursing facility
20 acuity changes over time, we also looked at a cohort of
21 nursing facility residents that had been in a nursing
22 facility for about two years as of September 2019. Overall

1 we found that after one year the use of therapy services as
2 measured by RUGs was less than 20 percent of what it was at
3 admission. There wasn't as much of a decline in the
4 nursing component of RUGs, which may explain why there's
5 less of a difference between RUGs and PDPM on the nursing
6 indices.
7 All right. So what does this all mean for
8 Medicaid? Well, the differences vary for base and
9 supplemental payments. So for base payments, because CMS
10 has now delayed the transition and the phase-out of the
11 RUGs-related questions, states will have a little bit more
12 time than they initially thought to assess changes to their
13 base payment methods. However, our analyses find that
14 switching from RUGs to PDPM will be a bit more challenging
15 for Medicaid than it was for Medicare. It may be possible
16 for states to retain some aspects of PDPM such as the
17 nursing component or to somehow adjust PDPM to account for
18 the different needs of Medicaid residents, but doing so
19 will require additional time and resources.
20 CMS is now allowing states an option to collect
21 PDPM-related information for Medicaid-covered stays, which
22 would be a first step in enabling some of those further

1 analyses about -- more detailed analyses about how these
2 different payment methods compare and how if you switch
3 payment methods, how it might affect particular types of
4 providers.
5 For supplemental payments, states don't have as
6 much time to adjust because of CMS' rule that the data used
7 for UPL demonstrations must not be more than two years old.
8 As a result, it appears that states may need to begin using
9 PDPM instead of RUGs for UPL demonstrations beginning in
10 FY2022.
11 CMS has not yet issued guidance on how states
12 should calculate the UPL under PDPM, but because of our
13 finding that the case mix weights are much higher under
14 PDPM than RUGs, it does appear that shifting from RUGs to
15 PDPM may result in a higher estimate of what Medicare would
16 have paid, thus increasing the UPL and allowing states to
17 make more supplemental payments.
18 So that concludes my presentation for today. I
19 look forward to your feedback about this study as well as
20 our implications for our broader nursing facility payment
21 work. Some policy questions to help guide your
22 conversation are here on the slide.

1 First, what resources do states need to support
2 the development of nursing facility payment methods that
3 promote statutory goals?
4 Second, what are the implications of using
5 Medicare as an upper limit on Medicaid nursing facility
6 payments?
7 And, finally, the question of, you know, if
8 Medicare isn't the appropriate benchmark, then what is an
9 appropriate benchmark for Medicaid nursing facility payment
10 adequacy?
11 Thanks.
12 CHAIR BELLA: Thank you, Rob. And just to
13 reiterate what he said, this is one of many sessions in
14 this report cycle on nursing facility issues. So anybody
15 have questions or comments for Rob? Bill.
16 COMMISSIONER SCANLON: Yes, thank you very much,
17 Rob. I think this is an incredibly important topic, has
18 been for a long time, but even more so now with COVID. I
19 mean, it's clear that we have to be very concerned about
20 nursing home payment.
21 It's actually something that I used to spend a
22 lot of time on. In another context recently, I had to kind

1 of look back at what I had done in the past and realized
2 that I had worked in about a dozen states either advising
3 them on how they should structure their payments or working
4 on some of the court cases involving challenges to the
5 payments, either working to challenge the state's system or
6 to defend the state's system. So this is a topic of -- has
7 been a topic of significant interest to me.

8 I want to say sort of this is incredibly
9 important, but it's also an incredibly hard and complex
10 topic. And this idea of what's the appropriate benchmark
11 for Medicaid nursing facility payment adequacy, that was
12 the central question in all those lawsuits, and probably
13 it's no exaggeration that tens of millions of dollars were
14 spent trying to answer the question. And we probably do
15 not have a really great answer to the question.

16 The Boren amendment set the standard as saying
17 that Medicaid rates should cover the cost of efficiently
18 and economically operated facilities, and that's a very
19 good standard, but it's incredibly hard sort of to
20 implement or to decide whether there's been compliance.

21 Just in terms of the definition itself, I mean,
22 there was confusion. Efficiency, you can think of it in

1 the economic terms of where you're using resources to the
2 maximum extent necessary and you're not overpaying for
3 them. Economical was always thought of in the mini context
4 as a synonym for efficiency, but I don't think it really
5 was. I think it really meant economical in a different
6 sense. And you know since we had an earlier conversation,
7 I like to use car analogies to talk about nursing homes
8 because I think people are more familiar with cars than
9 they are with nursing homes. And in terms of economical
10 and efficiency, Cadillac, Lincoln, and Lexus can all
11 efficiently produce incredible sedans, but Chevrolet, Ford,
12 and Volkswagen can produce sedans that are functionally the
13 same, equally safe, and yet we would not think of the
14 Lexuses and the Cadillacs as economical. We would think
15 more of the Fords and the Chevys as being economical. So
16 there's that difference.
17 The issue of sort of, okay, if we say, all right,
18 this is -- we're going to look for the homes that are
19 efficient and economical, the question is how to identify
20 them. And I think that's almost an impossible task.
21 In a lawsuit that I was involved in, it ended up
22 sort of the court accepted this as the standard, which was

1 that if a sufficient number of homes in different
2 circumstances are having their costs covered, then the
3 system was considered as in compliance; it was falling
4 within a range of reasonableness that it was probably true
5 that the standard was being sort of fulfilled. And I think
6 that's the best one can do, but that's an incredibly labor-
7 intensive activity to identify sort of are there a
8 sufficient number of homes that are getting their costs
9 covered, because when you look at simple data on cost and
10 revenues, you're going to have homes that do not get
11 revenues that cover all of their costs. So that's the
12 issue there.
13 I think that given this framework or the outline
14 of sort of this issue, we have to as a Commission think
15 about what can we do that's going to be helpful in terms of
16 providing valid information that will be useful in terms of
17 guiding sort of future methods of nursing home payments.
18 Let me also say something about the acuity
19 adjustment changes. Acuity adjustment, when I started
20 working -- it was in actually in Minnesota, back in around
21 1985, there was only one state that had done an acuity
22 adjustment, and it was Illinois, and it was a relatively

1 simple one. As you've identified, it's become incredibly
2 widely prevalent, but to me the world has changed
3 tremendously since 1985. In 1985, nursing homes had
4 occupancy rates 95 percent and above, generally, and access
5 was the principal issue for thinking about why you wanted
6 to adjust payment rates for acuity, because you wanted
7 homes to take more difficult-to-deal-with patients or
8 residents. And the world has changed. Data that I have
9 seen recently is that nursing home occupancy is now in the
10 80s, maybe even sort of in the low 80s. So the question of
11 why a state is using an acuity adjustment in their payment
12 system has changed, and I actually -- if I was working in
13 states, I would be asking the question of is it worth your
14 time to use an acuity adjustment? Aren't there
15 alternatives that can accomplish the same goal in terms of
16 creating payment incentives that will accomplish sort of
17 what you have in mind? And I think that what you've got in
18 terms of data illustrates the very significant difference
19 between what Medicare used to have, which was data on
20 actual service use, versus a prediction of service use?
21 And as you saw, sort of the over time comparison, it
22 deteriorates completely.

1 So in some ways, I think it's an improvement to
2 not have data from Medicare which was in part sort of
3 influenced by economic incentives, to have something that
4 is more sort of individual based, but the problem is that
5 with anything that's built on a predictive model, you
6 always have the problem of the error prediction.
7 So, again, thank you for starting us down this
8 path into this incredibly important area.
9 CHAIR BELLA: Thank you, Bill. We can't tell at
10 all that you feel strongly in this area.
11 COMMISSIONER SCANLON: No, not at all.
12 CHAIR BELLA: It's all good.
13 Chuck, and then we'll see if there's any other
14 Commissioners, and then we'll get to the public comment and
15 try to stay on our schedule, which means we're coming to
16 the end. Chuck and then Fred.
17 VICE CHAIR MILLIGAN: Nice job as always, Rob. I
18 want to pick up on the last part, I think, of what Bill was
19 saying. I think the acuity adjustment to me has tremendous
20 value in Medicaid, even despite maybe the occupancy rate
21 issue, because I think it's critical to a successful
22 rebalancing strategy.

1 I think we need to have payment mechanisms that
2 discourage nursing facilities from keeping lighter-touch,
3 higher-functioning individuals because the rate-setting
4 system doesn't adequately distinguish among need. And so
5 for rebalancing to work, in my view, you have to incent the
6 nursing facilities to be adequately paid for the people who
7 just are too complex to be served in HCBS settings, so
8 people with a lot of technology needs and vent needs and
9 behavioral issues and all kinds of things.
10 So the point of this is I want to make sure that
11 we keep on top of the implications and Medicaid strategies
12 about risk adjustment as this transition occurs.
13 The second thing I want to just make sure that we
14 keep on top of is the potential program integrity challenge
15 if the UPL threshold goes up and states might see this as
16 another opportunity for kind of some of the gaming things
17 that have been criticized by Congress and others in the
18 past, and just for us to have a sense of, you know, where
19 that program integrity risk might go.
20 So I just want to -- I think this was a great
21 foundational piece. I think we'll be coming back to it
22 over time as you indicated. But to me, I'm focused on the

1 program integrity piece and then the relationship to a good
2 Medicaid nursing facility payment system that incentivizes
3 nursing facilities to be adequately paid for high-need
4 individuals so that they don't try to retain others.
5 And I guess the final comment I'll make in terms
6 of I think Bill's occupancy rate point, it's my
7 understanding anecdotally that nursing facilities set aside
8 beds for more of the post-acute Medicare folks because
9 they're higher paid, and so some of that occupancy is
10 really trying to manage payer mix in facilities. And so I
11 think we should keep an eye on that as well. And I'll
12 leave it there. Thank you.
13 CHAIR BELLA: Thank you, Chuck. Fred? Fred,
14 you're on mute.
15 COMMISSIONER CERISE: Sorry. Yeah, Chuck touched
16 on it, and so I'll be really brief. But on your second
17 point, you know, tying UPL to Medicare makes sense in
18 certain circumstances when it's the same service, you know,
19 hospital day for a particular diagnosis. But here where
20 you're comparing a skilled day to something that's, you
21 know, a boarding day, as you pointed out, this change in
22 methodology really has the potential to raise that UPL

1 place, and I would bet that states will find a way,
2 particularly since a lot of the state share is not coming
3 from the state general fund, to take advantage of that.
4 And so I know about the time -- that one needs an answer
5 soon because of the two-year window for setting UPL. So I
6 think you made a good point there, and I'm looking for some
7 guidance from CMS on, you know, why would you tie that UPL
8 to the new Medicare methodology. It didn't seem to make
9 sense.

10 CHAIR BELLA: Thank you, Fred.

11 We will turn now to see if there's any public
12 comment; then we'll come back and make sure there's no
13 additional Commissioner comment and make sure Rob has what
14 he needs. So it looks like we have someone with a comment.
15 If you could introduce yourself and where you're from, that
16 would be helpful. Could we unmute Courtney, please?

17 **### PUBLIC COMMENT**

18 * MS. KING: Hi. Thank you for taking public
19 comment on this. I'm the state Medicaid state plan
20 administrator in Alaska, and the discussion regarding the
21 non-emergency Medicaid medical transportation is an
22 alarming one for our state. Given our fiscal crisis, any

1 benefit that's moved into the optional category will be on
2 the table for cuts by the legislature. And given our
3 extremely small amount of our state that is covered by road
4 system, we're talking about the possibility of jeopardizing
5 access to a disproportionate number of Alaska Natives and
6 lower-income people in the state. The travel that happens
7 for rural people is flying into either hub or urban areas
8 to get transportation -- I'm sorry, to get medical
9 services. And so it's not just let's get a cab down the
10 road or a bus down the road. And so as you can imagine,
11 our transportation costs are significant, which would make
12 it an attractive feature for the legislature to cut.
13 So I would just really urge you to think about
14 the fact that the various states have different needs and
15 different challenges, and obviously this one's huge for
16 Alaska.
17 I would like to say in regards to the
18 telemedicine that Alaska is a leader in telemedicine
19 services, and yet the issue of broadband in rural Alaska is
20 not one that's been solved. And we continually work on it.
21 But, you know, if you've seen a satellite view of our
22 state, you can understand why.

1 So I would just consider -- I would really urge
2 you to consider that when you're talking about the
3 mandatory or optional nature of the non-emergency medical
4 transportation. Thank you.
5 CHAIR BELLA: Courtney, thank you for joining and
6 for taking time to make a comment, and I would just clarify
7 in case there was any confusion. I think what we're
8 deliberating is: Is this benefit, which is in regulation,
9 one that we should recommend to be in statute, you know,
10 continuing on a mandatory basis? But your comments are
11 reinforcing and very helpful to here since you're
12 administering the program on the ground. So thank you.
13 COMMISSIONER CARTER: Or in the air.
14 CHAIR BELLA: Right, or in the air.
15 I don't see any other public comment. Rob do you
16 have what you need from us on this session?
17 COMMISSIONER BARKER: Melanie?
18 CHAIR BELLA: Yes, Tom.
19 COMMISSIONER BARKER: Melanie, this is Tom
20 Barker. I apologize. My camera is not working. But I did
21 have one comment on Rob's presentation if I could.
22 CHAIR BELLA: Okay.

1 COMMISSIONER BARKER: So on that last bullet
2 point on Rob's slide about what is an appropriate benchmark
3 or Medicaid rates, I just want to point out we should think
4 about what happened back when there was a Boren amendment
5 and there was a Supreme Court decision in 1990 that held
6 that the Boren amendment was enforceable in the federal
7 court system. That decision has been eroded over the
8 subsequent three decades, and so I just want to point out
9 and I think we should think about, even if there were to be
10 a federal benchmark for nursing home rates, whether or not
11 that benchmark would actually be enforceable in the federal
12 court system. I think that's an important consideration.
13 CHAIR BELLA: Okay. Thank you, Tom, your voice
14 coming from the sky. But I appreciate the comment.
15 All right. Rob, you're in good shape on this
16 one? Okay. We'll see you again on the topic in our future
17 meetings.
18 We have now gotten through today's agenda,
19 everyone. Hopefully folks felt the format was a little
20 more -- a little less frenzied, but we will always take
21 feedback on the format. We start tomorrow at 10:30. We'll
22 spend a couple hours on access to mental health services

1 for adults. Chuck's going to lead us through that. We
2 have some introductory work and then a panel that should be
3 really enlightening as part of our work in this area, so
4 looking forward to that in the morning.
5 Thank you all for staying so engaged, and we
6 thank you to the public folks who joined us, and we'll see
7 you all back here tomorrow at 10:30. Bye, everyone.
8 * [Whereupon, at 4:19 p.m., the Public Session was
9 recessed, to reconvene at 10:30 a.m. on Friday, October 30,
10 2020.]
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PUBLIC MEETING

Via GoToWebinar

Friday, October 30, 2020
10:30 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
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 [10:30 a.m.]

3 CHAIR BELLA: Thank you. Good morning, everyone.
4 Welcome to day two of our October MACPAC session. We are
5 going to spend the morning talking about access to
6 treatment for adults with mental health conditions. We're
7 going to start out hearing from staff, and then we're going
8 to have a panel, and then we'll have some Commission
9 discussion, we'll have an opportunity for public comment,
10 and then we'll take a break for lunch. So, like I said,
11 we'll spend the next two hours on this, and Chuck, I'm
12 going to turn it over to you to lead the morning.

13 VICE CHAIR MILLIGAN: Thanks, Melanie, and
14 welcome again, all of the attendees today. I am very much
15 looking forward to the discussion about mental health
16 issues for adults.

17 Erin, I will turn it over to you and look forward
18 to what you and Melinda have to share ahead of the panel
19 discussion to follow.

20 **### ACCESS TO MENTAL HEALTH SERVICES FOR ADULTS IN**
21 **MEDICAID**

22 * MS. McMULLEN: Thanks, Chuck.

1 You might remember that last month we presented
2 some findings from an analysis of federal survey data which
3 showed that regardless of an individual's insurance status,
4 many individuals with mental health conditions report
5 difficulty in accessing services. This particularly holds
6 true for adults with serious mental illness.
7 In 2018, we found that roughly half of non-
8 institutionalized adults with serious mental illness
9 reported that they needed but did not receive mental health
10 treatment in the previous year. We also found that
11 Medicaid beneficiaries were more likely to receive
12 treatment in inpatient settings and less likely to receive
13 treatment in a private therapist's office.
14 So this month we're going to build off those
15 findings and continue our discussion regarding adults with
16 mental illness, paying particular attention to the
17 availability of non-hospital-based mental health treatment.
18 After our presentation, Commissioners will hear
19 from an expert panel on this topic, focusing on actions
20 that state Medicaid agencies are taking to improve access
21 to community-based care. And then after the panel,
22 Commissioners will have additional time to reflect on the

1 findings from this presentation as well as the conversation
2 with our panel.
3 Today's presentation will reflect two different
4 analyses that we conducted, one that examines coverage and
5 access to mental health services for adults enrolled in
6 Medicaid. In the first analysis, we'll present findings
7 from a 50-state review of Medicaid coverage policies for
8 mental health services, and I'd like to take a moment just
9 to thank Sameer Rao. Sameer was a research assistant with
10 us this past spring, and he was critical in locating the
11 different state-level documents that were used to conduct
12 this analysis.
13 The second analysis we'll present today explores
14 two often separate treatment systems for mental health --
15 specialty mental health treatment facilities and then
16 office-based solo and small group mental health practices.
17 And then we'll conclude our presentation with some
18 background information on federal Medicaid demonstrations
19 aimed at improving care for adults with mental illness, and
20 our panel will speak to those in greater detail.
21 So appropriate mental health treatment varies
22 with severity of an individual's condition. Some

1 individuals may experience mild to moderate mental illness
2 while others may have serious mental illness that
3 substantially interferes with or limits their ability to
4 perform one or more major life activities or activities
5 also known as activities of daily living.
6 Adults with mental illness really need access to
7 a continuum of care that offers a variety of services that
8 vary in intensity. This includes the availability of those
9 clinical services, such as outpatient treatment, partial
10 hospitalization, and inpatient psychiatric care, supportive
11 services such as supported employment or peer supports as
12 well as crisis services, which help divert individuals from
13 inpatient levels of care.
14 In order to assess access to this continuum, we
15 analyzed 15 discrete services that are shown on the next
16 two slides, and the definitions for those services are
17 included in your meeting materials.
18 In order to determine what services were covered
19 at the state level, we reviewed Medicaid state plans, 1115
20 and 1915(b) waivers, HCBS waivers, and other publicly
21 available documents. That documentation was then used to
22 align service descriptions with mental health services

1 shown on the slide.

2 State definitions of mental health services

3 aren't standardized and vary widely, so the MACPAC

4 categorization of state-level coverage really approximates

5 the closest level of service description. In instances

6 where that publicly available information wasn't available,

7 we did contact states directly to try to determine their

8 coverage policies.

9 Generally we found that Medicaid's role in

10 financing mental health services for adults varies

11 considerably at the state level, and many states don't

12 offer a full complement of services. All state Medicaid

13 programs did cover mental health screening and assessment

14 services, outpatient mental health services, and inpatient

15 psychiatric care. However, we did find gaps in coverage

16 for residential services. In part, this may be

17 attributable to the Institutions for Mental Diseases, or

18 IMD, exclusion, especially in states where the majority of

19 facilities are considered IMDs.

20 Despite this exclusion, I did want to highlight

21 for Commissioners that we did find, in 2018, that nearly

22 all states were making payments for services provided in

1 IMD settings via various exemptions and authorities from
2 statute, statutory exemptions for older adults and
3 children, demonstration waivers under Section 1115, as well
4 as an in lieu of service in managed care.
5 The next slide summarizes state coverage findings
6 related to recovery-oriented services as well as crisis
7 services. The largest gap in coverage we found was for
8 supported employment, and states offered crisis services to
9 varying degrees, with most states covering emergency crisis
10 services.
11 Offering mental health crisis care is a key
12 strategy to reducing psychiatric hospital bed overuse, to
13 decrease the boarding of individuals in a psychiatric
14 crisis and emergency departments, and to reduce the need
15 for law enforcement to respond to psychiatric crises.
16 However, as you can see on the slide, fewer states offered
17 mobile crisis services or residential crisis treatment.
18 The next several slides highlight findings from
19 our analysis of mental health treatment availability.
20 Before we discuss those findings, we wanted to discuss and
21 compare the two components of the specialty mental health
22 system.

1 The first includes specialty mental health
2 treatment facilities that typically treat individuals with
3 serious mental illness. These facilities participate in
4 Medicaid at high rates, and they are more likely to be
5 located in low-income communities than higher-income
6 neighborhoods. Medicaid beneficiaries with mental illness
7 are also more likely to receive care in these specialty
8 facilities, when compared to their privately insured peers.
9 And then the second component of the specialty
10 mental health treatment system is office-based, solo, and
11 small group practices, comprised of psychiatrists and other
12 mental health professionals, such as therapists. These
13 office-based providers are less likely to participate in
14 Medicaid when compared to specialty mental health
15 facilities, and often only provide services to those with
16 the ability to pay out of pocket. They are also more
17 likely to be located in high-income neighborhoods than low-
18 income communities. Accordingly, Medicaid beneficiaries
19 with mental illness are less likely to receive services in
20 these types of settings when compared to their privately
21 insured peers.
22 We also wanted to highlight that there is no

1 single data source providing information on both of these
2 components of the mental health treatment system, so as a
3 result we examined multiple data sources to illustrate the
4 availability of both specialty mental treatment facilities
5 as well as office-based practices.
6 Moving on to findings related to specialty mental
7 health treatment facilities, using the 2018 National Mental
8 Health Services survey, we examined the availability of
9 specialty mental health treatment facilities at the state
10 level as well as their participation in Medicaid. These
11 facilities provide services ranging from outpatient mental
12 health services to partial hospitalization to inpatient
13 psychiatric care.
14 In 2018, there were roughly 12,000 of these
15 facilities in the U.S., and 89 percent of them reported
16 accepting Medicaid. Moreover, as you can see on the slide,
17 participation in Medicaid varied at the state level. We
18 found that participation in Medicaid ranged from 72 percent
19 in Utah to 98 percent in Montana.
20 With that, I'll hand it off to Melinda to discuss
21 some of these findings in greater detail.
22 * MS. ROACH: Thanks, Erin.

1 So although specialty mental health treatment
2 facilities reported accepting Medicaid at high rates, the
3 availability of intensive community-based mental health
4 services varied. Most facilities reported offering
5 outpatient mental health services and accepting Medicaid,
6 and nearly half reported offering on- or off-site crisis
7 services. However, more intensive services such as partial
8 hospitalization, assertive community treatment, and
9 residential treatment were offered less often than
10 traditional outpatient services.
11 In 2018, few specialty mental health treatment
12 facilities reported offering recovery-oriented services.
13 Only one in four facilities offered peer support services,
14 and even fewer reported offering supported employment or
15 vocational rehabilitation. Most facilities offering
16 recovery-oriented services also reported accepting
17 Medicaid.
18 In 2018, roughly one in four specialty mental
19 health treatment facilities reported that they offered
20 telehealth and accepted Medicaid. However, there was wide
21 variation in the availability of those services at the
22 state level, ranging from 3 percent of facilities in

1 Connecticut to 71 percent in North Dakota.

2 Our analysis also looked at the share of

3 specialty mental health treatment facilities offering

4 mental health crisis services. In 2018, 44 percent of

5 facilities reported that they accepted Medicaid and had a

6 crisis intervention team to handle acute mental health

7 issues either on- or off-site. Fewer facilities offered

8 psychiatric emergency walk-in services and accepted

9 Medicaid.

10 Finally, we examined the extent to which

11 specialty mental health treatment facilities reported

12 integrating clinical care, given the high rates of co-

13 occurring conditions among adults with mental illness. We

14 found that specialty mental health treatment facilities

15 were more likely to offer substance use disorder treatment

16 than integrated primary care services, with roughly half

17 reporting that they provided substance use disorder

18 treatment and only one in four offering primary care.

19 As Erin mentioned, we also examined the

20 availability of office-based, solo, and small-group mental

21 health practitioners. There are many different providers

22 who delivery office-based mental health services, including

1 social workers, psychologists, psychiatrists, and
2 professional counselors. Because there is no data source
3 that captures the availability of these providers or their
4 willingness to participate in Medicaid, we examined the
5 Health Resources and Services Administrations Health
6 Professional Shortage Area, or HPSA, designations, which
7 identify provider shortages, including mental health
8 provider shortage areas. HPSA designations are not
9 specific to Medicaid but rather reflect the overall need of
10 a geographic area, based on the population-to-provider
11 ratio and other factors.

12 HPSAs can be used to estimate the percentage of
13 need that is being met in a geographic area. As you can
14 see, in 2019, most states were far from meeting even 50
15 percent of the estimated need for mental health services.
16 Nearly 6,200 mental health practitioners would have been
17 required to remove all mental health HPSAs in the United
18 States.

19 Access to office-based mental health services is
20 also affected by provider participation in Medicaid. A
21 recent study conducted by MACPAC found that just 35 percent
22 of psychiatrists accepted new patients on Medicaid in 2014

1 and 2015, compared to 62 percent who accepted new patients
2 with Medicare and private insurance.
3 During the panel later this morning you will hear
4 about two federal demonstrations designed to improve the
5 mental health delivery system for Medicaid beneficiaries.
6 One is a Section 1115 demonstration opportunity targeting
7 adults with a serious mental illness and children with
8 serious emotional disturbance. These demonstrations allow
9 states to receive federal matching funds for psychiatric
10 services delivered in IMDs while also expanding access to
11 community-based services.
12 States participating in the demonstration must
13 meet specific rules and milestones related to improving
14 access to a continuum of care, ensuring quality, improving
15 care coordination and transitions to community-based care,
16 early identification and engagement in treatment, and
17 reducing length of stay in emergency departments. CMS
18 began approving state demonstrations late last year, and to
19 date three states and the District of Columbia have
20 received approval, and three states have pending waiver
21 applications.
22 During the panel this morning you will also get

1 an on-the-ground look at the Certified Community Behavioral
2 Health Clinics, or CCBHC, demonstration. States
3 participating in the demonstration make enhanced Medicaid
4 payments to certain behavioral health providers under a
5 prospective payment system that is intended to reflect the
6 actual cost of providing care. To become certified as a
7 CCBHC, providers must offer comprehensive behavioral health
8 care and coordinate physical health care in accordance with
9 federal criteria.
10 Participating states must target adults with a
11 serious mental illness, children with a serious emotional
12 disturbance, and individuals with a substance use disorder,
13 and may also choose to prioritize the subpopulation such as
14 school-aged youth and individuals who were previously
15 incarcerated.
16 The demonstration launched in 2017, and was
17 recently expanded to include a total of ten states. While
18 results from the national evaluation are pending, initial
19 assessments show that CCBHCs have been able to hire
20 additional staff, offer new services, and invest in health
21 information technology to support care coordination and
22 quality reporting. Congress has extended the demonstration

1 several times, most recently through December 11th of this
2 year, and several demonstration states have amended their
3 state plans to continue their programs beyond the
4 demonstration period.
5 That concludes our presentation. We are happy to
6 take any questions.
7 VICE CHAIR MILLIGAN: Thank you, both, very much.
8 So let me just kind of describe the plan for the next chunk
9 of time. The panel is scheduled to start at 11 Eastern, so
10 we've got about 15 minutes. I think it would be great if
11 we first started with technical questions to Erin and
12 Melinda, based on what they presented to us, and then have
13 the panel discussion, and we'll have questions for
14 panelists. And if we've got broader policy issues for Erin
15 and Melinda we can pick that up when the Commission has our
16 follow-on discussion after the panel.
17 So in the interest of kind of using the next 15
18 minutes or so in a targeted way, if I could see if people
19 have technical questions related to what was just
20 presented. I see Darin, so why don't you start us off,
21 Darin, and then Martha, and then Kit.
22 COMMISSIONER GORDON: This is super helpful. I

1 am curious if you found anything in the research that might
2 give us a sense of why the low participation rate on
3 office-based providers. I know in our state I have heard,
4 and it was anecdotal, from some providers that there were
5 certain requirements to provide certain benefits, like case
6 management, that was a bit of a hurdle for some of them.
7 That was written into the law by our community mental
8 health centers back in the day. But I'm assuming payment
9 rates might be an issue too. But I didn't know if you ran
10 across anything that may give us a sense of what some of
11 the barriers might be for greater participation there.
12 MS. McMULLEN: Sure. So payment rates were
13 definitely one thing that came up. I also think that one
14 issue around the office-based providers is just there's so
15 much variability at the state level around how counselors
16 and therapists are licensed, and whether or not they're
17 able to bill state Medicaid agencies. So we didn't get
18 into additional analysis that looked at that level of
19 detail. We haven't conducted any research looking into the
20 care management issue that you brought up, but it's
21 something we definitely can dig into further.
22 VICE CHAIR MILLIGAN: Thank you. Martha and then

1 Kit.

2 COMMISSIONER CARTER: Yeah, Erin, thank you for

3 this. I wondered if your scan had captured the mental

4 health and substance use disorder services that were being

5 provided in FQHCs and the FQHC lookalikes, which I think,

6 from what I can see, provided those services to about 3

7 million people last year. So was that part of your office-

8 based analysis -- not to say that there isn't huge need,

9 and I thought your map of unmet need was very helpful.

10 MS. McMULLEN: So the two data sets that we

11 presented -- the one from HRSA and then the mental health

12 facility survey that SAMHSA administers -- I don't believe

13 they capture FQHCs. So we would have to -- we can do maybe

14 some additional work to make sure that's included as we

15 kind of go through this meeting cycle and into the spring

16 when you see a draft chapter.

17 COMMISSIONER CARTER: Thanks.

18 VICE CHAIR MILLIGAN: Kit, and I saw Sheldon also

19 raise his hand.

20 COMMISSIONER GORTON: Thank you, Erin and

21 Melinda. Are there data available for the territories?

22 MS. McMULLEN: That's a good question. I think -

1 - and I don't want to be held to this, but I think that
2 there are HPSAs that we potentially can get some additional
3 information. I would have to double-check on the facility
4 analysis that we did.

5 COMMISSIONER GORTON: Okay. I just think, you
6 know, out of sight, out of mind, and it's useful to surface
7 what's going on in the territories as well, just so we have
8 the full Medicaid picture.

9 VICE CHAIR MILLIGAN: Sheldon? Sheldon, you
10 might be on mute.

11 COMMISSIONER RETCHIN: How about now?

12 VICE CHAIR MILLIGAN: Yeah.

13 COMMISSIONER RETCHIN: Okay. I thought it was a
14 terrific presentation, and I really appreciate the fine
15 work you've done. Just getting back to something Darin
16 mentioned, so I know the payment rates have been cited, so
17 two points there would be: Do we have evidence that
18 payment rate variations in states where they may be paying
19 more, that there's elasticity, that actually there's a
20 higher participation rate? That's one issue.

21 The other issue maybe Bill knows more about, but
22 for Medicare, the HPSAs give a bonus payment of 10 percent,

1 but that's limited to Medicare. So I just wondered -- I
2 don't -- since states provide a rate, again, it gets back
3 to the elasticity on participation. Did you run across
4 anything there?
5 MS. McMULLEN: So we would probably have to do a
6 little bit more digging in on the rate issue and
7 participation. I think that we've done some work
8 previously, not related to mental health necessarily, that
9 shows provider participation increases if you're likely to
10 pay more. But specific to mental health and behavioral
11 health I guess more generally, we did see some results in
12 Virginia -- I'm citing their substance use waiver, not
13 mental health, so I want to make that caveat. But they
14 demonstrated through kind of some initial analysis of their
15 1115 waiver that when they increase rates, they were able
16 to increase provider participation.
17 So we can see if there are some other specific
18 studies that get into mental health and office-based
19 providers specifically to kind of support the analysis that
20 was in your background paper.
21 VICE CHAIR MILLIGAN: Before I kind of jump in,
22 are there other Commissioners who had questions you wanted

1 to pose to Erin or Melinda?

2 [No response.]

3 VICE CHAIR MILLIGAN: So I had a couple, and,

4 Erin, Melinda, whoever is appropriate, I think one of the

5 things that would be helpful to share with the public

6 attendees is where today's work and presentation fits into

7 the work plan in general, because I know we're going to be

8 picking up on parity and some other issues in upcoming

9 meetings, and I think if you could just take a minute or

10 two to contextualize what was just presented in the broader

11 work plan to give folks a sense of where all of this work

12 is going to be going, I think that would be helpful.

13 MS. McMULLEN: Sure. I'll speak to kind of what

14 we have planned related to parity, and then

15 interoperability among behavioral health providers. Then

16 I'm going to kick it over to Melinda to talk about a lot of

17 the work that we have underway related to kids and

18 behavioral health services.

19 So some of this, I would not be surprised if you

20 hear about some of this in our panel as well. But in

21 December, we're going to be coming back to discuss

22 interoperability among behavioral health providers. So one

1 barrier to improved care coordination around individuals
2 with behavioral health conditions as well as chronic
3 diseases, one barrier that's been cited is just a lack of
4 EHR adoption or a lack of meaningful use of EHRs. So we're
5 going to present some findings of an analysis that, again,
6 looks at the specialty mental health treatment facilities.
7 We're also going to be presenting findings related to
8 specialty substance use treatment facilities.
9 We'll also be comparing the findings of that to
10 what we've seen among physical health providers who were
11 eligible for meaningful use payments, which behavioral
12 health providers were not included in. Then, in January,
13 we're going to come back and discuss mental health parity.
14 So in order to assess mental health parity
15 implementation, we went ahead and conducted a series of
16 semi-structured interviews in three states. So those
17 interviews included the perspectives of the state Medicaid
18 agency, an MCO if relevant, and also an advocate or
19 beneficiary or providers in that state.
20 Mental health parity implementation was required
21 in October 2017, but a lot of states had requested a delay
22 in that implementation date, and some states are even still

1 working for their mental health parity analyses. So we're
2 going to kind of talk about the experience in those three
3 states, and it really does demonstrate that there's kind of
4 a wide range of things going on at the state level.
5 With that, I'll let Melinda maybe briefly talk
6 about the work we have underway related to youth and
7 adolescents.
8 MS. ROACH: Sure. So in December, we'll also
9 come back to you to present two analyses with children and
10 youth with behavioral health needs, so looking both at
11 children and youth with mental health and substance use
12 disorder conditions. Similar to the analyses we presented
13 with respect to adults with mental health needs, we'll be
14 looking at prevalence and treatment rates among children
15 with behavioral health needs, comparing their experience to
16 that of their peers with other forms of insurance. We'll
17 also be providing an analysis of the availability of
18 specialty mental health treatment for children with
19 behavioral health needs. And, finally, in December,
20 somewhat similar to the panel you'll be hearing from this
21 morning, we'll be bringing together another panel with
22 states and beneficiary representatives to discuss barriers

1 and opportunities with respect to access for children with
2 behavioral health conditions.
3 VICE CHAIR MILLIGAN: Thank you both very much,
4 and one of the reasons I had asked you to do that is for
5 the public attendees, to give them a sense of how today is
6 partly foundational for some of where we're going to be
7 going.
8 I had two data questions, technical data
9 questions, and that's all I had. One, in the data, when we
10 look at access and we look at site of care, if you will, or
11 where the service is delivered, can we discern in the data
12 whether it was a telehealth-delivered visit or not?
13 Because I think that's going to be an important thing to
14 track going forward based on I think where states have seen
15 a really important uptake in COVID, and I think states are
16 likely to want to retain a lot of telehealth or behavioral
17 health or mental health. So can we discern from the data
18 if telehealth was the source of the delivery?
19 MS. McMULLEN: So I think at least for the
20 analysis that we've done, that probably remains to be seen.
21 The data that we presented to you back in September was
22 based on -- that reflected site of care was based on survey

1 data and not claims data.

2 I think previously in some of the work that we've
3 done on telehealth, we've reported that a lot of times, in
4 order to know that that service was actually delivered by
5 telehealth, that providers actually need to use an
6 additional code when they're billing. And in a lot of
7 states, if providers don't use that code, there might not
8 be any way of knowing that that service was delivered via
9 telehealth.

10 I know that CMS had put out some information
11 around behavioral telehealth use during the pandemic, but I
12 think it's something that we probably have to dig into
13 more. I know that yesterday Aaron and Kacey mentioned that
14 we're doing some of our first work around T-MSIS with the
15 NEMT analysis, so we haven't started to dig into T-MSIS in
16 behavioral yet.

17 VICE CHAIR MILLIGAN: Thank you. And my last
18 question, again, kind of a data question, and I want to go
19 back to Martha's question. Can we discern, if there's an
20 FQHC claim, whether the underlying reason for the visit was
21 behavioral health versus physical health, et cetera? Do we
22 need to get into like the diagnoses? Or from the FQHC

1 encounter, can we discern the nature of the visit?

2 MS. McMULLEN: So I would definitely need to

3 check in with my colleagues who are more well versed in

4 FQHC methodology.

5 VICE CHAIR MILLIGAN: Okay.

6 MS. McMULLEN: But it's something that we can

7 follow up on.

8 VICE CHAIR MILLIGAN: Because I agree with Martha

9 that I think a lot of behavioral health and mental health

10 services are delivered through FQHCs.

11 We're just about at time for this part of the

12 agenda. Are there any other questions Commissioners might

13 have to Erin or Melinda of a technical nature?

14 [No response.]

15 VICE CHAIR MILLIGAN: Thank you very much, and I

16 think we're now ready to pivot to the panel. And I'm not

17 sure who's hosting our panelists. Is that you, Erin? So,

18 Erin, I'll turn it over to you, but let me just say as an

19 introductory comment, thank you all very much to our

20 panelists for offering your time and expertise, and for

21 making yourselves available. What you provide to us is

22 very helpful in our work, and thank you for generously

1 giving your expertise and time to our Commission today.

2 Erin, all yours.

3 **### PANEL: ACCESS TO TREATMENT FOR ADULTS WITH MENTAL**

4 **HEALTH CONDITIONS**

5 * MS. McMULLEN: Sure. Thanks, Chuck.

6 I'm really excited to introduce our three

7 panelists who are going to speak about their experiences to

8 improve access to mental health services for adults in

9 Medicaid. I'm just going to do some quick introductions,

10 and then I'll turn it over to our panelists.

11 So first we're going to hear from Dr. Sandra

12 Wilkniss. Dr. Wilkniss is director of complex care and a

13 senior fellow at Families USA. In this role, she leads

14 efforts on prescription drug affordability and advancing

15 the interests of consumers and families with complex care

16 needs and behavioral health concerns.

17 Prior to joining Families USA, she served as

18 program director for behavioral health and social

19 determinants of health at the National Governors

20 Association Center for Best Practices. Prior to joining

21 NGA, Dr. Wilkniss worked on Capitol Hill for three years.

22 She previously held an adjunct professorship at Dartmouth

1 Medical School and an assistant clinical professorship at
2 the University of Illinois-Chicago, and was chief
3 psychologist of the inpatient psychiatric unit at the
4 University of Illinois Hospital in Chicago.
5 Dr. Wilkniss holds a doctorate in clinical
6 psychology from the University of Virginia and a bachelor's
7 degree in psychology from Princeton University.
8 Next we'll hear from Melisa Byrd. She is the
9 senior deputy director and Medicaid director of the
10 District of Columbia's Department of Health Care Finance.
11 In this role, Ms. Byrd serves as the principal manager for
12 the District's Medicaid, CHIP, Alliance, and Immigrant
13 Children's Health programs. Previously, Ms. Byrd served as
14 the agency's chief of staff and as associated director to
15 the Office of the Public Provider Liaison. She has worked
16 on local, state, and national levels in both public and
17 private sectors, including Health Management Associates,
18 the Louisiana Department of Health, and the National
19 Governors Association. Ms. Byrd received her bachelor's
20 degree in government from Wofford College.
21 And then we'll hear from Mr. Dorn Schuffman.
22 Dorn is a senior consultant and coordinator at the Missouri

1 Department of Mental Health. In this role, he has led
2 three initiatives: the integration of primary and
3 behavioral health care at six community mental health
4 centers and federally qualified health center pairings;
5 implementation of Missouri's Community Mental Health Center
6 Health Home Initiative; and the implementation of the CCBHC
7 demonstration project and development of a state plan
8 amendment to continue to provide CCBH services at the end
9 of the demonstration. Mr. Schuffman has over 30 years of
10 experience in behavioral health care, including 20 years
11 with the Missouri Department of Mental Health, where he
12 previously served as the department's director under both
13 Democratic and Republican administrations.
14 Each of our panelists will give a brief
15 presentation, and then we're planning to use the majority
16 of the time allotted for today's session for conversation
17 between you and the panelists. Following this session,
18 you'll have additional time to reflect on your findings
19 from Melinda and my presentation as well what you hear from
20 our panelists. And, with that, I'll hand it over to Dr.
21 Wilkniss.
22 * DR. WILKNISS: Hello. Thank you. Can you hear

1 me okay? Okay, wonderful. Thanks for the invitation to
2 share today from the health care consumer perspective on
3 behalf of Families USA. I'm honored to join you and
4 appreciate the terrific overview you've already received.
5 I think I'll start by identifying the obvious in
6 the room, and while I think the first points are common
7 knowledge, it's critical to underscore the major negative
8 impact that the COVID pandemic has had on mental health and
9 the stability of the mental health system. This summer,
10 more than half of all adults surveyed reported a negative
11 impact on mental health. Those already managing mental
12 illness and substance use disorders are worse off and often
13 can't access care. We're seeing an uptick in anxiety,
14 depression, suicidal ideation, and substance abuse across
15 the board, and COVID has severely stressed an already
16 challenged safety net system.
17 According to the state mental health authorities,
18 the system is experiencing a major workforce shortage since
19 March, which, of course, is on top of what you've already
20 seen with respect to major workforce shortages in the
21 mental health arena, and significant financing challenges
22 to the enhanced public health protections and related

1 delivery shifts they've experienced.

2 Of course, telehealth flexibilities, as you were
3 noting earlier, have been seen as universally helpful, and
4 there's a desire for ongoing flexibility around offering
5 those services. That's underscored by both providers and
6 consumers, but significant access challenges remain
7 nonetheless.

8 Notably, those providers are in integrated care
9 arrangements, so providers who are integrating primary care
10 and behavioral health care or who have the capacity to move
11 away from fee-for-service are faring better. That's
12 according to the National Council and I think worth
13 pursuing. And, of course, as COVID has laid bare numerous
14 health care and health access inequities for communities of
15 color, the same is true for mental health and should be on
16 our radar.

17 All of this, of course, is occurring in the
18 context of state and local budgets in serious straits, and
19 counterintuitively, and importantly, that often means cuts
20 to behavioral health services and supports, often in the
21 form of global cuts rather than a surgical look at paying
22 for what works and discontinuing paying for what does not

1 work.

2 So an initial consideration for this body is to
3 facilitate work with states to consider preserving access
4 to interventions people want and that are shown to be cost-
5 effective rather than cutting across all services equally,
6 which we anticipate may happen, and applying an equity lens
7 in two ways: one, addressing disparities generally in
8 access to evidence-based care for people with mental
9 illness, and also the additional disparities in access to
10 culturally informed and effective interventions for
11 communities of color.

12 So what works and what do people want? People
13 with mental illness want access to health care that
14 addresses their whole person with dignity, that's
15 culturally competent and maximizes the person's potential
16 for a healthy, meaningful life as an integral member of
17 their community. It's often the case that others'
18 interpretation of a healthy, meaningful life for someone
19 with mental illness is one free of symptoms. That symptom
20 reduction is the first and most crucial step, and only when
21 suppressed may the rest of a healthy, successful life be
22 pursued. And I will argue that decades of evidence and

1 story after story from people with mental illness shows
2 that this is not the case. People with mental illness
3 identify a healthy, meaningful life much as the rest of us:
4 a safe place to live, a job, friends, less contact with the
5 mental health system, and more participation in their own
6 communities.
7 We know that outcomes for people with mental
8 illness are better with community-based services and
9 supports that address physical and mental health and social
10 support needs in a coordinated fashion and when the goal of
11 treatment is established by the patients, and you'll hear
12 more about specific models from other panelists, but let me
13 talk about just a few to highlight here.
14 And, of course, the needs, as Melinda pointed
15 out, vary by degree of illness. For people with mild to
16 moderate mental health symptoms, such as anxiety and
17 depression, integrated whole-person care can sit in the
18 primary care office where medical and mental health care
19 can be provided together, with the benefit of increased
20 access to mental health interventions in a less
21 stigmatizing environment, and an added opportunity to
22 identify and address broad determinants of health, such as

1 safe and affordable housing, employment, food security, all
2 leading to improved outcomes.
3 The most studied integrated approach is the
4 collaborative care model. I won't go into a lot of detail.
5 We can save that for questions if anyone's not familiar
6 with it, but there are over 80 randomized controlled trials
7 showing its cost-effectiveness. The model involves a
8 patient-centered approach in which a team comprised of the
9 patient, a primary care physician, a behavioral health care
10 manager, and psychiatric consultant collaboratively work
11 together toward the patient's goals using evidence-based
12 intervention and a measurement-based approach.
13 Several state Medicaid programs are paying for
14 collaborative care, but given the extraordinary cost-
15 effectiveness data, the Commissioners may consider
16 encouraging wider adoption.
17 Of course, it goes without saying that cost-
18 effective models with a clear return on investment should
19 be of great interest, given the current economic climate.
20 So, some of my remarks are really focused there.
21 For people with more serious mental illness,
22 integrated coordinated care that links clinical services

1 with social supports provided in the community is also a
2 goal. While mental health services in Medicaid still tend
3 to be structured more institutionally, as we saw earlier in
4 the slides -- inpatient, outpatient -- it's critical to
5 understand that outcomes don't improve when consumers are
6 pigeonholed into services they don't want and that don't
7 work, like antiquated partial hospital programs.
8 What does work and what people want are whole
9 personal recovery-oriented services in the community and
10 outside of institutional care. In fact, the most evidence-
11 based cost-effective interventions for people with serious
12 mental illness are those that provide mental health
13 supports while helping people achieve their meaningful life
14 goals, like supportive housing and supported employment.
15 Those are two key examples that I just want to hit the
16 highlights around.
17 Numerous studies have demonstrated that
18 supportive housing is associated with improved quality of
19 life, lower health system costs, and decreased involvement
20 in the justice system. Medicaid's role in supportive
21 housing services and supports was described in detail in a
22 2015 CMS bulletin entitled "Coverage of Housing-Related

1 Activities and Services" for individuals with disabilities,
2 and while some states have exercised the options laid out
3 in that bulletin in the various approaches, more should be
4 encouraged to do so.
5 The Commissioners may want to consider additional
6 supports to states to revisiting the guidance and also
7 through mechanisms such as a successful innovator
8 accelerator program. There was one that was dedicated to
9 long-term services and supports and specifically Medicaid
10 housing agency partnerships.
11 That brings me to supported employment. You saw
12 in the slides earlier -- and it's not surprising that
13 employment is a key determinant of health. This is on
14 stunning display right now in the COVID era for people in
15 general who are unemployed. Mental health challenges are
16 significant for people with serious mental illness. This
17 is the case as well, and people with serious mental illness
18 want to work. Employers like to employ them, and with
19 evidence-based supports, they can.
20 And I want to flag that the slide presentation
21 showed equal investment in vocational services and
22 evidence-based supported employment, and I want to point

1 out that decades of evidence -- and there were 25
2 randomized control trials -- show that the Individual
3 Placement Support model for supported employment leads to
4 superior outcomes and is cost effective.
5 Under the IPS model, people with serious mental
6 illness succeed in attaining competitive employment two to
7 three times more than other employment models. So really
8 looking at the evidence-based models that work is going to
9 be key here in addition to supporting vocational-type
10 models.
11 That brings me to crisis. Of course, people also
12 experience psychiatric crises. You saw some of this in the
13 presentation as well. There are more needed services here.
14 Building a robust continuum of care and supports that
15 diverts from these settings and provides -- sorry --
16 diverts from institutional care settings, provides
17 interventions to individuals in the community as much as
18 possible, allows for a timely reintegration that's key.
19 People don't do well in acute care settings, hospitals and
20 emergency departments, or jail, where they typically end up
21 when they're in psychiatric crisis, and it invariably
22 causes more harm and enhanced trauma among these

1 individuals.

2 So I point you to the SAMHSA-issued National
3 Guidelines for Behavioral Health Crisis Care. They were
4 issued this year, and they lay out in excruciating detail,
5 the continuum of care from crisis call centers, including
6 recently passed, recently enacted law around establishing
7 the 988 crisis call line, all the way through crisis team
8 response and crisis stabilization facilities. All of that
9 is detailed there, and the Commissioners may want to
10 consider Medicaid's role in building and sustaining that
11 continuum; for example, Medicaid can align with other
12 payers to pay for capacity for this continuum through a
13 pool or other mechanism rather than a one-off fee-for-
14 service approach that often ends up holding up the system
15 in a fragmented way, as it does currently.

16 Accordingly, you may consider issuing guidance
17 similar to the joint SAMHSA-CMS guidance on school-based
18 mental health to lay out exactly how Medicaid can be used
19 to support a crisis continuum.

20 Just a couple of other points before I turn it
21 over, and I'm happy to, of course, talk about any of this
22 in more detail. For justice-involved populations, as you

1 know, a large portion of people in the justice system have
2 mental illness and/or substance use disorders and likely
3 suffer from chronic health issues and are more likely to be
4 people of color. These are people who are also
5 disproportionately represented in Medicaid when they leave
6 the justice system.
7 Evidence shows that continuity of care
8 facilitates successful reentry and access to health care
9 and reduces recidivism. CMS can promote successful
10 community reentry for people who are incarcerated by
11 issuing guidance to ensure continuity of coverage and allow
12 states to reactivate Medicaid benefits for justice-involved
13 individuals 30 days before release as provided for in the
14 SUPPORT Act.
15 Two other things. A real opportunity to enhance
16 the workforce is through the peer workforce. Encouraging
17 maximum use in Medicaid to support peers while also
18 recognizing that they need a career ladder, like community
19 health workers, is an important investment and opportunity
20 for you all to weigh in on.
21 Finally, the Commissioners may consider expanding
22 the reach of the successful Money Follows the Person

1 demonstration to people with behavioral health needs. As
2 we heard earlier, there's a lot of uptick of the IMD
3 exclusion, and people with behavioral health needs are in
4 IMD settings. And it might be really optimal to use the
5 Money Follows the Person approach to help those people
6 reintegrate into the community successfully.
7 I have much more to share, but I'm going to stop
8 there so that I don't go over my time. And thank you for
9 your attention.
10 MS. McMULLEN: Next, I believe we're going to
11 hear from Melisa Byrd from the District of Columbia.
12 * MS. BYRD: Thank you, and good morning. On
13 behalf of the D.C. Department of Health Care Finance, thank
14 you for inviting me to speak with you about Medicaid and
15 access to treatment for adults with mental health.
16 The conversation this morning is very timely, as
17 the District is just entering the second of a five-year
18 reform of our Medicaid program. Creating a system that
19 supports whole-person care is our goal, and changes to our
20 behavioral health system is integral to achieving that
21 goal.
22 In January, we began implementation of our

1 combined SMI/SUD Behavioral Health Transformation
2 demonstration, which leveraged CMS guidance on IMD waivers.
3 Effective this month, all of the waiver services are
4 implemented. So we are currently shifting towards ongoing
5 operations and monitoring and evaluation.
6 Today I will talk about why we chose the combined
7 waiver approach, how it is designed to facilitate access to
8 a continuum of services, and how we are leveraging this
9 opportunity with other efforts to advance changes to the
10 behavioral health system in the District.
11 Of course, all of this is shared with an
12 underlined uncertainty because of the pandemic. Specific
13 to the waiver, we don't know how the public health
14 emergency will impact our overall goals and objectives, but
15 we do know already that the pandemic is shaping the system
16 from take up of telemedicine to new and more serious
17 interest in alternative payment methods that we can augment
18 our initial efforts with these new opportunities to advance
19 our goals and expand access to quality health care.
20 Before I go further on our waiver experience, I
21 want to provide a few points on the D.C. Medicaid program
22 for context.

1 The Department of Health Care Finance programs
2 provide health care coverage to nearly 40 percent of
3 District residents, supporting universal coverage in the
4 District of Columbia. D.C. has the second lowest uninsured
5 rate in the nation, and D.C. Medicaid covers approximately
6 270,000 individuals. While this may be small in number
7 compared to other jurisdictions, the portion of the
8 population that we cover, nearly four out of ten District
9 residents, is substantial.
10 One of the reasons for our high coverage rates is
11 due in part to the expansion of Medicaid to all low-income,
12 non-elderly adults. So even for childless adults, we have
13 coverage up to 210 percent of the federal poverty level.
14 Despite the high coverage rates, we still have
15 persistent health challenges. Life expectancy is highly
16 variable across the District. We see a 17-year difference
17 in lifespan if you live in the northwestern part of the
18 city compared to those individuals residing in the
19 southeastern portion of the city, where many of our
20 Medicaid beneficiaries reside.
21 We have the twelfth highest 911 call volume in
22 the country, and our hospital emergency departments have

1 very high rates of ambulatory care-sensitive conditions.
2 About a year ago, we announced a five-year reform
3 effort signaling a pivot from our focus on coverage to
4 focus on whole-person integrated care with intent to
5 improve health outcomes. We know that if we want a chance
6 at success of whole-person integrated care, we must make
7 significant changes within our behavioral health system.
8 Looking at our behavioral health system, we
9 recognized a couple of key things. One, gaps in Medicaid,
10 behavioral health service array, and two, a real complex
11 and overlapping oversight infrastructure that makes it
12 harder to manage services in a holistic way that's
13 integrated with other medical treatments.
14 Specific to the service gap, we experienced a
15 disparate access to IMD services between Medicaid managed
16 care and our fee-for-service programs in the District. Up
17 until October, our program was about 75.5 -- 75 percent of
18 individuals served through managed care and 25 percent
19 through our fee-for-service program. Because of the in-
20 lieu-of policy and managed care, individuals in our
21 Medicaid managed care program had access to IMD services.
22 They're 19 to 64 years old, while those individuals

1 similarly aged in the fee-for-service program did not.

2 The gap was particularly clear to the District.

3 We have prior experience through the Medicaid Emergency

4 Psychiatric Demonstration, or the MEPD program, from 2012

5 to 2015, where we had the opportunity to reimburse for IMD

6 services. It was also during that time; we did see the

7 referral patterns established because of the inclusion of

8 IMD services and unfortunately saw that those referral

9 patterns were not maintained after the MEPD ended.

10 In the District, oversight of Medicaid behavioral

11 health services is divided with overlapping authority,

12 primarily among the Department of Health Care Finance, our

13 Medicaid managed care plans, and the Department of

14 Behavioral Health, which serves as the District's

15 behavioral health authority.

16 The most intensive behavioral health services

17 offered through the mental health rehabilitation option are

18 carved out of the managed care program and provided solely

19 through fee-for-service by network of Department of

20 Behavioral Health certified providers.

21 These systemic issues became even more apparent,

22 and the urgency for change increased exponentially with the

1 opioid epidemic.

2 As we were looking at how to address these
3 systemic issues, exacerbated by the opioid crisis, a unique
4 opportunity to improve access to IMD services was made
5 available by CMS. The District pursued the combined
6 SUD/SMI waiver option because it was the most comprehensive
7 approach allowing us to potentially serve more Medicaid
8 beneficiaries, including those with co-occurring SMI and
9 SUD diagnoses.

10 For the District, too, given our coverage levels,
11 the waiver has no impact on eligibility. The services
12 under the waiver are available to all Medicaid
13 beneficiaries.

14 Additionally, we view the waiver as the first
15 step in transforming our behavioral health services,
16 allowable under Medicaid, as the waiver does provide a
17 broader continuum of Medicaid behavioral health treatment,
18 and additionally, it supports the Mayor's goals in fighting
19 opioid use and substance use disorders. And it does move
20 us toward more whole-person integrated physical and
21 behavioral health care.

22 Specific to our waiver, we received authority

1 from CMS for 10 services, but that authority is limited to
2 two years for the non-IMD community-based services. The
3 cornerstone of the waiver, if you will, is the coverage of
4 IMD services for individuals age 21 to 64 with SMI or SUD,
5 and the number of community-based services range from
6 psychosocial rehabilitative services, which we refer to as
7 "clubhouse services"; recovery support services, transition
8 planning services for individuals leaving a hospital, IMD,
9 or other facility; and then trauma-targeted behavioral
10 health services and much needed supported employment
11 services, particularly for those with SUD.
12 So we've now experienced developing and
13 implementing the waiver. Our close collaboration with CMS
14 resulted in expanded services for District residents in
15 less than a year from development and implementation.
16 So I think the best word to describe our
17 experience is "fast." CMS issued the SMI guidance in
18 November 2018. The District submitted its combined waiver
19 in June 2019. It was approved in November, and we began
20 implementing services January 1st of this year.
21 The speed was really critical in meeting the
22 urgent needs and better supporting the folks that we serve

1 here in the District.

2 So far in our experience, we have seen that the
3 waiver is really a valuable tool for enforcing the need for
4 data collection, analysis, and evaluation. If you look
5 across our program, certainly on the behavioral health
6 side, that is an area where it doesn't meet the same
7 analysis that we've experienced on the physical health
8 side.

9 Additionally, we're utilizing the waiver to
10 increase health information exchange participation among
11 behavioral health providers; for example, building an HIE
12 participation as a requirement to provide particular
13 services.

14 And we do think transformation could advance at a
15 faster pace with increased flexibility and support in
16 building core infrastructure and competencies. On the
17 first, increased flexibility, the managed care in-lieu-of
18 policy remains, making the first 15 days of an IMD stake
19 covered by managed care, and then that coverage transitions
20 to waiver authority and fee-for-service reimbursement.
21 While we understand some of the underpinning reasons for
22 this, operationally, this is really complex and cumbersome.

1 The best example I can describe hearing from one
2 provider is that that provider can end up with three to
3 four prior authorizations from multiple payers for one
4 particular case or individual residing in an IMD, and it
5 also for the District creates some similar walls preventing
6 better care coordination, similar to our mental health
7 rehab services options that are carved out, so that you
8 start -- an individual who is in managed care starts with
9 those services paid for through managed care that
10 transitions and just doesn't have the same kind of
11 continuity we'd like to see for care coordination.
12 Additionally -- and I think this was alluded to a
13 little bit in a prior panelist discussion -- the transition
14 planning services that just went live through the waiver
15 earlier this month, we believe is just of utmost importance
16 for individuals. We were hopeful and intended to allow
17 those services for individuals residing in a criminal
18 justice setting prior to their release, but at this time,
19 it was not included in the waiver.
20 Second is the building and support for practice
21 transformation and infrastructure. On technical
22 assistance, providers need support if we expect them to

1 change how they do business. The District has had a lot of
2 experience, both positive and negative, based on the level
3 of assistance we have been able to make available to
4 providers.

5 In our first Health Homes program that was
6 targeted to behavioral health, we, I would say, certainly
7 underestimated the compacity and across-the-board maturity
8 of providers to make significant changes to how they do
9 their business. We learned from that experience, and when
10 we implemented our My Health GPS program, which focuses --
11 it's a Health Homes program focused on people with multiple
12 chronic conditions -- we engaged in an intensive two-year
13 technical assistance program that really supported
14 providers in making those changes to the outcomes that we
15 would like to see.

16 I think, again, based on our first Health Homes
17 experience, this kind of technical assistance is extremely
18 important with working with behavioral health providers.
19 The variety across behavioral health providers is great,
20 some with great infrastructure and resources to others that
21 have much more limited capacity.

22 The other thing that we believe in the District

1 is very important in the work of moving towards integrated
2 care is having the right Health Information Exchange and
3 health information technology resources. This can range
4 from providing devices and support for data plans to
5 building the infrastructure to support appropriate privacy,
6 preserving information exchange.
7 DHCF is leveraging other opportunities to ensure
8 that we have this foundation needed to support integrated
9 care. For us, this includes participation in the SUPPORT
10 Act's SUD provider capacity grant and utilizing HITECH
11 funding.
12 One of the key components of the SUD provider
13 capacity grant, which I always refer to --- it's not
14 particularly exciting in talking about it, but it is our
15 focus on consent management and building an infrastructure
16 so that we can enable structured data collection and
17 communication with behavioral health providers. And this
18 includes developing and implementing consent management
19 tools to facilitate appropriate exchange afforded to CFR
20 Part 2 data.
21 Without this component, it's unclear to me how we
22 can actually move forward with physical and behavioral

1 health integration if the providers don't have the basic
2 ability to communicate in a quick and easy way.
3 Additionally, through the SUD provider capacity
4 grant, we are bringing on an integrated care technical
5 assistance program, which is focused on building core
6 competencies for practice transformation. We will be
7 providing education and technical assistance to Medicaid
8 providers to build capacity, to integrate behavioral and
9 physical health care, and treat individuals with SUD in
10 community settings.
11 Finally, we've been able, through the past few
12 months, to leverage HITECH funding to provide laptops, data
13 plans, telehealth licenses for providers. We in the
14 District made changes at the very beginning of the pandemic
15 to better enable the utilization telemedicine. Two key
16 changes that we made included allowing home as originating
17 site and then also allowing audio-only for telemedicine
18 services.
19 To support that, we were able to leverage the
20 HITECH funding to support providers and making sure that
21 they have the resources they need. However, there is a gap
22 in providing similar access to beneficiaries, so that

1 assistance that we have right now is limited to providers.

2 And so with that, I will conclude my remarks. We
3 are building on the opportunity of the 1115 waiver plus
4 other grant opportunities and funding options to move us
5 forward to provide expanded access to treatment for mental
6 health care. But the District, we are looking next at
7 carving in our behavioral health benefits, our mental
8 health rehab services into managed care, and will continue
9 our work over the next several years.

10 Thank you so much for the time to speak today.

11 * MR. SCHUFFMAN: Good morning. I'm Dorn
12 Schuffman. I'm from the state of Missouri and I'm very
13 happy to be speaking to you this morning. I'm going to be
14 talking to you about the CCBHC, or Certified Community
15 Behavioral Health Clinic, prospective payment demonstration
16 project.

17 And from the beginning, in Missouri, we planned
18 this to be a statewide initiative. We already were doing
19 this that we knew that this project would be successful.
20 When we started we thought all of our 26 service areas
21 would be able to participate. As it turned out, we only
22 got 19 to be able to participate, primarily because of

1 information system issues at some of the centers that just
2 weren't ready to do the heavy lifting that this requires.
3 The demonstration project has two key elements to
4 it. The first is that SAMHSA, under the demonstration
5 promulgated certification criteria for the CCBHCs. I'm
6 going to share with you some of the requirements of those,
7 just to give you a feel for that.
8 CCBHCs are required to provide 24-hour mobile
9 crisis teams, an array of outpatient substance use disorder
10 treatment services, basic outpatient service, psychiatric
11 rehabilitation services for children, adolescents, and
12 adults, peer and family support services, primary care
13 screening and monitoring of health status and chronic
14 disease, and I'll talk some more about that later, and an
15 array of evidence-based practices, as selected by the
16 states.
17 In addition, they have certain care coordination
18 requirements. They are required to track hospital
19 admissions and discharges for the people that they serve
20 and to make reasonable attempts to follow up on hospital
21 discharges within 24 hours. They are also supposed to make
22 sure that the people that they serve have access to or have

1 a primary care physician, if they don't already try to
2 connect them with one, and then coordinate care with the
3 primary care physician, and also coordinate care with
4 specialty care providers if the individual has those, and
5 then with a variety of community service providers and
6 support providers.
7 Even though they target adults with serious
8 mental illness and kids with serious emotional disturbances
9 and individuals with substance use disorders, they really
10 serve the general public. It goes back to community mental
11 health, or an FQHC sort of model. Anybody who needs
12 service related to behavioral health is certainly welcome
13 to show up at a CCBHC and get service.
14 There is also access requirements. The standards
15 require that people with urgent needs be seen within one
16 business day and people with routine needs, whatever that
17 is, be seen within 10 business days, and there are many
18 more. So the standards are good. They do require some
19 centers to make significant improvements. In our case,
20 most of our centers were meeting most of the standards
21 already, because we have been doing a number of these
22 things for a while.

1 The other major part of the initiative, which is
2 what I'm going to focus on because I think your interest,
3 in particular, is in access, so that's what I'm going to
4 focus on. I could share a lot of other things. But what's
5 really important is the other piece of the demonstration,
6 which is prospective payment. And under the demonstration,
7 CMS published guidelines that gave states a choice of using
8 a daily rate or a monthly rate, and Missouri chose a daily
9 rate. I think two of the eight states chose a monthly
10 rate, so most of us are on the daily rate. So I'm going to
11 focus on how that works.
12 Providers get paid for a visit, which is a face-
13 to-face or a telehealth encounter with an eligible consumer
14 by an eligible practitioner, when they provide one of the
15 CCBHC services. So it's visit-based. Some people call
16 them encounters, but in the demonstration they are called
17 visits, for any face-to-face interaction, even by
18 telehealth.
19 And the way the rates come up, they are
20 individual. They are developed for each CCBHC, so it's
21 cost-based system. And to come up with the rate you divide
22 the total cost for providing CCBHC services for that

1 provider by the total number of expected visits, and you
2 get a cost-per-visit rate, and that's what they get paid
3 when they provide a visit.
4 To do that, centers have to do a cost report, and
5 the cost report documents their actual cost for providing
6 services, based on their most recent audit, and segregates
7 out those that are related to their CCBHC services. And
8 then the cost report also includes what they project to
9 spend, the new expenditures they have over and above their
10 previous audited costs, which largely have to do with maybe
11 meeting new requirements or expansion of existing services.
12 And the state gets to review those, and obviously
13 they review and approve the expansion items particularly,
14 to say "Yes, we want you to, for example, add more peer
15 specialists. That is one thing we really want to see you
16 hire more of those people. We want you to expand your
17 substance use treatment, because we don't think you do good
18 enough stuff there." So states review that part of it.
19 The other part of the cost report is documenting
20 the visits that they provided the previous year and their
21 projected visits. So you have total costs, total visits.
22 You add the total visits into the total costs and that gets

1 you the prospective payment rate that they will receive
2 when they provide a visit. That's adjusted annually by the
3 Medicare Economic Index and can be adjusted by rebasing
4 periodically, particularly when you're changing the array
5 of services you want them to provide.
6 The PPS, prospective payment system, is really
7 important for access, and that's what I'm going to focus
8 on. Obviously, the first thing it does, it allows you to
9 recoup the cost for any additional staff that you are
10 bringing on in order to meet the standards. And so in our
11 case, as I mentioned, we significantly wanted providers to
12 improve the number of peer specialists and family support
13 providers that deal with kids with serious emotional
14 disturbances. We wanted to increase those.
15 Some places weren't providing -- they were major
16 behavioral health providers but had small substance use
17 treatment. We required that they hire additional people,
18 so they could build those costs into their rate.
19 The other thing we asked them to do was to create
20 their systems in a way that they could provide next-day,
21 same-day appointments. Instead of saying, you know, for
22 those that need urgent care they can come in and be seen in

1 the day, and those that are routine in ten days, we wanted
2 to be in a position to say if you need care come in and you
3 will be seen by somebody today. And so that was a major
4 push. It required some additional hiring of people, and
5 certain required retraining of people on how to do that.
6 As a result of that, during the first year, from
7 the year prior to the demonstration to the end of the
8 second year, there was a 20 percent increase in the total
9 of number of people served by these organizations. It went
10 from 122,000 people just the year prior to the
11 demonstration and at the end of the second year the same
12 providers were serving 146,000. A significant increase in
13 access.
14 The move from their historic ways of working to
15 same-day, next-day access, one center down in Joplin,
16 Missouri, if used to be when you called them, before the
17 demonstration, it would be 22 days before you could come in
18 and see anybody. Now you can see somebody today. A major
19 change.
20 Prospective payment also allowed them to
21 restructure their salaries. In some places, you saw on
22 that map that they showed that Missouri is an underserved

1 area, and that's partly reflected by the fact that prior to
2 this, in fee-for-service, we were paying very little for a
3 lot of services. People could not afford to compete with
4 other states and even with other providers in the system.
5 So with demonstrated need it allowed them to restructure
6 salaries.

7 As a result of that, access to psychiatry has
8 improved dramatically. So a couple of examples. Clark
9 Center, which is a very small center down in a very rural
10 part of Missouri, down southwest, it used to be three weeks
11 to see a psychiatrist. Now it's less than a week. Family
12 Guidance Center up in St. Joseph, Missouri, it used to be
13 two months to see a psychiatrist there. Now it's down to
14 almost same-day, next-day access to psychiatry.

15 If you're going to do evidence-based practices
16 there are costs to those. There's training costs, there's
17 documentation costs, there's care coordination costs. And
18 typically there aren't ways to pay for those. But when you
19 do a prospective payment you can build those costs into the
20 rate. And so we required a number of evidence-based
21 practices. Most of the centers were doing several of
22 these, but not all of them were doing all of them. We

1 required motivational interviewing, cognitive and
2 behavioral therapy -- everybody was doing those --
3 integrated treatment for co-occurring disorders, trauma-
4 informed care -- we had particular expectations for that --
5 hiring tobacco treatment specialists, special training for
6 those people, participating in zero-suicide academy. And
7 we did wellness coaching training for a wide range of
8 people.

9 And then we had been doing medication-assisted
10 treatment, but not everybody had been doing that, and there
11 are some parts of the state where that was not available to
12 individuals with substance use disorders. From FY17, just
13 before we started the project, or as we were starting the
14 project, we served 3,100 people with MAT. This last year
15 that more than doubled to 6,200, so a significant growth in
16 the availability of medication-assisted treatment.

17 Perhaps for access purposes, among the most
18 critical things that having a prospective payment allows
19 you to do is to do outreach and engagement activities, to
20 build in those costs that you haven't yet got that person
21 in treatment, you can't bill for a visit, but you're
22 reaching out to them, engaging them in care. And we've had

1 a couple of different projects we were doing on a small
2 basis.
3 In the case of emergency rooms, prior to the
4 demonstration, we were funding with state revenue, teams at
5 a few of our CMHCs, to reach out to emergency rooms and to
6 be responsive to the emergency room, and to try, when the
7 emergency room had somebody who had a behavioral health
8 issue, that was not somebody the center was already
9 serving, the team would go out and engage them.
10 Under the demonstration, we've expanded that to
11 all of the participating CCBHCs. University of Missouri
12 St. Louis has done a study of that, and for this last
13 fiscal year, 2020, the what we call emergency room
14 enhancement teams, the ERE teams, served 2,029 individuals.
15 Of those, in 2020, 40 percent of them were homeless at the
16 time, that we first contacted them. At the end of six
17 months, there had been a 76 percent reduction in
18 homelessness for that population.
19 At the time of first contact, 19 percent of them
20 had law enforcement involvement. At six months, there had
21 been a 69 percent reduction in the number of people with
22 any kind of law enforcement involvement. At the time that

1 we first contacted them, 16 percent were unemployed. At
2 six months there had been a 60 percent reduction in
3 unemployment. But, of course, the most dramatic thing is
4 ER visits and hospitalizations, both of which saw a 74
5 percent reduction at six months.
6 Similarly, we were, before the demonstration,
7 doing some outreach to law enforcement and the courts, to
8 sheriffs and police around the state. We beefed that up
9 under the demonstration. We have now staff at every CCBHC
10 that do outreach and engagement with law enforcement and
11 the courts. In fiscal year 2018, those individuals had
12 8,300 referrals to law enforcement and the courts. This
13 last year that went up to 15,000, so almost doubled the
14 number of connections that we have with people coming in
15 law enforcement and the courts. And, of course, a
16 significant number of those individuals at the time of the
17 contact were a threat to themselves or others, about 40
18 percent. We engaged these people in care, get them in
19 care, try to keep them out of the jails, try to get them
20 not having to go even to court, if possible, and engage
21 them in care.
22 Similarly, a couple of the CCBHCs did things with

1 their local jails. Up in St. Joe, Missouri, the jail up
2 there was sending two or three people a week from their
3 jail to the local behavioral health unit at the hospital.
4 So the CCBHC there hired a licensed professional clinician
5 and placed them in the jail. In the first year they saw
6 361 individuals there, they worked with. Only two people
7 from the jail were hospitalized that first year.
8 Care management, another thing that typically is
9 not paid for. You know, it's certainly not paid for in the
10 fee-for-service system, and it's really critical to have an
11 impact on people's lives. Again, before the demonstration,
12 we were already doing health homes. You know that, as has
13 already been mentioned, people with serious mental illness
14 are over-represented in terms of chronic diseases. In a
15 CATIE study which looked at individuals who in
16 antipsychotic drug trials, found the people they were
17 looking at who were getting antipsychotic drugs and they
18 were in drug trials, 88 percent of them had untreated
19 dyslipidemia, and 62 percent had untreated hypertension,
20 and 30 percent had untreated diabetes. That led us to move
21 towards what we call CMHD health care homes. And under the
22 demonstration they referred to that primary care screening

1 and monitoring, so now any state that participates in the
2 demonstration or going forward can do this under
3 prospective payment.

4 We know that small changes make a big difference,
5 that a 10 percent reduction in blood cholesterol can have a
6 30 percent reduction in coronary heart disease. And in our
7 health home, in the first three years, the LDL level went
8 from 131 down to 106 on a mean, for all the people in the
9 program, which is a 19 percent reduction. If you reduce
10 blood pressure by 6 points that impacts stroke by as much
11 as 42 percent. Again, we've been able to, in health homes,
12 reduce the mean systolic and diastolic blood pressure of
13 individuals. During the first two years that went from
14 systolic, the mean, for everybody that was receiving
15 services, which is about 17,000 or 18,000 people that year,
16 went from 141 down to 131 in two years, a 13-point
17 reduction. And the diastolic pressure went from 92 to 80,
18 about 8 points. So if you reduce 6 points you can have a
19 big impact.

20 A 1-point reduction in A1C can have a 21 percent
21 reduction in diabetes-related deaths, and in the first two
22 years we saw an average 1.5-point reduction in A1C levels.

1 So you can have a big difference in people's health care
2 needs.
3 But the real issue is if you do good care
4 management, not only dealing with their chronic diseases
5 but also following them up as they come out of the
6 hospital, as the CCBHC standards now require, you can have
7 a big impact on health care costs. And in Missouri, our
8 Missouri Medicaid agency estimates that the health care
9 home program, which is now just being folded into just the
10 CCBHC program, they are all required to do that, under
11 primary care screening and monitoring, in Missouri they
12 have estimated they have saved $377.9 million over the
13 first seven years we've been doing it, or about $54 million
14 a year.
15 If you provide these --
16 VICE CHAIR MILLIGAN: Dorn?
17 MR. SCHUFFMAN: Yes.
18 VICE CHAIR MILLIGAN: I'm sorry. With a time
19 check and not knowing if the panelists have a hard stop at
20 noon I want to make sure that we have --
21 MR. SCHUFFMAN: I've got one more thing.
22 VICE CHAIR MILLIGAN: Okay. Thank you.

1 MR. SCHUFFMAN: I was just going to end by saying
2 you can understand, given all this, why we went ahead and
3 have done a state plan amendment to continue this after the
4 demonstration is over, and our strongest supporters in this
5 are the hospitals, the sheriffs, the police, the courts,
6 and the schools, in which we also do outreach and
7 engagement..
8 And that's it. Thank you.
9 VICE CHAIR MILLIGAN: That was a great last
10 sentence, Dorn. Thank you. All of the panelists, thank
11 you very much. We have about 15 minutes, and I want to
12 open it up now for Commissioners who might have questions
13 for this panel. We'll start with Sheldon.
14 COMMISSIONER RETCHIN: Hi. Thanks for your
15 presentations. They were illuminating, and this is such an
16 important area, and obviously we have selected experts in
17 the field and you've brought a lot of information to us.
18 My question and comment really is for Dr.
19 Wilkniss. Something that you mentioned that is, I think,
20 exceedingly important in this particular space, that there
21 is opportunity for reform. And that's the relationship of
22 inaccessibility to mental health services for adults who

1 end up becoming incarcerated.

2 And so it's not just with the justice health
3 system but some of the stats in that area are actually just
4 absolutely staggering, that 1 in 5 prisoners in the U.S.,
5 which has the highest incarceration rate, by far, in the
6 world, 1 in 5 prisoners have serious mental illness, and
7 that 6 of the top 10 states with poor access to mental
8 health services, not coincidentally, have the highest
9 incarceration rates among the top 10 states incarceration
10 rates.

11 And I wonder, with the appetite for prison
12 reform, the First Step Act did not address this problem,
13 that is there opportunity for trying to put that together,
14 that reform the prison system, by getting to pre-booking
15 diversion? The vast majority of these prisoners with
16 serious mental illness come from, or were Medicaid
17 beneficiaries, Medicaid beneficiaries of color, who are
18 being incarcerated, and instead of being diverted prior,
19 with nonviolent crimes. I wonder if you could address
20 that.

21 DR. WILKNISS: Yeah, I'm happy to, and I'm sure
22 the other panelists are very familiar with this issue and

1 with your questions and might have other ideas as well.
2 But I would say that, you know, a couple of sources in
3 terms of understanding the issue, but, first of all, our
4 data aren't that great. We need better data on really, you
5 know, who these folks are in jail and prison. They're
6 really outdated data sources, as far as I know, so it would
7 be great to get better data there and better data on people
8 at different nodes of intersects with the criminal justice
9 system. But I would say the SAMHSA GAINS Center has
10 created an intercept model, has a lot of really rich
11 information on points of diversion, best practices at
12 diversion, what's happening in states and localities with
13 respect to good models, for diverting at all points of
14 contact with the criminal justice system. So that's one
15 place I would point you all to for additional information.
16 Of course, I'm happy to provide additional resources there
17 as well.
18 But it is a major problem, and, of course, it's
19 exacerbated. We're in a pandemic. They're in a congregate
20 setting, right? They're getting infected. They're
21 infected not only with COVID but with hepatitis C and all
22 the other issues that are really a challenge to the system.

1 So helping get a glide path out of that setting is really
2 critical. But I'm sure others have maybe more concrete
3 information on the ground in their programs to offer.
4 COMMISSIONER RETCHIN: Thank you.
5 CHAIR BELLA: Chuck, I think you're on mute.
6 VICE CHAIR MILLIGAN: Thanks, Melanie. Melisa
7 and Dorn, did you have anything you wanted to add to Dr.
8 Wilkniss' observations? And then I do see Kit and Martha
9 next.
10 MR. SCHUFFMAN: Of course, the CCBHCs are dealing
11 with community-based people, not people who are already in
12 the prisons. We do other things with people in prisons,
13 and as I mentioned, we do have -- a major part of what we
14 do is outreach engagement with police and sheriffs to
15 provide -- try to prevent people from being incarcerated.
16 DR. WILKNISS: Do you mind if I just add --
17 VICE CHAIR MILLIGAN: Do you have anything to
18 add, Melisa? Please, go ahead.
19 DR. WILKNISS: Yeah, I was just going to point
20 you to Arizona and Ohio are a couple of states that have
21 done really good, Arizona in particular in the Medicaid
22 program, including some additional funding they received

1 for targeted investments, have been looking at really
2 shoring up this issue of addressing justice-involved
3 populations and usually the managed care are involved too.
4 VICE CHAIR MILLIGAN: Thank you. Kit?
5 COMMISSIONER GORTON: Thanks, Chuck. Thank you
6 all for coming. My question is for Dorn in particular.
7 It's nice to hear about a program in a later stage. We
8 often hear about early-stage programs, and to be able to
9 see a more mature program and outcomes that you've been
10 able to produce is very helpful.
11 The results are breathtaking. I started my
12 clinical career in FQHCs in the city of St. Louis 35 years
13 ago, and what you're describing now is not the St. Louis or
14 the Missouri that I remember. So congratulations on that.
15 I guess my question would be, putting aside the
16 glow of the moment and the great numbers that you have --
17 and thank you for collecting data, which is often something
18 we don't see. What next? What do you want to -- what are
19 you going to do to build on this? Obviously, you have this
20 wonderful continuous quality improvement kind of mentality
21 in the state now and in the behavioral health system. And
22 so where do you want to go next with it? And sort of as a

1 parallel to that, do you have the authorities that you
2 need, or are there things that MACPAC could potentially
3 help influence folks to remove barriers?
4 MR. SCHUFFMAN: So a couple things. Let me just
5 mention kind of an aside. Dr. Wilkniss mentioned this when
6 she was talking about the importance of hotlines, and, you
7 know, one of the requirements for CCBHCs is that you have
8 24-hour mobile crisis teams. Now, we had those prior to
9 the demonstration, but when we went into the demonstration,
10 they were reluctant to let us include the cost of the
11 hotline. But we finally convinced them to do that.
12 When we went to write the state plan amendment,
13 they refused to let us include the cost of the hotlines.
14 They said, "We don't pay for hotline. Medicaid doesn't pay
15 for that." So we spend our general revenue on it because
16 how can you do a 24-hour mobile crisis team if you don't
17 have a place for people to access 24 hours through the
18 phone? That's just a small thing.
19 But where we're going next is we have -- as I
20 said, we've got 15 -- or 19 of our 26 areas covered. We're
21 working with the other providers to get them up to speed.
22 Probably starting next July we will add at least three or

1 four of them. There's a lot of work to get to this level,
2 and you need to be doing it for a while before you see the
3 benefits. One of the major downsides of the demonstration
4 -- it was a 2-year demonstration. It's been extended a
5 little bit. But you don't start to see outcomes for a
6 while. You have to learn how to do this. And that's why
7 it's good to have a demonstration. We viewed it as a
8 pilot, which means we're going to do this; we're just going
9 to figure out how to do it for a couple years. And so it's
10 been very successful for us.
11 In terms of other things we plan to do, it's
12 basically expanding it statewide, and there are areas, even
13 though, you know, we meet the standards in some cases; we
14 meet them well or not so well, and so that's a continuing
15 effort. We'll probably add some additional evidence-based
16 practices that we require.
17 VICE CHAIR MILLIGAN: Thank you. Martha?
18 COMMISSIONER CARTER: Thank you. My question is
19 around the interaction between your programs and the FQHCs,
20 the community health centers.
21 For Melisa, how have you integrated the health
22 centers into your service delivery? And what are the

1 strengths and the barriers of that interaction?

2 And then for Dorn, what's the interaction between

3 the CCBHCs and the FQHCs in your model?

4 MR. SCHUFFMAN: Okay. You want to go first?

5 MS. BYRD: Thanks for that question. For our

6 federally qualified health centers, or FQHCs, we went

7 through a significant reimbursement methodology revision

8 two to four years ago where we went from our PPS system,

9 which had not been updated maybe in 20, 30 years, to adding

10 or expanding to include alternative payment methodology

11 where by now we have rates individually for physical

12 health, behavioral health, and for dental services. So we

13 have acknowledged, if you will, the importance of FQHCs as

14 an access point for behavioral health. In the District,

15 it's really for the lower-acuity services, for counseling.

16 It does not -- some of our FQHCs do serve as mental health

17 rehab providers as well, but I would say generally it's on

18 the lower-acuity level. But having that separate rate for

19 behavioral health-specific services has been extraordinary

20 important to us in expanding that access.

21 MR. SCHUFFMAN: In Missouri, six of the 16 CCBHCs

22 are FQHCs as well. You know, this all kind of started with

1 an initiative where I was working with six pairs of FQHCs
2 and CCBHCs, or at that time mental health centers, to try
3 to integrate their care. And we learned a lot from that,
4 which led into our Health Home Initiative both for our
5 primary care health home and the CCBHC health home. But
6 right now, you know, all politics is local, and so in some
7 cases the FQHC is the CCBHC. In many cases, the CCBHC and
8 the FQHC share a lot of individuals. They collaborate in
9 serving people. The primary care physician is at the FQHC,
10 and the CCBHC is providing the behavioral health services,
11 and they work very close together.
12 But, of course, there are other areas where at
13 the local level there's just not that relationship, and
14 that's something that has to be worked on and developed.
15 VICE CHAIR MILLIGAN: Thank you. I'll come to
16 Melanie next.
17 CHAIR BELLA: Great. Thank you, Chuck.
18 Melisa, I had a question for you similar to the
19 one that Kit asked Dorn, which is it sounds like you've
20 taken advantage of a lot of the CMS flexibilities and you
21 have had a lot of positive experience with that. What
22 other tools do you need? What could the Commission do to

1 help continue to further your efforts? Are there more
2 tools or are you gathering what you need to continue to
3 drive your agenda?
4 MS. BYRD: Sure, and thanks for that question.
5 What I highlighted earlier, I always say it's not
6 particularly exciting to talk about, but the
7 infrastructure, I can't emphasize the resources to support
8 infrastructure building, particularly among providers. I
9 think it's even more crucial with behavioral health
10 providers. I know it was alluded to earlier, some of the
11 same funding opportunities haven't been available to
12 behavioral health providers as they have been to physical
13 health providers through the federal lens, but, you know,
14 we have seen particularly through the technical assistance
15 and the My Health GPS program, I mean, the amount of effort
16 and assistance needed to help providers think through their
17 work flows and how to change those to better support the
18 outcomes that we want to see is significant. And some
19 providers have the capacity and wherewithal to be able to
20 start to move that forward on their own, but others, they
21 do not. And I just feel like we can add access to a lot of
22 services and so forth, but if we don't really have that

1 foundational component, it will really limit us going
2 forward. So really just those components are particularly
3 important.
4 On the service side, I would say -- it was also
5 raised earlier -- you know, housing supports would be
6 welcome for sure. Again, back to the earlier question on
7 incarceration, we were really excited about the potential
8 to include the transition planning services for those soon
9 to be released, and we're disappointed to have to hold on
10 that for the time period, although we are having some --
11 through our mobile crisis and outreach services under the
12 waiver, we do have outreach opportunities for diversion
13 efforts. But really being able to support folks in
14 transitioning back to the community and lowering the
15 recidivism rate would have been really helpful to the
16 District.
17 CHAIR BELLA: Thank you.
18 VICE CHAIR MILLIGAN: Thank you. And can the
19 panelists hang with us for a couple extra minutes? Because
20 I have -- I think Fred wanted to go next, and then I had
21 one question. Fred?
22 COMMISSIONER CERISE: Thanks, Chuck, and thank

1 you guys for a great presentation. It's good to see you,
2 Melisa.
3 I think you all did a great -- made a great point
4 that, you know, for this complex population you have to
5 build systems of care to provide services, and I'm
6 wondering how -- you know, within Medicaid, we're serving a
7 portion of the population, and, Melisa, you're probably the
8 most -- you said, I think, 40 percent of the population is
9 Medicaid, so you can probably make the most broad impact.
10 But, still, I wonder. How do you weave the payers together
11 so that, you know, the patients that need services can
12 access these comprehensive services that you're talking
13 about? Sandra, you talked about that.
14 So I have a couple of questions, one for Dorn.
15 What percentage of the patients you serve are Medicaid and
16 what percent are otherwise? And then for Sandra, you know,
17 what are your thoughts about Medicaid's role in trying --
18 in working with these providers to try to weave services
19 together? When someone's in crisis and you get that call,
20 you can't do a Medicaid determination at that point, right?
21 And so you have to -- these providers have to go through
22 services. And so how do you -- you know, how can Medicaid

1 help support those providers to do like you said, doing the
2 hotline that's going to serve a bunch of people, not just
3 Medicaid? And, Melisa, maybe you can talk about, you know,
4 with 40 percent of the population under Medicaid, as you
5 help providers build those systems, has that translated to
6 other parts of their business? And does your waiver pick
7 up uninsured too even though it's just a small amount? So
8 that's a bunch, but maybe, Dorn, what percent are Medicaid?
9 MR. SCHUFFMAN: You know, it varies by site,
10 obviously. But I think overall it's around 30 percent.
11 But, you know, the state has been spending -- we spend a
12 lot of our state general revenue on other individuals who
13 are not Medicaid-eligible, and we just continue to do that.
14 People who are in CCBHC can be private pay; they can be
15 Medicare; they can be Medicaid. And some of them are in
16 managed care; a few of them -- we have permanently and
17 totally disabled carved out of managed care in the state.
18 But some of those that are -- get their funding through
19 managed care companies. So it's a variety of funding
20 sources.
21 Yeah, the thing about the crisis response, it's
22 great that it's required for this, because, you know, the

1 mobile crisis team, you don't go out -- as you said, you
2 can't say, "Well, are you Medicaid-eligible? Can I serve
3 you?" No. You intervene with people, and you find -- you
4 know, so that cost is not -- it's a cost of the team. It's
5 the cost of a capacity. The capacity to respond has to be
6 built into the rate, and you just have to recognize that
7 that's necessary. So we don't bill it as a visit. The
8 cost of the team is built into the rate as a capacity that
9 you've got to have to respond.
10 COMMISSIONER CERISE: That's good.
11 DR. WILKNISS: I'm happy to add to that, just to
12 say in my experience just exactly what Dorn described. I
13 mean, most providers, especially more sophisticated
14 providers offering a variety of services, have figured out
15 how to braid together dollars to do the work they do and
16 supplement the rest with donations and with state general
17 funds. And we know that state general funds are really
18 going to be in short supply.
19 What can Medicaid do? I don't have the answer to
20 that other than to say, you know, CMS generally sets a
21 signal and can really be a leader in saying we want to
22 align with other payers in order to figure out how to build

1 this capacity across the system. And I'm happy to do some
2 more research and provide some more ideas, but I think that
3 it's really figuring out how you all can set that signal
4 and work with other payers to align to build the capacity,
5 and the state general funds simply won't be there. And so
6 the system that's just getting launched -- so I think about
7 mobile crisis in New Jersey, all general funds, especially
8 for kids and families. Mobile crisis developed in rural
9 parts of North Dakota, all general funds. It’s really
10 supporting that work.

11 So it's unsustainable, and I will do my darnedest
12 to get you more answers, but I hope you all will also
13 connect with other folks to come up with something.

14 MR. SCHUFFMAN: The same is true with any
15 outreach and engagement. You know, you can't tell until
16 you've done it whether somebody's Medicaid-eligible, but
17 you've got to do it. So you really need that capacity.
18 It's the availability of the capacity to do that. But
19 you're going to an emergency room, you know, they have an
20 apparent behavioral problem, but are they Medicaid-
21 eligible? I have no idea. But I can't sit and wait to see
22 if they are.

1 VICE CHAIR MILLIGAN: Melisa?

2 MS. BYRD: Thanks. So the waiver does not expand
3 eligibility coverage to any additional populations, but
4 what I will say, though, in the District, you know, part of
5 the 40 percent of our footprint also includes a couple
6 local-only programs that are small in scope in terms of I
7 think it's about 20,000 individuals. So for individuals
8 also low-income or below 200 percent of the poverty level
9 who are otherwise ineligible for Medicaid, there is a
10 coverage option there.

11 And then for those who may be uninsured, our
12 public behavioral health system supports individuals who
13 need services, and the behavioral health services provided
14 through local funds only, they align to what you see in the
15 Medicaid program. So they're pretty closely aligned.

16 I think the other question about, you know, some
17 of the investments [inaudible] that, you know, have we seen
18 an impact a little bit broader. And on the HIE HIT tools,
19 I think it's been really helpful in allowing the
20 opportunity for more connections between provider types.
21 Some of the practice transformation efforts that we've
22 seen, one of the challenges is -- and I certainly don't

1 have any answers on this one -- you know, we go and we ask
2 providers to change how they do their work for just one
3 payer. And I think it's very challenging to ask a provider
4 to change how they do business to meet our needs as one
5 pair where they might have -- you know, in the District, we
6 pay lots, we cover a lot, so it's significant. But we're
7 certainly not the only source of -- not the main payer
8 source for providers. So it's really difficult, I think,
9 to ask providers to make that leap.
10 And, additionally, you know, usually Medicaid,
11 what you heard today, there have been demonstration
12 programs or pilot programs, so additionally you're asking
13 providers to make changes that might go away after a
14 couple-year period and make those investments. What we saw
15 through our Health Homes program and My Health GPS with the
16 intense technical assistance, even with that intense
17 technical assistance we tended to see that impact the
18 program in an individual and not having that full practice
19 transformation that we wanted to see across the providers,
20 all folks that they serve.
21 And then, finally, I think something else that
22 would be particularly helpful and can help us move that way

1 is just the payment flexibility. We're still -- I know
2 providers are very interested here in the District in more
3 of a capitated or per member per month on the behavioral
4 health side so that they have the flexibility to do what
5 they need when they need to do it for folks.

6 I hope that answers some of your questions.

7 COMMISSIONER CERISE: Good. Thanks.

8 VICE CHAIR MILLIGAN: Thanks. So that will
9 conclude the panel part. Fred picked up what I was going
10 to ask.

11 I want to thank the panelists very much for what
12 you offer to us and the data that you shared. I hope that
13 either you have passed it along to Erin or you will,
14 because that will help us in our future work.

15 If we were all in person, we would give you a
16 round of applause, so consider this a virtual round of
17 applause. And as we pivot to the Commission-only
18 discussion, you're free to stay and listen. But if you
19 need to jump back to your day jobs, feel free to jump as
20 well.

21 Again, thank you very much for everything you
22 contributed to help us in our work.

1 MR. SCHUFFMAN: Thank you.

2 VICE CHAIR MILLIGAN: Thank you.

3 MS. BYRD: Thank you.

4 **### FURTHER DISCUSSION BY COMMISSION**

5 * VICE CHAIR MILLIGAN: Okay. So, Commissioners,
6 we've got until the bottom of the hour to sort of talk
7 about where we want to take the work or suggest that Erin
8 and others kind of continue the work, thoughts around our
9 role in terms of federal policy or are there things that we
10 should be potentially weighing in on down the road and
11 other kind of foundational research that might be helpful
12 as we go forward.

13 So opening it up now to the Commissioners to just
14 sort of see what observations you have and thoughts you
15 have for MACPAC going forward. Anybody want to jump off
16 and start us off?

17 Kit and then Martha.

18 COMMISSIONER GORTON: So mine is a question
19 because I sort of was taken aback by the "No, we won't fund
20 hotlines," "We won't fund the crisis." I get the issue
21 about not paying for services for people who are not
22 Medicaid-eligible, but at the same time, I would just like

1 to understand the policy rationale from the federal
2 perspective on why you would say no to a state that wanted
3 to do that, particularly a state that has already
4 demonstrated huge savings from the model that they're
5 deploying. So I'd like to hear more about that.
6 To the extent that that is a real barrier, I'd
7 like to think about how we address it. What
8 recommendations could we make to whoever, whether it's the
9 agency or Congress or whomever?
10 So that's just my question. I'd like to have
11 follow-up on that. It seems like a no-brainer to be
12 funding that kind of stuff.
13 VICE CHAIR MILLIGAN: Thanks, Kit.
14 I have Martha. Then I have Fred after that.
15 COMMISSIONER CARTER: Thanks. I'd like to follow
16 up more on workforce issues.
17 We heard in a previous presentation, the lack of
18 psychiatrists and taking new patients, and that map that
19 you showed of unmet need -- or met need, my state is at 17
20 percent. It's very difficult to recruit psychiatrists.
21 I know anecdotally that the family docs I know
22 are seeing more mental health at a higher acuity level than

1 they ever thought they would, and I'm sure that's the same
2 for psychiatrists in these rural areas and areas where
3 hospitals have closed.
4 So I think workforce is a really big issue in
5 terms of access to mental health services, especially in
6 some parts of the country. So I think we maybe could even
7 develop something toward a recommendation in that area.
8 VICE CHAIR MILLIGAN: Thank you.
9 Fred and then Toby.
10 COMMISSIONER CERISE: Yeah. Just following up on
11 Kit's comment, there is an infrastructure issue here,
12 capacity-building issue. In the report, it struck me.
13 Like, I can't imagine any or very much services being
14 provided by the kind of solo practitioner when we're
15 talking about the complexity of what goes on here.
16 Really, there's some positive stuff happening,
17 these certified community behavioral health centers. That
18 model that's going to support infrastructure and capacity
19 is important and flexibility with that model. So how much
20 can you put into there to get support, whether it's
21 hotlines or whether it's residential support or whether
22 it's the work support?

1 But, you know, it necessarily bleeds over to,
2 like I was saying earlier, to other payers, and so I don't
3 know how much flexibility within Medicaid you have to
4 support that. But I do think looking at that and how much
5 capacity building we can support would be important to
6 understand.

7 VICE CHAIR MILLIGAN: Thanks, Fred.

8 Toby, and then I think I saw Sheldon after that.

9 COMMISSIONER DOUGLAS: Just an overall comment
10 for us to think about for our work ahead. There were so
11 many different interventions that we're talking about, and
12 part of the problem I have when I think about this is we're
13 not talking about one population. We're talking about
14 those with mild and moderate mental health needs and
15 behavioral health needs and those with persistent, severe
16 mental illness. So when we think about the provider types
17 and the needs, who are we talking about with these
18 interventions?

19 I don't know if it's thinking more about the
20 targeted interventions, especially around those with severe
21 mental illness, which are going to need more comprehensive
22 approaches, but there are clearly a lot of needs for

1 modalities for those with mild to moderate, especially as
2 we've seen during this pandemic.
3 But it was really hard to know, given moving back
4 and forth, which population and where the needs are for
5 which group. So not articulated well, but it was bouncing
6 around a lot, and it was making me think about we really
7 need to hone in on who we're talking about and the needs of
8 which population.
9 VICE CHAIR MILLIGAN: Thanks, Toby.
10 Sheldon and then Brian.
11 COMMISSIONER RETCHIN: Yeah. I would build a
12 little bit on what Toby just said. I do think the focus on
13 serious mental illness, if I had to make a choice, the
14 Medicaid population is most urgent need.
15 To that end -- and I would like to -- I'm still
16 interested in the interaction with the justice system, but
17 I think really for the purposes of review, I'd like to see
18 more data in terms of scope of practice and whether
19 variations of scope of practice on a state level, whether
20 we're seeing better access, where there's more autonomy
21 granted to advance practice, non-physician providers,
22 whether that makes a difference, because the supply of

1 psychiatrist, it is increasing in terms of match rates but
2 really at a snail's pace and will not be the answer for a
3 population of those, with this in mind, a vast majority of
4 which need pharmacologic intervention.
5 VICE CHAIR MILLIGAN: Thank you, Sheldon.
6 Brian and then Tricia.
7 COMMISSIONER BURWELL: I think I'm picking up on
8 the same thread.
9 What I'm learning from the discussion is that as
10 acuity goes up, access goes down. So if we're going to
11 focus on access issues, we really need to focus on how that
12 relates to the acuity of the population being served. So
13 I'd like to see our research kind of focus on that as a
14 factor and why that's true. We heard a lot of reasons why
15 those with more severe mental illness aren't getting the
16 access to services on a wide range of issues.
17 But I agree with Sheldon that I think some of it
18 is the lack of psychiatrists, a psychiatrist's willingness
19 to serve that population, given that there's excess demand
20 for their services already; hence, scope of services is
21 important. If other people in the health care community
22 are given authority to do medication management, I think

1 that that would be a significant benefit.

2 I heard the panelists saying that because serving
3 this population requires a wide continuum of services that
4 they were advocating for some type of capitation payment
5 that would allow providers to provide a broad range of
6 services within a single-payment methodology.

7 But then I agree with Toby and Sheldon. It's
8 like, how do we define that population? I didn't hear
9 anybody say how are they defining their eligible population
10 in the demonstration in terms of who gets that payment, who
11 is eligible for that payment and who's not.

12 VICE CHAIR MILLIGAN: Thank you, Brian.

13 Tricia and then back to Fred.

14 COMMISSIONER BROOKS: So just a couple of quick
15 comments. When we think about workforce, I'd like to
16 remind us to think about this through a health equity lens.
17 Part of the reason we have such a crisis in the justice
18 system is not understanding the population that's being
19 served, and I'd like to know more about workforce
20 development in terms of recruiting people of color into the
21 field and also children's mental health. We know there's a
22 shortage of people to deal with that as well.

1 Just to make a point I think I've made before in
2 terms of the Commission, concern over the fact that some
3 states do implement EPSDT in a way that mental health
4 services are only available to children if they have a
5 diagnosis, and a lot of providers are reluctant to label,
6 particularly a very young child, with a diagnosis. So it's
7 another aspect of access I want to keep on our radar
8 screen.
9 VICE CHAIR MILLIGAN: Thank you.
10 Fred?
11 COMMISSIONER CERISE: One other thought, these
12 certified behavioral health centers they're done in a
13 handful of states now. I think it's important, because
14 this is a relatively new phenomenon, that we get data. If
15 these are demos, then we should be getting good data to
16 look at their effectiveness.
17 I heard Dorn give some really strong outcomes. I
18 would make sure that CMS is putting some rigor behind these
19 analyses, and if we haven't done that on the front end with
20 the first group, then perhaps expand it to a few -- I know
21 there's other states that are interested in doing this.
22 Expand it with some really strong evaluation component to

1 it, because I think it has potential to make an impact and
2 to support -- it's a cost-based payment method, which I
3 think will need strong support to say, "Yeah, that's a good
4 way to go."
5 I suspect you'll find it, but I don't know what
6 kind of evaluation has been done on these and with what
7 sort of rigor. But that's something that I would take a
8 look at and emphasize the need for.
9 VICE CHAIR MILLIGAN: Thank you.
10 I know, Sheldon, I saw your hand.
11 Melanie, did you raise your hand as well?
12 [No response.]
13 VICE CHAIR MILLIGAN: No? Okay.
14 Sheldon, to you.
15 COMMISSIONER RETCHIN: I just wanted to circle
16 back just to level set. I know the Commission knows this,
17 but just to make sure, when we talk about serious mental
18 illness, that has diagnostic specificity. It's not a
19 continuum.
20 So there are three diseases or conditions --
21 bipolar disease, major depressive disorder, and
22 schizophrenia -- just to make sure that it's not a -- I

1 think focusing on that area is of great importance.

2 VICE CHAIR MILLIGAN: I had one or two things,

3 but I want to make sure that I catch everybody else first.

4 Were there any other hands raised?

5 [No response.]

6 VICE CHAIR MILLIGAN: I'm seeing none.

7 Erin, I had a question for you first, which is

8 when individuals have mental illness, it's not just access

9 to mental health treatment that there are access

10 challenges. But kind of the failure to deliver access to

11 address mental health can then kind of also result in less

12 access or less frequent use of preventive services for

13 physical health or somatic conditions.

14 There's a lot of research that shows that

15 individuals with mental illness, you know, there's less

16 vaccines, less screening for cancers, there's less

17 preventive services, and less kind of adherence to

18 treatment of chronic conditions outside of the mental

19 illness field.

20 In our work or in what you've learned so far,

21 have you seen any data that correlates access challenges in

22 the mental health area with disparities of treatment in the

1 physical health area for individuals with a mental health
2 diagnosis? And I'm wondering partly whether that should be
3 in scope or out of scope of kind of where we go with all of
4 this.
5 MS. McMULLEN: So the data that we presented to
6 you in September, some of that focused on the co-occurring
7 chronic physical health conditions in people who are SMI.
8 Due to limitations in the survey data, we're only
9 able to look at it on a national level. So for us to do
10 kind of a more layered or more nuanced analysis that looked
11 at unmet need in different states in addition to the
12 chronic health layer -- the number of chronic health
13 conditions people have, it would be very challenging for us
14 to do that, just because the data doesn't really let us get
15 -- there's not enough power to get that granular.
16 VICE CHAIR MILLIGAN: Thank you. That's helpful
17 to know.
18 Because I do think that one -- and I want to pick
19 up on something Fred said. One of the elements of
20 evaluating some of these demos and some of these pilots,
21 including the health home model that was in the Affordable
22 Care Act, was -- a lot of times, if you embed attention of

1 physical health in a mental health center, you see -- I
2 think you tend to see in the data, better outcomes with
3 physical health because it's a trusted health home for
4 addressing the other barriers to treatment, homelessness
5 and employment challenges and housing challenges and SDOH
6 and all of that. So I just want to make sure that we keep
7 that strand, and I'm not asking to kind of go deeper than
8 what we can see in the data.
9 So let me try to summarize what I heard in the
10 comments from the Commissioners and then see if I missed
11 anything and then see, Erin, if you have any questions for
12 us.
13 One of the themes that I heard is very strongly
14 focused on workforce and having a better understanding of
15 workforce. I think there were issues around workforce in
16 the sense of scope of practice, workforce in the sense of
17 adequacy of providers who are serving at the SMI or SPIMI
18 kind of end of the diagnostic area, workforce around
19 treatment for children that Tricia raised, workforce kind
20 of supporting the justice-involved community because there
21 is a strong health equity lens in all of this. So I think
22 one theme that I heard was workforce.

1 A second theme that I heard was around Medicaid
2 coverage rules and Medicaid-matching rules. This came up
3 in the context of some of the crisis lines or the help
4 lines. It came up in the context of some of the initial
5 screening activities that -- before a provider knows
6 whether somebody is on Medicaid or not. I think there's a
7 -- what are the ground rules around federal match for that
8 and federal financing for that kind of stuff?
9 I heard -- and separate from what I mentioned
10 around workforce, I heard a theme around trying to have a
11 better understanding of the access challenges, especially
12 among individuals with SMI. Brian made the comment -- I
13 think it was Brian -- that the more acute the need, the
14 harder the access might tend to be.
15 Toby made the comment around wanting to
16 understand kind of more of the segmentation from
17 individuals who had maybe mild or moderate conditions
18 versus severe conditions.
19 So I think the more we can understand the access
20 challenge at kind of that diagnostic level, including
21 children with SED, I think that would probably be helpful
22 for us to understand the nature of the problem.

1 Those are my notes. Did I miss anything from the
2 Commissioners?
3 And, Erin, do you have any questions for us, or
4 do you have what you need before we kind of wrap this
5 particular part of the agenda?
6 I'd say the same question to you, Melinda.
7 VICE CHAIR MILLIGAN: Okay.
8 MS. McMULLEN: Yeah. And I think. I think this
9 was very helpful --
10 VICE CHAIR MILLIGAN: Same with Melinda?
11 VICE CHAIR MILLIGAN: Okay.
12 MS. McMULLEN: And just as a reminder, you'll
13 hear about the kids in December. We'll be back to talk
14 about children's behavioral health issues in much more
15 detail, so stay tuned.
16 VICE CHAIR MILLIGAN: Great.
17 Okay. So I want to open it up now for public
18 comment, if there is any public comment, and after public
19 comment, the Commissioners are going to take a break until
20 1:30 Eastern.
21 Are there any individuals? And I do see one
22 individual whose hand is raised. So if we can take Stuart

1 off of mute, please? Stuart, it's all yours.

2 ### PUBLIC COMMENT

3 * MR. GORDON: Thanks, Chuck.

4 First of all, kudos to Erin and Melinda on their
5 presentation. It was pretty magnificent, and we've already
6 sent it out on our listservs to all of our members.

7 I did send the staff a couple of documents I
8 thought might be of interest to you all. One is a NASHP
9 research institute. They are not part of NASHP.

10 I'm sorry. I'm Stuart Gordon, director of Policy
11 and Communications with the Mental Health Program
12 Directors.

13 The NASHP Institute did a survey of state
14 directors. They got a response from 41 of them about the
15 impact of the COVID-19 pandemic on their services. I think
16 it's something that would be of value to the Commission to
17 look at.

18 We also did a survey at the request of SAMHSA, we
19 and NASADAD, the association representing the substance
20 abuse directors, on the impact of telehealth. We got quite
21 a response. I think that's worth looking at. We provided
22 that to SAMHSA and to PCORI. As you might expect, every

1 state is looking to extend those telehealth flexibilities
2 beyond the pandemic and trying to find a way to convince
3 CMS to extend it to telehealth flexibilities as well.
4 I also sent Erin and Melinda some work notes from
5 a workgroup that we have formed with the psychiatrists
6 under the SMI advisor rubric that's looking at rural
7 health, rural behavioral health access. I've included
8 notes there, and I think one of the important pieces of
9 information we got from the first discussion -- and there
10 will be two more -- is the lack of resources, the lack of
11 workforces making it very difficult for providers to do
12 evidence-based practices in rural settings.
13 Then finally, I heard a mention of Medicare peer
14 support coverage. There is no Medicare peer support
15 coverage. We are working hard with almost everybody in the
16 mental health liaison group -- and that's about 70
17 organizations -- to get passages in the legislation that
18 would provide coverage under collaborative care and
19 integrated care models.
20 I do want to point out that the IMD waiver is --
21 well, it was taken up by 35 substance use agencies. Only
22 seven mental health agencies have taken up the waiver. The

1 agencies are saying the reporting requirements are just too
2 difficult for them to access to apply for that waiver.
3 CCBHC data. There were eight. There are now ten
4 states in that demonstration project, but at the same time,
5 Congress has been handing out money directly to CCBHCs
6 rather than through the states. So the collection of data
7 from those other CCBHCs and the money that's gone out has
8 been in the billions over the last two years. It's going
9 to be missing, I think, a large number of the CCBHCs.
10 Crisis, funding for crisis services. The House
11 last year included in their funding under SAMHSA a 5
12 percent set-aside in the mental health block grant, not a
13 lot of money, but some money for crisis services. The
14 Senate did not include it. We've gotten the House to
15 include it again this year, and we're continuing to press
16 to get a Senate signoff on that as well.
17 And I think that's the only points I have to
18 make, but thank you all for listening very graciously.
19 VICE CHAIR MILLIGAN: Thank you very much,
20 Stuart.
21 Are there any other members of the public who
22 want to make comment?

1 [No response.]

2 VICE CHAIR MILLIGAN: Okay. Seeing none, we're
3 going to take a break now, and the Commission will resume
4 our afternoon agenda at 1:30. So I hope to see you folks
5 back then. Thank you all very much.

6 * [Whereupon, at 12:34 p.m., the Public Session was
7 recessed, to reconvene at 1:30 p.m. this same day.]

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22 AFTERNOON SESSION

1 [1:30 p.m.]

2 CHAIR BELLA: Welcome back, everyone, from our
3 break. I want to go ahead and get us started, because we
4 have a lot to talk about in this session, and so I hope
5 everybody is energized and ready to be engaged.

6 Martha, we'll turn it over to you to get us
7 started. Thank you.

8 **### CONSIDERATIONS IN EXTENDING POSTPARTUM COVERAGE**

9 * MS. HEBERLEIN: Thank you, Melanie.

10 During the last report cycle we spent
11 considerable time examining Medicaid's role in maternal
12 health, culminating in two chapters in the June report.
13 Over the course of that work, the Commission expressed
14 interest in making a recommendation to extend the
15 postpartum coverage period.

16 In this report cycle, the Commission will explore
17 issues related to such a recommendation. I also wanted to
18 note that we are continuing other work related to maternal
19 health, including examinations of the value-based maternity
20 payments and access to maternity providers, and we plan to
21 bring those back at subsequent meetings.

22 Today I want to begin with a review of the

1 current coverage available to pregnant women before
2 describing the postpartum interruptions in coverage and the
3 health issues they experience. I'll then briefly review
4 state and federal actions to extend the postpartum coverage
5 period before moving on to outline possible
6 recommendations.
7 All states are required to provide Medicaid
8 coverage for pregnant women with incomes at or below 133
9 percent of the federal poverty level. Currently, all but
10 four states extend coverage to pregnant women with higher
11 incomes, and states may also provide comprehensive health
12 care coverage for uninsured targeted low-income pregnant
13 women through the State Children's Health Insurance
14 Program, or CHIP, and six states currently do that.
15 States must extend coverage to women eligible for
16 Medicaid because of their pregnancy, as well as pregnant
17 women covered in CHIP for 60 days postpartum. Women who
18 are otherwise eligible in Medicaid, for example, as a low-
19 income parent, and become pregnant, can retain their
20 existing coverage and generally are not required to shift
21 to a pregnancy-related eligibility pathway. As such, they
22 do not face an end to their coverage at 60 days postpartum.

1 It is also important to note that during the
2 public health emergency pregnant women who reach the end of
3 their postpartum coverage period cannot be disenrolled due
4 to the continuous coverage requirements tied to the
5 enhanced federal matching rate provided by the Families
6 First Coronavirus Response Act.
7 At the end of a woman's 60-day postpartum
8 coverage period, states are required to screen her for
9 continued eligibility through other pathways or transfer
10 her to the federal or state health insurance exchange if
11 she is no longer eligible for any type of Medicaid.
12 Whether another Medicaid pathway is available depends upon
13 the state's eligibility threshold for pregnant women, the
14 threshold for parents, and whether the state has adopted
15 the Medicaid expansion. Regardless of whether the state
16 expanded Medicaid, the income eligibility thresholds for
17 pregnant women are higher in the vast majority of states
18 than they are for any alternative pathways. So,
19 Commissioners, the appendix tables in your materials
20 includes state-by-state eligibility levels.
21 In those state that have expanded Medicaid to
22 low-income adults, a woman may be eligible for ongoing

1 Medicaid coverage if her income is at or below 133 percent
2 of the federal poverty level. Postpartum women with
3 incomes above 133 percent could be eligible for a
4 subsidized coverage on the exchange.
5 In a non-expansion state, a postpartum woman
6 would need to be eligible for another pathway, likely as a
7 parent, in order to retain Medicaid. The parent
8 eligibility threshold in non-expansion states is about 36
9 percent of FPL. Postpartum women who have income above
10 this threshold but at or below 100 percent FPL would not be
11 eligible for Medicaid or subsidized coverage on the
12 exchange. Subsidized exchange coverage may be available to
13 women with incomes above 100 percent FPL.
14 So states have taken different approaches to
15 coverage for pregnant women, parents, and Medicaid
16 expansion adults. This slide shows a visual representation
17 of a few states with variation in that coverage.
18 Pregnant women are typically entitled to the full
19 Medicaid benefit package. However, for women covered
20 through poverty-level pregnancy pathways, states may limit
21 services to those related to pregnancy. Although the vast
22 majority of states provide the full Medicaid package to all

1 pregnant women, four states -- Arkansas, New Mexico, North
2 Carolina, and South Dakota -- provide only pregnancy-
3 related services.
4 Pregnancy-related services are defined as those
5 that are necessary for the health of the pregnant women and
6 fetus, including prenatal care, delivery, postpartum care,
7 family planning services, and services for other conditions
8 that might complicate the pregnancy, threaten carrying the
9 fetus to full term, or create problems for a safe delivery.
10 States may take a more or less expansive view of what
11 constitutes pregnancy-related services, and it is not
12 necessarily clear what the actual effect of these
13 limitations are.
14 In March 2014, MACPAC recommended aligning
15 benefits across eligibility pathways, asking Congress to
16 require states to provide full Medicaid benefits. This was
17 out of a desire to align coverage for pregnant women and
18 ensure the best possible outcomes for women and newborns.
19 So looking at coverage disruptions for women that
20 they experienced during and around pregnancy, between 2015
21 and 2017, one-third of women experienced a change in health
22 insurance from preconception to postpartum. The

1 disruptions occurred across the pregnancy, with 25 percent
2 of women experiencing a change from preconception to
3 delivery, and almost 29 percent experiencing a change from
4 delivery to postpartum.
5 In states that chose not to expand Medicaid, the
6 preconception rate of uninsurance was nearly double that of
7 expansion states, and the postpartum uninsurance rate was
8 nearly triple that of expansion states.
9 There are also racial and ethnic disparities in
10 insurance status and continuity of coverage for women
11 spanning pregnancy. One study found that three-quarters of
12 white, non-Hispanic women were continuously insured. This
13 is in comparison to 55 percent of Black, non-Hispanic
14 women, 50 percent of indigenous women, and about 20 percent
15 of Hispanic Spanish-speaking women.
16 So what has been termed the fourth trimester, the
17 12-week period after childbirth, is marked by significant
18 changes. Woman may experience health concerns during the
19 postpartum period that require ongoing medical care, and
20 many of these concerns may continue beyond this fourth
21 trimester. As we discussed last year, one-third of
22 pregnancy-related deaths occur postpartum, including almost

1 12 percent that occur in the last postpartum period, so
2 between 43 and 365 days postpartum. There are considerable
3 racial and ethnic disparities in pregnant-related
4 mortality, with a greater proportion of deaths among Black
5 women occurring in the late postpartum period in comparison
6 to white women.

7 An increasing number of pregnant women have
8 chronic conditions that may require continued medical care
9 in the postpartum period, and some studies have shown that
10 these disproportionately occur among low-income and
11 minority women, including women covered by Medicaid.

12 Women also face behavioral health issues in the
13 postpartum period. For example, perinatal mood and anxiety
14 disorders affect 1 in 7 pregnant and postpartum women.
15 These conditions often go undiagnosed and untreated, with
16 about half of women with diagnosis of depression receiving
17 any treatment.

18 A lack of coverage can create a barrier to
19 postpartum care. For example, Strong Start for Mothers and
20 Newborns participants raised concerns regarding their lack
21 of coverage. Some focus group participants indicated that
22 while their infant would be covered under Medicaid, they

1 were concerned about losing their own coverage. They
2 commented that securing Medicaid outside of pregnancy was
3 difficult, and the lack of coverage affected their access
4 to care.

5 However, lack of coverage is not the only
6 barrier. Only about 61 percent of women on Medicaid had a
7 postpartum visit within eight weeks of delivery. A lack of
8 information related to when their coverage would end, the
9 importance of postpartum visits, as well as available
10 programs or services hindered postpartum visit attendance
11 among Strong Start participants. Logistical barriers such
12 as transportation and child care were also cited as
13 barriers.

14 So 11 states have expanded or sought to expand
15 coverage beyond typical 60-day postpartum coverage period
16 although they may target a particular population such as
17 women with mental health or substance use disorders or a
18 particular service such as family planning. For example,
19 using state-only dollars, California provides an additional
20 10 months of postpartum care for women in Medicaid, as well
21 as those covered under the unborn child option. These
22 women must be diagnosed with a maternal mental health

1 condition in order to receive ongoing coverage. Rhode
2 Island and Wyoming target their family planning programs to
3 postpartum women.
4 Many of the 11 states noted in your materials
5 have not yet implemented their extension. To receive
6 federal funding for this coverage, states need CMS approval
7 of the Section 1115 waiver, and some states taking such
8 actions are still waiting approval. For example, back in
9 the spring, we heard from New Jersey and their proposal to
10 extend the postpartum period for six months, and the state
11 is waiting on CMS approval for that waiver amendment.
12 Additional states, as noted in your materials,
13 have legislation or have proposed legislation to extend the
14 postpartum period.
15 So on to federal action. On September 29th, the
16 U.S. House of Representatives passed H.R. 4996, which would
17 give states the option of extending the postpartum period
18 from 60 days to a full year, regardless of the individual's
19 eligibility pathway. Services provided during the extended
20 postpartum period will be full Medicaid, meaning not
21 limited to pregnancy-related or postpartum services. If
22 states chose to adopt the extension in their Medicaid

1 program, they must also extend the postpartum coverage
2 period to pregnant women in CHIP if they provide that
3 coverage. The Senate has not yet acted on this
4 legislation.
5 So as I mentioned at the outset, the Commission
6 has expressed interest in the last report cycle in making a
7 recommendation to extend the postpartum coverage period.
8 Such a recommendation could take different forms and could
9 be part of a package. In determining which approach you
10 take, the Commission may want to consider the number of
11 people affected, costs, consistency across states and
12 programs, and possible improvements in health outcomes.
13 So on to the options. The Commission could
14 recommend a mandatory extension of the postpartum period.
15 Such a recommendation would change the existing requirement
16 that eligibility end following a 60-day postpartum period,
17 and extend it for a longer period of time, such as one
18 year. As the current time frame is tied to the eligibility
19 pathways specifically for pregnant women, this
20 recommendation would change the length of postpartum period
21 for those women eligible by virtue of their pregnancy.
22 This approach would ensure a national standard of coverage

1 for postpartum women remains, but for a longer time period.
2 States would continue to have flexibility in terms of
3 establishing eligibility thresholds.
4 Alternatively, the Commission could recommend
5 that states be provided an option to extend the postpartum
6 period. This approach would provide additional flexibility
7 for states to extend the period through a state plan
8 amendment, as opposed to requiring a waiver to secure
9 federal matching funds. While it would ease the
10 administrative path to implementation, it would not result
11 in a national standard for the length of the postpartum
12 period. Similar to the prior option, this would apply only
13 to women eligible by virtue of their pregnancy, and states
14 would continue to determine the income eligibility
15 thresholds for these women.
16 A third approach would be to recommend an
17 extension of the postpartum period, regardless of
18 eligibility pathway. As discussed earlier, women who are
19 otherwise eligible for Medicaid, for example, as a low-
20 income parent or an individual with disabilities, and
21 become pregnant, can retain their existing coverage and
22 generally are not required to shift to a pregnancy-related

1 pathway. Because of this, they do not face an end to
2 coverage at 60 days postpartum. However, they would face
3 routine redeterminations once every 12 months, and could be
4 subject to disenrollment if they become otherwise
5 ineligible during that time frame.
6 An extension of the postpartum period, regardless
7 of eligibility pathway, may provide ongoing coverage for
8 women who might otherwise be disenrolled. It would also
9 apply to women eligible through pregnancy-related pathways
10 that are subject to the 60-day postpartum coverage period.
11 The Commission could recommend that states are
12 given the option to extend the coverage period for
13 postpartum women regardless of their eligibility status.
14 This was the approach taken in the House legislation on the
15 last slide.
16 So two possible companion recommendations could
17 be to align the recommendation for pregnant women in CHIP.
18 So if the Commission recommends extending the postpartum
19 period either as a requirement or state option, you might
20 want to mirror this recommendation for pregnant women
21 covered in CHIP in order to maintain consistency across the
22 programs.

1 The Commission could also reiterate its prior
2 recommendation related to pregnancy-only benefits,
3 requiring states to provide the full Medicaid package to
4 all pregnant and postpartum individuals, reiterating the
5 earlier recommendations from March 2014.
6 Staff are interested in which approach, if any,
7 you would like to take, as well as any additional research
8 that might be helpful in your deliberations.
9 And with that I will turn it over to you for
10 discussion and questions.
11 CHAIR BELLA: Thank you, Martha. That's very
12 succinct and I appreciate you leaving us a lot of time for
13 discussion.
14 So as Martha has said, and you all know, this has
15 been an area of interest for us. We have spent some time
16 on it. We have been heading down a path toward a potential
17 recommendation for the June report, and so what Martha has
18 done is laid out potential options for us.
19 So what I'd like to ask is that we have a
20 discussion around those options, and as she said, any
21 additional information we would need in order to be able to
22 think about those options and which one or ones we might

1 want to pursue.

2 I am going to start with our Martha, Martha

3 Carter, to kick us off. I'm sorry. You both are Marthas.

4 I'm trying to distinguish.

5 COMMISSIONER CARTER: This is the Martha team

6 here. Martha, thank you for laying out the recommendation

7 so succinctly.

8 I first want to be sensitive to and acknowledge

9 that not all birthing people identify as women. So we just

10 want to be sensitive to that.

11 You know, as Martha pointed out, our topic around

12 postpartum coverage is part of a larger plan that we have

13 to examine the role of Medicaid programs in access and

14 quality of maternity care, and especially the role that

15 Medicaid can play in preventing -- in eliminating, I think

16 I'd want to say -- preventable maternal morbidity and

17 mortality, especially in individuals of color.

18 So we're aiming to publish more on this topic,

19 but I would like to consider the topic of extending

20 postpartum coverage somewhat separately and work toward a

21 recommendation, or a set of recommendations, with all

22 possible speed.

1 Actually, I have four points and they're brief,
2 and I think we can delve into them in more detail. This is
3 sort of a highlight.
4 I want to anchor our discussion about extending
5 postpartum coverage to 12 months, and I think there are
6 some good reasons to adopt this time frame. First of all,
7 clinically, we consider postpartum to be 12 months.
8 Postpartum depression can have a late onset, as late as 12
9 months, and there is a high rate of relapse in substance
10 use disorder in postpartum individuals. So making sure
11 there's access to behavioral health and substance use
12 disorder services is really important.
13 In addition, coverage 12-month postpartum allows
14 follow-up of conditions that manifested through the
15 pregnancy -- hypertension, diabetes, depression, cardiac
16 disease -- and we really need to make sure that birthing
17 individuals get follow-up for those conditions.
18 While most people consider postpartum to be an
19 event after, as a midwife I actually consider the
20 postpartum period to be actually interconceptional or even
21 preconceptional, so I consider it actually to be a period
22 before, in many situations. So the United States doesn't

1 do a very good job of preconception care, and that is
2 really important because that's the period of time where
3 chronic conditions can be identified and managed before the
4 individual becomes pregnant.
5 So to the extent that people gain coverage
6 through the pregnancy, allowing them to retain coverage
7 through 12 months is actually a move towards better
8 preconception care. And I know that's a different framing
9 of this issue, but I think it's highly important, because a
10 lot of the excess maternal morbidity and mortality is
11 related to not addressing these chronic conditions before
12 pregnancy.
13 As far as a specific mechanism for extending
14 coverage, while I think mandatory coverage would be
15 optimal, I think providing a mechanism through a state plan
16 amendment would be a really good alternative. And I think
17 I would also recommend that we mirror in CHIP any changes
18 in Medicaid.
19 So that's my high-level overview and I think we
20 can dig into any part of that, or anything else.
21 CHAIR BELLA: Thank you, Martha, for framing that
22 up. Other Commissioners? Kisha, then Stacey. And just

1 the time box says we have about 25 minutes, so we have a
2 decent amount of time to get through this, but it will also
3 go quickly, because I know we have a lot to say on this.
4 COMMISSIONER DAVIS: Thank you to both Marthas,
5 and I want to echo a lot of what Martha Carter just said.
6 You know, I fall on the side of recommending a full
7 Medicaid benefit for the entire 12 months after, and, you
8 know, being specific and not necessarily tying that to the
9 mother caring for the child. And so I would want to make
10 sure that our postpartum moms who maybe suffer a tragic
11 loss, a stillbirth or a SIDS baby or who decide to give the
12 child up for adoption, still would retain that benefit,
13 because regardless of whether that child continues with
14 them they still have the same risk for postpartum
15 depression and maybe even worse, and health complications
16 and postpartum preeclampsia that come related to the
17 pregnancy. So making sure that that's something that is
18 spelled out.
19 And, you know, in addition, making sure those
20 benefits are comprehensive and all-inclusive and not just
21 related to pregnancy, when we're looking at those benefits.
22 As Martha alluded to, patients still have diabetes, high

1 blood pressure. They still get cancer. And many of those
2 disorders are uncovered during pregnancy, for women who may
3 not have had care or routine care in the past. And so
4 making sure that they are on a good glide path for
5 continuing to get those disorders managed and not just
6 dropped at the time of birth, especially when they need
7 that additional support.
8 You know, and to that end, much of that is
9 covered in the House bill, and so I fall in support of that
10 and I wonder what that means in terms of timing for us, in
11 terms of recommendations for a June report, if something
12 were to happen sooner than that, you know, what
13 implications that has for us and our recommendations.
14 CHAIR BELLA: Thank you, Kisha. Kit and then
15 Stacey.
16 COMMISSIONER GORTON: So I want to start with my
17 pediatrician hat on, because it is profoundly traumatic and
18 disruptive for an infant to have a mother who becomes ill
19 or who dies. And so to the extent that we're committed to
20 helping children grow up without trauma and have a good
21 start to lead healthy lives, they need their mothers. And
22 while some moms can't do that, as Kisha said, there are

1 reasons why moms can't fulfill that role. But where they
2 can, we ought to do what we can to support that. So I
3 absolutely am comfortable aligning myself with a state
4 option to extend up to 12 months afterwards, and I think
5 there are data to say that if you're going to extend, you
6 ought to extend it to 12 months because of the data that
7 we've heard before and that Martha Carter just cited.
8 I certainly would agree with aligning the
9 recommendation with CHIP for all the same reasons. And
10 then I certainly think that full benefit and aligning the
11 benefits for all pregnant -- I guess Martha’s right -- for
12 all pregnant people is an important thing.
13 For that I'll put on my medical director hat.
14 The undefined term "pregnancy-related" is, of necessity,
15 arbitrary. In my experience, when we create those
16 arbitrary lines, it leads to a lot of people exercising a
17 lot of discretion, sometimes in bad ways. That produces
18 inequities. You get self-editing. You get providers who
19 will say, "I'm not going to recommend that because Medicaid
20 won't pay for it." And at the end of the day, for a
21 pregnant person, what isn't pregnancy-related? It's a
22 clinically foolish concept, sort of like taking teeth and

1 minds out of bodies.

2 And so I just think there -- it's a hard -- the
3 only rationale for it is to control costs, and I think what
4 the data have shown us in this particular realm is that the
5 modest expenditures one makes should only have a very
6 substantial return, going back to my initial argument,
7 which is making sure that, if it's at all possible, kids
8 have access to their moms. Thanks.

9 CHAIR BELLA: Thank you, Kit. Stacey, then
10 Darin, then Chuck.

11 COMMISSIONER LAMPKIN: I am supportive of us
12 moving towards a recommendation in this area. Certain
13 parts of it seem pretty straightforward to me. The full
14 benefits for 12 months makes sense. Alignment with CHIP
15 makes sense.

16 When I think about the mandatory versus optional
17 angle to it, though, I wonder about the variation in the
18 states. It seems clear this would be a big deal for non-
19 expansion states. It's less clear to me, you know, how
20 much gap we have on the expansion states, at least gap in
21 opportunity. Do we have any way to -- so this is a
22 question for Martha, I think. Do we have any way to know

1 how many women do actually lose coverage and have a gap in
2 coverage after losing -- after the sixty-day postpartum
3 period ends? And do we have that at the state level? Or
4 can we get it if we don't have it? Is it available?
5 MS. HEBERLEIN: We do not have it at the state
6 level as far as I know. There was a recent blog that, like
7 a data watch blog, that looked at the percent of uninsured
8 among new mothers by state. And so those are some of the
9 numbers that I cited in your memo, and it does include
10 state-level information. There are very few women who are
11 uninsured or individuals who are uninsured when they give
12 birth, and so this looked at, you know, women who were
13 uninsured but had been pregnant in the last year. And so
14 it doesn't say that they necessarily had Medicaid, is my
15 understanding. So I think it's, you know, here's the
16 uninsured universe by state of women who were pregnant in
17 the last year and who might be covered.
18 We could look -- those data were based on ACS
19 data, and so we could look at the ACS data more closely.
20 Those are state by state but it does not track over time,
21 though. So the problem with that is that it doesn't give
22 you the pre and post. So I'd have to think about it a

1 little bit more. I think there might be some additional
2 data we can bring, but it's not -- it's probably not going
3 to fully answer the question you're looking at.
4 CHAIR BELLA: So, Stacey, your biggest question
5 is can we see what the impact would be on an expansion
6 state versus a non-expansion state or what the need is?
7 COMMISSIONER LAMPKIN: Well, and really
8 underlying that is kind of what is the variability by
9 state, and I assume that would be the biggest determinant,
10 but maybe there are other things I'm not thinking about,
11 too.
12 CHAIR BELLA: Yeah, I do agree with the way
13 Stacey is framing -- the way the comments are coming out,
14 it is coming -- you know, we're talking about 12 months.
15 We're talking about CHIP, aligning with CHIP. We're
16 talking about full benefit, that there does seem to be --
17 people have used different words as to whether this should
18 be optional or mandatory for the states. So as you make
19 comments, we're going to be thinking about where you might
20 have a difference of opinion in those key categories.
21 Darin, then Chuck, then Tricia.
22 COMMISSIONER GORDON: Well, Melanie, thanks for

1 setting that up for me. I too agree with aligning the
2 recommendation to CHIP and the benefit being -- the
3 reiteration of prior recommendations around a benefit being
4 broader than pregnancy only. And I agree with doing
5 something here. Whether it's six to 12 months, you know,
6 I'll defer to the evidence on the appropriate length. But
7 I definitely want to align myself with making it an option
8 for states, and that's just my general tendency not to
9 increase mandates on states, you know, particularly -- and
10 this is a good example of one that -- you know, our state
11 in Tennessee was really excited about, was one of the early
12 states out pushing to expand coverage. But then COVID hit,
13 and they pulled it back. It even passed the original
14 budget, but the COVID budget had them pull it back. So
15 there's a will and a desire there, but the financing of it
16 in the short term is just hard to pull off during COVID.
17 So, again, it's an example, but just a general
18 perspective, I mean, that I'm always going to lean more
19 toward giving options to states than imposing mandates.
20 CHAIR BELLA: Thank you, Darin. Chuck?
21 VICE CHAIR MILLIGAN: I want to align myself with
22 what Darin said and what many of the comments have been.

1 So I think it makes sense to align with CHIP. I'm much
2 more inclined to make a recommendation along the lines of a
3 state option.
4 There are a couple of other things I wanted to
5 mention, though, and one is picking up on Stacey's
6 comments. I think it would be good, Martha -- and I'm not
7 sure what's possible in terms of data. But I think it
8 would be good to have a much clearer understanding of what
9 happens currently after the 60-day postpartum coverage
10 ends, because I think there is an element about Medicaid
11 expansion states, which is women or individuals below 133
12 percent of the poverty level might, you know, continue to
13 be eligible for Medicaid but in a different eligibility
14 category. But there's a separate piece, which is
15 individuals above 133 percent of the poverty level where
16 states might have offered 60-day postpartum coverage at a
17 higher poverty level, 185 or 200 or something, and when
18 that coverage ends, those women would have access to the
19 exchange, but that means, among other things, probably a
20 narrower benefit that might not pick up some of the
21 behavioral health needs that we've been discussing and
22 probably more cost sharing, more out-of-pocket for a bunch

1 of follow-up care. So I think having a better
2 understanding of that, you know, what happens after 60 days
3 postpartum and, you know, where do those individuals go or
4 what are they eligible for.
5 The other comment I wanted to make, and, you
6 know, forgive me for kind of making this a financing point,
7 because I do think the coverage and health outcomes is the
8 most important piece. But on the financing piece, there's
9 going to be a lot of demand on Congress for a lot of
10 investments. You know, we talked yesterday about some of
11 the continuous coverage and the tail of continuous
12 coverage. There's going to be a lot of -- there's going to
13 be a lot of COVID-related and economy-related demands that
14 Congress is going to confront, and I think for purposes of
15 evaluating whether our recommendation should be a state
16 mandate or a state option, not only do I agree with Darin
17 that it should be optional because of state -- you know,
18 sort of federalism issues, but I also think that would make
19 the mechanism by which CBO scores this kind of
20 recommendation to be a much more palatable fiscal impact
21 that might make it more viable in terms of how Congress
22 takes up all of the pent-up demand for federal funding, you

1 know, in the aftermath of the pandemic.

2 So those are my comments.

3 CHAIR BELLA: Thanks, Chuck. Before we go to

4 Tricia, Martha, Chuck mentions I think a slight variation

5 on what Stacey had said, and you may have had some data on

6 that in the chapter. Is there anything you want to respond

7 now? It's fine if you pass. I just want to make sure we

8 gave you a chance.

9 MS. HEBERLEIN: I think there was -- there's some

10 information out there on sort of where, you know, the

11 numbers on the slide look post-ACA and look at where women

12 went. So, you know, the rate of coverage changes from

13 perinatal to -- or across the perinatal period declined

14 pre-ACA to post-ACA. So that definitely happened, and, you

15 know, you can sort of intuit that some of that is because

16 of the Medicaid expansion.

17 There's also been some other studies that have

18 looked at the effect of Medicaid expansion on coverage of

19 mothers and women more specifically, and some of that was

20 also in your memo. But we can do some more digging and

21 some thinking about what other data sources we could pull

22 from. You know, I mentioned we've used the PRAMS before to

1 look at pregnant women’s coverage and other researchers
2 have, too. So we can do some more looking around to see,
3 you know, what the effects might be.
4 VICE CHAIR MILLIGAN: And if I could just follow
5 up, I definitely want to -- my request is kind of what's
6 feasible but also a couple of elements. One is I think
7 it's going to be helpful to talk about just -- one that
8 might move into an exchange product, you know, at 150
9 percent of poverty, let's say, implications about covered
10 benefits and implications about cost sharing, and also as
11 we pull this into future meetings and potential votes and
12 recommendations like that, I want to make sure that we
13 publicly present some of the information that is going to
14 be relevant to those decisions. Thank you.
15 CHAIR BELLA: Anne, did you have a comment?
16 EXECUTIVE DIRECTOR SCHWARTZ: Just that Chuck was
17 talking about folks above poverty -- who might be eligible
18 for exchange coverage, but in the non-expansion states,
19 there might be a big gap between what someone might be
20 eligible for as a parent or caretaker and still not
21 eligible for exchange subsidies. So there's a big piece in
22 there which I think in Martha's earlier slide was

1 mentioned, not a change in the source of coverage but
2 basically just becoming uninsured.
3 CHAIR BELLA: Tricia.
4 COMMISSIONER BROOKS: So, you know, it definitely
5 seems like there's interest in moving forward. I think one
6 of the questions is how quickly we do that, noting the
7 House bill and whether June is too late. I think 12 months
8 is important rather than six. And I want to echo Kit's
9 comment about how important that first year of life is for
10 children and making sure that their moms are healthy and
11 don't have to deal with a lack of continuity of care. The
12 idea of having a newborn and figuring out marketplace
13 coverage and getting enrolled, you know, right when you've
14 got an infant who doesn't sleep all night I think is
15 extremely challenging.
16 I definitely support full benefits, and, in fact,
17 when the ACA was implemented, a number of states actually
18 were saying that they did not provide full benefit to all
19 pregnant women. The requirement is based on old AFDC
20 levels. And yet when they went and really took a look at
21 how they were administering benefits after delivery, they
22 found out that for the most part they were providing all

1 benefits. And I think it just points out there can be
2 discretion, but it also just complicates it, and there are
3 only four states that are doing that.
4 I think the issue of mandatory versus optional,
5 we already have deemed newborns. Babies that are born to
6 moms on Medicaid or CHIP are covered for a full year, and
7 as Anne noted, if it were an option, that there would be
8 gaps in the non-expansion states. Very few of them -- most
9 of them are covering parents below 50 percent of the
10 poverty level.
11 And then I think the option also would be a
12 disincentive to expansion states who actually would just --
13 could reconcile it by saying, well, they can go into the
14 marketplace and look at a 90 percent match for that, and
15 then that leaves out those pregnant women above 138
16 percent, which is arguably not a high enough income to
17 afford private coverage necessarily. And we all know that
18 the marketplace plans don't necessarily provide that
19 affordability.
20 So I would be in favor of mandatory, but it
21 certainly doesn't seem like the best consensus among other
22 Commissioners, but I did want to make that case.

1 CHAIR BELLA: Thank you, Tricia. Leanna, not to
2 put you on the spot, but I've seen your head nodding a
3 couple times. Would you like to make any comments?
4 COMMISSIONER GEORGE: Yeah, I planned on making a
5 comment here in a moment. I also want to keep in mind that
6 while many of these families who, if the mom was working,
7 she has FMLA, Family and Medical Leave Act, she still, if
8 she had private health insurance, is paying that premium
9 out of her paycheck. She's not getting that during that
10 time off after having -- or even before having the child.
11 So that gets quite expensive, as I'm sure we all know. Not
12 to mention there's always uncertainty if she even goes back
13 to work after having a child because then you have child
14 care that you're paying for, which for a low-income parent,
15 for a newborn, once again, around here it's like $200 a
16 week for a newborn for child care. That was 15 years ago
17 when my newborn was born, so it's probably even more now.
18 But for those reasons, I'm all for extending it
19 for a full year.
20 CHAIR BELLA: Okay. Thank you. I'm actually
21 going to -- I see you, Tricia. Just one second. We're
22 actually pretty -- there's a lot of consensus here in terms

1 of I'm hearing everybody say yes, align with CHIP. Now,
2 mind you, not every single one of you has spoken, so raise
3 your hand if you don't, those of you who haven't spoken,
4 disagree with this, but alignment with CHIP. It sounds
5 like most folks are for 12-month. I haven't heard anyone
6 advocating for six months. I'm going to put the stake in
7 the ground that we talk about 12 months, and to do full
8 benefits. And so the area where we are not aligned is on
9 mandatory/optional.

10 I think to get to the answer of -- one of the
11 answers about timing and could we do this in June or could
12 we do this in March or when do you want to do this, we
13 really need to get a sense of where the Commission is on
14 that place that we're not in alignment. And so I realize
15 we don't usually do things this way. This is going to be a
16 non-binding poll. I am going to ask each of you, just so
17 we could take a temperature of the Commission, where you
18 are on these two things. So if you are in favor of
19 mandatory, please raise your hand. Wait, wait, keep it up,
20 keep it up.

21 [A show of hands.]

22 CHAIR BELLA: All right. If you are in favor of

1 optional.

2 [A show of hands.]

3 CHAIR BELLA: Okay. Did anyone not vote? Let me

4 see how many -- we don't --

5 COMMISSIONER CARTER: I'd like to note that I'm

6 in favor of mandatory, but don't think it's realistic. So

7 I would make a recommendation that was more realistic.

8 That's all.

9 CHAIR BELLA: Okay. Anne, I'm going to ask as a

10 point of process, or Martha, can you talk to us a little

11 bit about the timing and the question of, you know, that

12 there is a bill, there is interest on the Hill. Is it kind

13 of too little too late if we're going in June? If we're

14 this close, like what would you need for us to go earlier?

15 Can you just talk about that for a second? And then we'll

16 see what else we need to get from the members before we

17 break on this topic?

18 EXECUTIVE DIRECTOR SCHWARTZ: Do you want me to

19 go, Martha?

20 MS. HEBERLEIN: No, I think this is really

21 helpful because it just crossed like three things off my

22 list of what options to give you guys: 12 months, align

1 with CHIP, and full benefits. And my counting may not be
2 right, but it looks like it was a split between mandatory
3 and optional choice. So I think, you know, coming back
4 with that, I think we can do some more digging in terms of
5 what data has already been there, I think put out in terms
6 of where women go at the end of the 60-day period, and like
7 the income breaks, maybe some race and ethnicity breaks. I
8 don't know how much I can -- I'm not going to promise you
9 what I can do, but we can certainly look more into that and
10 bring that back, because that seems like that is important
11 information.

12 If there's other information other than, you
13 know, to Darin's point, he prefers state options for a
14 different reason than what I could bring to you, so if
15 there's other things that would be helpful in making your
16 decision about whether it's an option or a requirement,
17 that would be really helpful to know because I think that
18 would also feed into our timeline and other things in that
19 area, and that would be great.

20 CHAIR BELLA: Tricia, you had a comment from
21 before. Do you still have that comment?

22 And, Martha, I see you as well. You can go after

1 Tricia.

2 COMMISSIONER BROOKS: I just want to remind us --

3 CHAIR BELLA: By the way, we have about five

4 minutes left, just so we are all aware.

5 COMMISSIONER BROOKS: I just want to remind us of

6 our interest in health equity here and how we do have a

7 maternal health crisis in this country, particularly among

8 Black women, and when we look at the states that haven't

9 expanded Medicaid, you're going to see high disparities in

10 their birth outcomes and maternal outcomes. And I think

11 that's one of the more persuasive arguments for mandatory.

12 CHAIR BELLA: Thank you, Tricia.

13 Martha and then Stacey.

14 COMMISSIONER CARTER: Tricia, I agree with you.

15 Thank you.

16 Even though we're limited to publishing twice a

17 year in March and June, if we make a recommendation, it's

18 public right away, right? So we could still make a

19 recommendation at a meeting, craft it, vote on it, make it,

20 and it would be known, even if it wasn't published until

21 later. Is that accurate, and is that a reasonable way to

22 go?

1 CHAIR BELLA: Anne, do you want to comment on
2 that?
3 EXECUTIVE DIRECTOR SCHWARTZ: Sure. I mean, you
4 can make a recommendation at any time, and it does take us
5 some time from when you vote on a recommendation until when
6 we can actually get the whole thing put together. It's a
7 little bit shorter if we're not publishing it in a report.
8 I would say on the timing, I mean, it sounds like
9 we need to come back at least one more time with some more
10 evidence that Martha Heberlein was mentioning, which could
11 feed into a decision, and the earliest we could do that
12 would be in December. And that's right at the time when
13 Congress would be taking its final action for this
14 Congress.
15 I'm not going to take odds on whether the Senate
16 is going to take up the House piece in December because I
17 don't think anybody knows, but if they miss that, if they
18 don't get to that, I have my doubts that when they come
19 back as a new Congress in January that this would be the
20 first thing that they would do.
21 So I think we have time, and I think we should
22 make sure that we have the evidence that we need. And to

1 pile on what Martha Heberlein said, if there is information
2 that you would need that would help you make a distinction
3 between whether something would be, more or less, effective
4 as mandatory versus optional versus you just generally have
5 a feeling that you don't want to create more burdens on
6 states because states have a lot of burdens. Maybe evidence
7 doesn't really help in that regard, I think that's the
8 other thing that we would need to sort out.
9 I agree with Martha Heberlein. This is very
10 helpful in narrowing the focus of what we do next.
11 CHAIR BELLA: Stacey?
12 COMMISSIONER LAMPKIN: And this is along the
13 lines of what Anne just said, and I'm just still processing
14 the mandatory-versus option.
15 Looking at the table of the states that are
16 headed in this direction, it looks like it's state-only
17 funds or 1115s. Other than perhaps the challenges of the
18 authority, do we think that money is the main reason that
19 would keep a state from taking up this option? Is there
20 anything else that's a downside to the state other than the
21 financial side? And you don't have to answer right now,
22 but that's part of what I would think I would want to

1 process on this.

2 CHAIR BELLA: And, Martha, I want to piggyback on
3 that. I was going to ask you, have we talked to any
4 states? I mean, oftentimes states say, "We need cover. We
5 want to do this, but we can't get our legislature to do
6 it." And we heard from many states who either are asking
7 do they not even -- maybe they don't even know they could
8 ask us to do something in this regard, but I'm just
9 curious. Have we had any opportunity to hear from
10 expansion to non-expansion states on this issue?

11 MS. HEBERLEIN: We heard from New Jersey back
12 from the panel in the spring, in February, and they clearly
13 wanted to do it. And I think from my recollection of that
14 conversation, Jennifer was thinking six months might be
15 something that CMS might approve, and so that's why they
16 felt -- part of the reason they went with six months. I
17 think they had huge backing from the governor. I mean, it
18 was in the state legislature before they submitted their
19 waiver. They just haven't gotten approval yet.

20 So I think, you know, in that case -- I mean, I
21 haven't reached out to other states that are looking to
22 expand for a waiver, but reading through their applications

1 -- like, Illinois cited their maternal health, their MMRC,
2 their maternal mortality review committee put this as one
3 of their recommendations to extend the postpartum period.
4 They cited the outcomes in their state and racial equity in
5 their state, and so I think there is an appetite. Those
6 are both expansion states, for example. I think Georgia
7 also in their recent legislation cited the same maternal
8 health issues. So I'm not sure. I think to get federal
9 dollars, they would need a waiver, and so far, South
10 Carolina is the only one that's gotten that approval for
11 500 slots for women with substance use disorder or serious
12 mental illness. So I think that's what we know from
13 states, so just more feeding on that as well.
14 CHAIR BELLA: Okay. What you just said about New
15 Jersey made me think this could just be like an unnecessary
16 complication, but maybe get some thought to whether we
17 would ever have some sort of hybrid where you would have a
18 mandatory expansion of 6 months and have it optional up 12
19 months. Like, maybe there's a way to hit a middle ground.
20 If that complicates things, don't even bring it back to us,
21 but it's just kind of thinking about how we might kind of
22 split those differences.

1 All right. Chuck, I think, for the last comment.
2 VICE CHAIR MILLIGAN: Sorry. I know we're a
3 little past time.
4 I think, Martha, one of the things that would be
5 helpful in terms of framing up this optional versus
6 mandatory is a little bit of history around previous
7 mandatory expansions because there have been mandatory
8 expansions over time around kids up to age 6 to higher
9 poverty levels, you know, kids 6 to 18 up to higher poverty
10 levels, all of that where it's been legal. But then there
11 is the ACA adult expansion where the Supreme Court said
12 that even though the ACA, I think, was contemplated to make
13 that a mandate nationally, that was perceived to be an
14 infringement on state sovereignty, and it led to becoming
15 an option or discretionary to states.
16 I think it's going to be important just to frame
17 up the optional versus mandatory to set some of the context
18 for us around why a potential mandatory recommendation we
19 think would not invoke the ACA-related Supreme Court
20 decision, that that was too much of an incursion into state
21 sovereignty in terms of state expense that would be
22 required.

1 We can't get to mandatory and optional without
2 raising the fact that the expansions themselves became
3 optional, because the Supreme Court said Congress can't
4 just impose this cost on states.
5 CHAIR BELLA: All right. Martha, do you have any
6 other questions for us?
7 COMMISSIONER DOUGLAS: I do.
8 CHAIR BELLA: What's that?
9 COMMISSIONER DOUGLAS: You're ignoring me all the
10 time. Second time.
11 CHAIR BELLA: Oh. You're way over in the corner
12 of my screen, and you're way back.
13 COMMISSIONER DOUGLAS: Ignored me earlier. Now
14 you -- okay.
15 CHAIR BELLA: All right. Toby and then --
16 COMMISSIONER DOUGLAS: I was just going to add I
17 think -- and it gets to the other piece, and this goes back
18 to California, thinking about CHIP and some of the
19 expansions with the -- under previous administrations on
20 flexibility to cover all pregnant moms and just the options
21 around CHIP was really around unborn child and just
22 thinking back again, it's ACA, but it's also CHIP where we

1 have to think through flexibilities here and what's
2 optional versus mandatory to cover.
3 CHAIR BELLA: Thank you.
4 What I was going to say is although we were going
5 to take public comment at the end, I think this is a
6 separate enough subject. And I would just like to see if
7 there's anyone in the public that would like to comment on
8 this before we end this session. So let me give folks a
9 second to raise their hand icon on the webcam thing, if
10 anyone would like to make a comment.
11 In the meantime, I would like to thank the
12 Commissioners. I think that we surprised Martha and team
13 in how quickly we narrowed down some of the options, so
14 well done, crew.
15 Okay. We do have one public comment. If we
16 could unmute Emily? And if you could let us know your name
17 and organization, that would be great.
18 [No response.]
19 CHAIR BELLA: Could we unmute Emily, please?
20 Thank you.
21 Okay. Emily, you should be unmuted now.
22

1 **### PUBLIC COMMENT**

2 * MS. ECKERT: Oh. Can you hear me now?

3 CHAIR BELLA: Yes.

4 MS. ECKERT: Okay, excellent. Sorry about that.

5 Hi, everyone. My name is Emily Eckert. I'm a
6 policy manager with the American College of Obstetricians
7 and Gynecologists, or ACOG. I've made public comments on
8 this very topic to you all before.

9 So I just want to thank you for the really
10 thoughtful conversation today and just echo the comments
11 that I've made before that ACOG is a strong supporter of
12 this policy.

13 We, of course, endorse the MOMMA's Act, Robin
14 Kelly's legislation that was introduce, gosh, like two
15 years ago now, and the package that passed out of the House
16 at the end of September, you know, is a variation of that
17 bill, as Martha mentioned, turning to a state option. And
18 we're also strong supporters of that legislation as well.

19 So I think we're going to be really pleased, no
20 matter where the Commission settles on mandatory versus
21 optional, but I would just echo some of the comments from
22 Martha and Anne that the quicker you can do it the better,

1 because we are very hopeful that the Senate is going to
2 take up some version of this legislation before the end of
3 the year. It seems to be high on the priority list of
4 Chairman Grassley in the Senate Finance Committee. So
5 we're watching that very closely, and I think any
6 recommendation out of MACPAC could be really helpful.
7 So thank you all very much, and feel free to
8 reach out to ACOG if you have any questions.
9 CHAIR BELLA: Great. Thank you.
10 I don't see any other hands. I think Darin has
11 one last technical question, and then we'll wrap this.
12 COMMISSIONER GORDON: Yeah. I'm just trying to
13 think about expansion and non-expansion states, and it
14 looks like several of the non-expansion states are thinking
15 about this already, which is good. But I'm trying to think
16 about if -- and maybe you can answer this question for us
17 as part of the research.
18 If by making this mandatory, how would that
19 impact match rates for the expansion states? In other
20 words, would that then make groups that they're currently
21 covering, this population they're currently covering, if
22 the enhanced match rate now becomes the state's regular

1 match rate? Something that maybe you can help as part of
2 the research because I think that obviously would be very
3 important.
4 Thank you.
5 CHAIR BELLA: Okay. We're running a little bit
6 over, but it's an important thing.
7 Martha, thank you for teeing this up. We will
8 look forward to what you come back to us with, and we
9 really appreciate your work in this area. Thank you,
10 everyone.
11 We are now going to transition to DSH, and Aaron
12 is going to join us. This is our draft chapter for the
13 March report.
14 Aaron, I'm sorry that we've eaten into your time
15 a little bit. We have a break that we can eat into a
16 little bit if we need to. So I will just hand it to you
17 and have you give us your update, and I think what we're
18 looking for from Commissioners -- and correct me if I'm
19 wrong -- is just if there's anything in particular you want
20 to emphasize in this chapter or any other messages you want
21 to make sure that are highlighted in the chapter. Again,
22 this is our statutorily required analysis.

1 So, Aaron, it's all yours. Thank you.

2 [No response.]

3 CHAIR BELLA: I think you might be on mute,

4 Aaron.

5 ### **DRAFT CHAPTER FOR MARCH 2021 REPORT: STATUTORILY**

6 **REQUIRED ANALYSES OF DISPROPORTIONATE SHARE**

7 **HOSPITAL ALLOTMENTS**

8 * MR. PERVIN: I apologize. Can you hear me now?

9 CHAIR BELLA: Yeah. You're great. No problem.

10 MR. PERVIN: Okay. Good afternoon,

11 Commissioners. As you know, MACPAC is required to report

12 annually on a variety of data related to Medicaid DSH.

13 I'll begin today's presentation by providing a

14 background on Medicaid DSH payments, and then I'll provide

15 an update on the data elements that MACPAC is required to

16 report, which are listed on this slide. Finally, I will

17 review DHS allotment reductions, which are currently

18 scheduled to take effect December 11, and will end the

19 presentation with an update on how DSH payments relate to

20 other funding hospitals have received during the public

21 health emergency.

22 So just a little bit of background on DSH. As a

1 reminder, under the Medicaid statute, states are required
2 to make DSH payments to hospitals that treat a high
3 proportion of Medicaid and low-income patients. State DSH
4 payments are limited by federal allotments, which vary by
5 state. Allotments are based on state DSH spending in
6 fiscal year 1992, and as the Commission has previously
7 noted, DSH allotments have no meaningful relationship to
8 measures of need for DSH funding.
9 States also have a wide latitude to distribute
10 DSH payments to virtually any hospital in the state, but
11 total DSH payments to a hospital cannot exceed the total
12 amount of uncompensated care that the hospital provides.
13 Defined here is the sum of unpaid costs of care for
14 uninsured individuals and Medicaid shortfall, Medicaid
15 shortfall being the difference between a hospital's cost of
16 care for serving Medicaid patients and the payments that it
17 received for these services.
18 Moving along to the changes in the uninsured.
19 According to the American Community Survey, 30 million
20 individuals were uninsured in 2019, which is a
21 statistically significant increase from 2018. This
22 represents the second year in a row where we have seen a

1 statistically significant increase in the uninsured rate
2 since 2009.
3 This slide summarizes the Census' findings on the
4 uninsured rate increases. This table provides information
5 about the increase in the uninsured rate by demographic
6 group. There were statistically significant increases for
7 children under the age of 19, non-elderly adults, most race
8 and ethnicity groups, and also across all income groups.
9 As in previous years, we find that the uninsured
10 rate among states that did not expand Medicaid under the
11 Affordable Care Act was almost twice as high as the
12 uninsured rate that did expand, 13 percent and 7 percent
13 respectively.
14 Pivoting now to uncompensated care for uninsured
15 individuals, which is one of the components of the DSH
16 definition of uncompensated care. According to Medicare
17 cost reports, hospitals reported a total of $41 billion in
18 charity care and bad debt in FY 2018. This represents 4.2
19 percent of hospital operating expenses, which is a slight
20 increase from FY 2017. Amounts of uncompensated care
21 reported on Medicare cost reports vary widely by state, but
22 in the aggregate, hospitals in states that did not expand

1 Medicaid reported more than twice the amount of
2 uncompensated care as a share of operating expenses for
3 hospitals and states that did expand Medicaid.
4 Medicaid shortfall is another component of the
5 DSH definition of uncompensated care. It is defined as the
6 difference between a hospital's cost of care for Medicaid-
7 enrolled patients and the total payments it received for
8 these services. Because Medicare cost reports do not
9 include reliable information on Medicaid shortfall, we use
10 the annual American Hospital Association survey for a
11 national estimate. The latest AHA survey indicates that
12 Medicaid shortfall totaled $20 billion in 2018, which is a
13 decrease of approximately $3 billion from FY 2017.
14 One reason for this decline is that the payment-
15 to-cost ratio increased by 2 percentage points between 2017
16 and 2018, indicating that either payments for Medicaid
17 increased or costs decreases or a combination of the two.
18 Prior research has shown that there is wide variation in
19 Medicaid shortfall at the state level; however, due to
20 prior litigation about the DSH definition of shortfall, we
21 cannot report state-level estimates since states did not
22 report shortfall data consistently on their Medicaid DSH

1 audits.

2 We expect that shortfall data will improve in
3 future years since the outstanding litigation has now been
4 settled. CMS has clarified its guidance that cost and
5 third-party payments will be included in the shortfall
6 definition for 2017 DSH audits and future years.

7 For the final statutory requirement, we used data
8 elements from the Medicare cost reports and the AHA annual
9 survey to report on the number of deemed DSH hospitals that
10 provide essential community services, using the same
11 definition MACPAC has used in prior years. As a reminder,
12 deemed DSH hospitals are statutorily required to receive
13 Medicaid DSH payments because they have a high Medicaid or
14 low-income utilization rate.

15 Overall, of the 744 hospitals that appeared to
16 meet the deemed DSH criteria in SPRY 2016, 92 percent of
17 these hospitals provided at least one essential community
18 service while 59 percent provided three or more.

19 In this year's report, we also took a closer look
20 at the role DSH hospitals played in supplying hospital bed
21 capacity in their communities before the pandemic. Most
22 notably, we found that although DSH hospitals account for

1 12 percent of hospitals -- sorry, deemed DSH hospitals
2 account for 12 percent of hospitals, they account for 20
3 percent of ICU beds.
4 Moving along to DSH allotment reductions, the
5 Affordable Care Act included reductions to state DSH
6 allotments under the assumption that increased coverage
7 would lower hospital uncompensated care and reduce the need
8 for DSH payments. These reductions were originally
9 scheduled to take effect in 2014, but have been delayed
10 several times. They are currently scheduled to take effect
11 -- they are currently scheduled to be reduced by $4 billion
12 in FY2021, which is about 31 percent of states' unreduced
13 allotment amounts. Allotment reductions increased to $8
14 billion for each of fiscal years between 2022 and 2026,
15 which is more than half of states' total unreduced
16 allotment amounts.
17 FY2021 began October 1st of this year, but the
18 continuing resolution enacted earlier this month delayed
19 the DSH cuts for the current year from taking effect until
20 December 11th of this year, but does not change the size of
21 the overall reductions. This approach is similar to the
22 temporary delay of FY2018 reductions that Congress passed

1 before the ultimately delayed cuts to FY2020.

2 During this temporary delay period between now
3 and December 11th, states can make payments as if
4 allotments were not reduced, but if allotments do take
5 effect as scheduled, then payments must be reconciled to
6 the final reduced allotment amount.

7 The statute also requires CMS to develop a
8 methodology to distribute reductions based on a variety of
9 factors such as the uninsured rate and the extent to which
10 a state targets DSH payments to hospitals that serve a high
11 share of Medicaid patients and have high levels of
12 uncompensated care. In this year's report, we provide CMS'
13 projections of FY2021 allotment reductions, and as in past
14 year, we find no meaningful relationship between DSH
15 allotments and the different measures of need that Congress
16 has requested MACPAC to consider. This is true for both
17 the unreduced and also the reduced allotments amounts.

18 We wanted to close the presentation with an
19 update on how the public health emergency may affect the
20 amount of DSH funding that hospitals may have received.

21 First, some states are using DSH funding as a
22 tool to help support hospitals affected by the pandemic.

1 For example, New Mexico is making accelerated DSH payments
2 to help offset some of the financial disruptions to their
3 hospitals.
4 However, states and the federal government have
5 also been using non-DSH sources of funding to support
6 hospitals. This may affect the amount of uncompensated
7 care that DSH audits will report on their 2020 DSH audits -
8 - sorry, DSH hospitals will report on their 2020 DSH
9 audits, which affects the amount of DSH funding that
10 hospitals are eligible to receive.
11 Furthermore, because DSH allotments are a cap on
12 federal funding, the enhanced FMAP rate provided during the
13 public health emergency may reduce total amount of state
14 and federal DSH funding that a provider receives. For
15 example, if a state has a 50 percent FMAP rate and a $1
16 billion DSH allotment, total state and federal DSH payments
17 would equal $2 billion. However, with a 6.2-percentage-
18 point FMAP bump, the total state and federal DSH payments
19 in the state would lower to $1.8 billion.
20 We do not yet have complete data on how the
21 pandemic and relief funding has affected hospital finances,
22 but we plan to continue to monitor this issue and report on

1 it in future reports as data becomes available.

2 Next steps after this presentation is we plan on

3 publishing this draft report in the MACPAC March report,

4 and staff will continue to monitor congressional action on

5 DSH allotment reduction between now and when they are

6 scheduled to take place on December 11th.

7 I now turn it over to the Commission for your

8 questions and comments.

9 CHAIR BELLA: Aaron, thank you. You got us

10 through a lot of information very quickly but very clearly,

11 so I appreciate that.

12 Questions or comments from Commissioners? Bill.

13 COMMISSIONER SCANLON: I was going to let someone

14 else go first because this is my annual comment about the

15 Medicaid shortfall, and, Aaron, I'm introducing you to

16 this. I continue to be concerned about the term. I

17 understand that it's cemented in sort of tradition. And

18 I'm going to change my sort of tack this year, which is to

19 say maybe we could footnote it, saying that a genuine

20 shortfall might be more in line with what I was talking

21 about yesterday with the standard for nursing home payment,

22 which is that if Medicaid is not paying the cost for

1 efficiently and economically operated hospitals, then
2 there's a shortfall. And if we want evidence that there is
3 a potential problem with efficiency and economy in
4 hospitals, MedPAC has periodically reported on hospitals
5 that are doing quite well on quality but having much lower
6 costs. It's part of the MedPAC work that is trying to
7 establish the premise that all hospital costs, even though
8 they're incurred, are not necessarily necessary. So I'll
9 be shorter today than I was yesterday. Thanks.
10 CHAIR BELLA: Thank you, Bill. Other comments or
11 questions for Aaron? My screen flipped, but I saw a couple
12 hands. Can you put your hands up again? Fred and then
13 Chuck. Thank you.
14 COMMISSIONER CERISE: Yeah, since Bill started,
15 I'll just -- a quick question, Aaron. On the shortfall,
16 the AHA says that hospitals are paid 89 percent of their
17 costs in Medicaid. Remind me, does that include their
18 supplementals or -- so that does include supplementals, and
19 they still say it's at 89 percent.
20 MR. PERVIN: Yeah, that -- so I can't speak
21 strongly to the aha methodology for how they're calculating
22 the Medicaid shortfall, but traditionally, at least within

1 the Medicaid DSH audits, that does include non-DSH
2 supplemental payments.
3 COMMISSIONER CERISE: Okay.
4 CHAIR BELLA: Anything else, Fred?
5 COMMISSIONER CERISE: No.
6 CHAIR BELLA: Okay. Chuck?
7 VICE CHAIR MILLIGAN: Nice job, Aaron. Forgive
8 me, I didn't make it through the whole chapter in the
9 materials. The question I have is whether we plan to
10 reference some of the court actions and some of the
11 decisions that happened, you know, over the last year
12 around the treatment of TPL, and my comment is really
13 flagged based on Bill prompting this Medicaid shortfall
14 issue where there's been some dispute among some providers
15 about whether the collection of payment from third-party,
16 upstream primary payers should or should not be counted.
17 So in the chapter, do we present that context in
18 terms of how we assess shortfall or how some of the
19 litigation is played out? Because I think that this is the
20 first March report since a lot of that has changed. That's
21 my question.
22 MR. PERVIN: Yeah, so there's a brief bit in the

1 chapter narrative where we do discuss the litigation, but
2 it's mostly focused on where CMS has landed. So in August,
3 I believe, of 2020, CMS came out with additional guidance
4 basically clarifying that they will be implementing the
5 2017 DSH third-party payment rule. But we can try to
6 strengthen and maybe add a few footnotes within the DSH
7 chapter to kind of elaborate and maybe some additional
8 language on kind of how the courts have -- how those
9 decisions have been going through the court system.
10 VICE CHAIR MILLIGAN: Because I didn't read it,
11 maybe you did a perfectly fine job already. I just think
12 that that drumbeat is not ending in terms of some of the
13 provider advisory, and so I do think we need to
14 contextualize the DSH report based on kind of where that
15 currently stands. Thank you.
16 CHAIR BELLA: I'm wondering if I should take a
17 straw poll of how many people read the report to see if we
18 get mea culpas like Chuck. All right. Are there any other
19 questions or comments for Aaron? And I want to say thank
20 you, too, for the point about the PHE, so I think that's an
21 important thing for us to understand, kind of a nuance
22 maybe. Kit and then Stacey.

1 COMMISSIONER GORTON: So I did review the
2 chapter, but in reviewing the chapter, I was left with
3 perhaps a more fundamental question, which is as an
4 operator of things, periodically you should ask yourself
5 whether there's still value in doing something. I
6 understand from the statute that should we be thinking
7 about saying to Congress, are you getting value out of this
8 the way it's currently structured? Do you want to tweak it
9 a little bit? Do you want to think about it? That's what
10 I was hoping for, is Anne's response to this.
11 CHAIR BELLA: Oh, Anne hasn't responded.
12 COMMISSIONER GORTON: I just want to have some
13 sense of whether we're using limited resources against the
14 biggest problems we have to solve and whether it's time to
15 ask Congress to revisit this.
16 CHAIR BELLA: Anne, would you like to respond?
17 EXECUTIVE DIRECTOR SCHWARTZ: So two points. One
18 is -- and, Aaron, don't take this the wrong way -- it takes
19 far fewer resources to do this now than when we first
20 started to do it. The first year we did it, it was a half
21 a million dollar investment, just the data.
22 The other point, though, is you have to be very

1 careful when you ask Congress to muck around in the statute
2 of what else they might put in there. It does sunset in
3 FY24, and so the path of least resistance is just to kind
4 of muddle along and see if they do anything. Since they
5 haven't resolved like the generic problem, that may also
6 suggest that there is some value to Congress in being
7 reminded of this going forward.
8 CHAIR BELLA: Stacey and then Sheldon.
9 COMMISSIONER LAMPKIN: Okay. I'll be real quick.
10 I want to loop back to Fred's technical question and be
11 technical again. But before I even ask that question,
12 Aaron, I thought you did a really good job especially kind
13 of bringing in the pandemic uncertainty and the other
14 payment streams. I thought that was really helpful.
15 So one of the things that I -- I did read the
16 chapter. One of the things that I noticed read it -- and
17 you alluded to it in the slide -- was the drop in the AHA-
18 reported Medicaid shortfall. So my question was: Does AHA
19 also capture directed payments that are flowing through
20 MCOs in that calculation as well as fee-for-service
21 supplementals? Or do we think that -- you know, increasing
22 directed payments may be part of what is changing the

1 shortfall. Or do we know what's changing it?
2 MR. PERVIN: So unfortunately we don't, and I
3 don't have a large amount of insight into the specifics of
4 the AHA methodology. We do not get very -- like I said, we
5 don't get very good data right now on Medicaid shortfall
6 within the Medicaid DSH audits because of much of that
7 state quality and the standardized way that that data is
8 reported on the Medicaid DSH audit. Do I don't know if I
9 could speak very strongly to how those other-directed
10 payments are [inaudible] definition of Medicaid shortfall.
11 I can say that these shortfall numbers were all
12 hospitals, and usually MACPAC, I believe we usually report
13 the Medicaid shortfall for specifically DSH hospitals.
14 CHAIR BELLA: Sheldon for the last comment,
15 please.
16 COMMISSIONER RETCHIN: Oh, I'm on, yeah. I was
17 going to say that taking DSH away from MACPAC's mandate
18 would be like taking the Corvette away from Chevrolet, but
19 I won't say that.
20 I will say that I was astonished that Rob would
21 have given this up, but, Aaron, you've done a tremendous
22 job, but I'm just very -- it must have been very difficult

1 to wrest it away from Rob.

2 Getting to Chuck's comment, can you refresh --

3 maybe, Chuck, you can, or Aaron -- refresh my memory on the

4 -- I actually thought that was done until I did see the

5 court case. It has to do, I think, with the children's

6 hospitals. But refresh my memory about the third-party

7 coverage. What's the defense for that, I mean, other than

8 the fact that it's a technicality that you said you

9 wouldn't do it or it's -- what's the defense? I understand

10 the shortfall, even though I'm starting to agree with Bill

11 on that, so I must have been doing this way too long. But

12 what's the defense on the third-party coverage not being

13 counted?

14 MR. PERVIN: So I don't know if I could speak

15 super strongly on this, but I believe that the way the

16 court cases is laid out is that the HHS Secretary did not

17 have authority to change the formula -- or at least did not

18 have authority to include third-party payments within those

19 final calculations. However, again, I'm not -- I don't

20 know if I could speak super strongly on this, but that's my

21 understanding at least.

22 COMMISSIONER RETCHIN: Okay.

1 CHAIR BELLA: Does anyone --

2 COMMISSIONER RETCHIN: Chuck, if you want to --

3 CHAIR BELLA: Yeah, a 30-second refresher for

4 Sheldon. I mean 30 seconds, please.

5 VICE CHAIR MILLIGAN: Yeah, it wasn't a policy-

6 related comment. It was an authority-related comment.

7 COMMISSIONER RETCHIN: Yeah. Okay.

8 CHAIR BELLA: Okay. Aaron, do you need anything

9 else from us?

10 MR. PERVIN: No, I don't believe so. Thank you.

11 CHAIR BELLA: Okay. Thank you very much for your

12 work on this.

13 We're now done with this session. We are going

14 to take a break for 15 -- actually 13 minutes, so 3 o'clock

15 Eastern. We're going to come back and do the high-cost

16 drugs and pipeline analysis. We have two sessions left and

17 one hour to do them, so we will start promptly at 3

18 o'clock. And thank you, everyone, for your participation

19 so far.

20 * [Recess.]

21 CHAIR BELLA: Okay. We are going to go ahead and

22 reconvene. Welcome back, everyone. We are going to talk

1 about high-cost drugs and pipeline analysis. Welcome to
2 Amy and Chris and Caroline.
3 I think, if I'm understanding correctly, you are
4 going to report to us on the first of three meetings that
5 we've had and talk to us a little bit about what to expect
6 over the next couple of meetings, gearing up for some
7 additional information and analysis coming back to us in
8 January. But if that's not correct, let me know.
9 Otherwise, I'll turn it over to you guys to tell us what
10 you've learned so far. Thank you.
11 ### **ADDRESSING HIGH-COST DRUGS AND PIPELINE ANALYSIS**
12 * MS. ZETTLE: Thank you. Yes, that's exactly
13 right. We're going to be providing you with a quick update
14 on our work related to high-cost specialty drugs this
15 afternoon.
16 I just wanted to start by saying while you'll be
17 hearing from me and Caroline today, Chris Park has been
18 working closely on this project as well.
19 So I'll begin with a brief background on high-
20 cost specialty drugs and the Commission's previous work on
21 this topic. I'll then provide an update on the technical
22 advisory panel that MACPAC is convening to further our

1 work. And then I'll turn it over to Caroline Pearson.
2 Caroline is a Senior Vice President at NORC at the
3 University of Chicago. We contracted with NORC to conduct
4 pipeline analysis and convene our technical advisory panel.
5 She will walk us through the findings from our pipeline
6 analysis. You can find her bio in your background
7 materials.

8 Specialty drug spending is becoming a growing
9 share of Medicaid pharmacy budgets. As of 2018, 12 of the
10 top 20 Medicaid drugs by spending were specialty products,
11 including those for HIV/AIDS, hemophilia, cystic fibrosis,
12 and hepatitis C.

13 Specialty drug spending is growing at a faster
14 rate than traditional, single-molecule drugs. The net cost
15 per claim for a traditional, small-molecule drug actually
16 fell by 0.4 percent from 2018 to 2019. The net cost per
17 claim for specialty drugs, however, increased 8.6 percent
18 over that same period.

19 During the last cycle, MACPAC convened an expert
20 roundtable to help us better understand some of the unique
21 challenges that high-cost specialty drugs present. The
22 experts largely agreed that these drugs are harder for

1 states to manage. These drugs can have complex
2 manufacturing requirements, they have particularly high
3 drug prices, few clinical alternatives, and they can often
4 be distributed through the medical benefit.
5 We presented these findings from the roundtable
6 and shared some of the key challenges and policy options
7 that were discussed. Many of you thought that it would be
8 helpful for us to continue our work on this topic, and
9 there was a strong interest to better understand the drug
10 pipeline and specific challenges that these drugs in
11 development could create for Medicaid over the next three
12 to five years.
13 You also asked us to consider how each of these
14 policy options might crosswalk to specific challenges of
15 managing specialty drugs, to better understand which
16 options would be best suited for which types of drugs.
17 To help us to continue our work on this issue, we
18 convened this technical advisory panel that will continue
19 to meet through the end of the year. The group is
20 comprised of state and federal officials, legal and drug
21 policy experts, and beneficiary advocates. We had our
22 first meeting earlier this month, and that focused on the

1 drug pipeline to identify high-cost specialty drugs in
2 development that could have a significant or
3 disproportionate effect on Medicaid. You will hear more
4 about this analysis shortly and the specific challenges
5 that the panel identified.
6 In November, the expert panel will consider
7 policy options that could specifically address these
8 challenges and consider the design components of each of
9 these models. The policy options will range in scope and
10 complexity, and the panel will identify the statutory and
11 regulatory changes that would need to take place to
12 implement these models.
13 And then in December, the panel will reconvene
14 with the addition of some industry stakeholders who can
15 help assess the operational barriers and some of the
16 potential effects of these policy options.
17 Before I turn it over to Caroline to walk us
18 through the pipeline analysis, I just want to note that we
19 will have time for questions on the work plan and your
20 thoughts on the pipeline, and we're specifically interested
21 to know whether or not you would be interested in
22 publishing this information on our website.

1 So with that I'll turn it over to you, Caroline.
2 * MS. PEARSON: Great. Thanks, Amy.
3 So when we set out to look at the specialty drug
4 pipeline and then understand what critical products in the
5 pipeline were going to have a high impact on Medicaid, that
6 was sort of a daunting task. There's somewhere around
7 7,000 products in development at any given time. Only a
8 fraction of those ever make it to market, and many of them
9 are not going to be highly utilized by Medicaid
10 beneficiaries.
11 So we needed to sort of narrow our focus. The
12 first thing that we did is agree that for most of the drugs
13 we were going to focus on Phase III, products that are in
14 Phase III trials and beyond, and those are the products
15 that have the greatest amount of evidence, they are most
16 likely to get approved as a result, and they are going to
17 have the nearest-term impact on the program.
18 The second step was really to apply a filter for
19 which of those products were going to be important for
20 Medicaid beneficiaries really through the lens of the
21 prevalence of those conditions in the Medicaid population.
22 And we worked with Chris, Amy, and Acumen to look at claims

1 data, to estimate the prevalence results that you are going
2 to see in some of these slides.
3 But in terms of really trying to understand what
4 the total spending was going to be, we needed a framework
5 for beginning to tackle some of these drugs, and so we
6 started off with this construction, looking at really three
7 product types as the priorities.
8 The first is high-cost pediatric medications.
9 And we knew that some of the most important drugs in this
10 category were going to be cell and gene therapies, and so
11 we looked at cell and gene therapies for children across
12 all phases of development. The gene and cell therapies
13 that have come to market to date, as you probably know,
14 range in price from about $500,000 to over $2 million in
15 list price, and so we've heard a lot of concern in the
16 first roundtable last year about how states were going to
17 manage these products with extremely high list prices and
18 really frontloaded costs, because most of them are one-time
19 or short-term therapies.
20 But we also wanted to look at any other pediatric
21 products that might have a big impact, and so we'll talk
22 about that in a moment.

1 The second set of drugs was adult gene therapies.
2 Similarly, there were enough concerns about how states were
3 going to be able to manage their budgets related to gene
4 therapies that we wanted to look at both pediatric and
5 adults.

6 And then, lastly, we had the third category which
7 is other high-cost, high-spend classes, where we see high
8 prevalence in Medicaid and relatively high list prices that
9 combine for generally big budget impact.

10 So that was the framework that we began with, and
11 let's go to the next slide and dive into the pediatric
12 drugs first.

13 As we look at pediatric products, about a quarter
14 of the pediatric drugs in the pipeline are actually gene
15 therapies, and many of them are focused on very rare
16 genetic conditions where it will be something that affects
17 state budgets but the number of patients is likely to be
18 very, very small in any given year. However, we did find a
19 few conditions with higher prevalence that we should be
20 aware of, and the first really is sickle cell disease. At
21 the moment there are three products in development in Phase
22 III trials for sickle cell disease. We have more than

1 100,000 beneficiaries in Medicaid today that have some sort
2 of sickle cell disorder. Not all of those would be severe
3 enough to be eligible for a gene therapy, but we're
4 anticipating initial list prices likely around $1.8 million
5 for sickle cell gene therapy. And so the combination of a
6 reasonably large patient population and those list prices
7 made this cause for attention.

8 As you may know, sickle cell disease is a painful
9 and relatively debilitating condition that's not well
10 treated today, so we could see tremendous clinical benefit
11 for some of these patients, but likely added costs.
12 Typical treatment for kids with sickle cell disease is
13 about $10,000 a year today, about $30,000 for adults, but
14 both of those being relatively small compared to the cost
15 of the gene therapy. So we're looking at some significant
16 potential increases in incremental costs.

17 The second set of conditions that we looked at
18 were pediatric blood cancers, so that's the leukemia and
19 lymphoma bars here. And these are actually the products
20 that have already come to market for children. We have
21 Kymriah for pediatric leukemia. There are about 10,000
22 kids with leukemia in Medicaid today, about 5,000 with

1 lymphoma, and multiple products in the pipeline that could
2 continue to target this. So as we think about state
3 spending on pediatric cancers, potential for real
4 increases, which of course come with high costs in addition
5 to those clinical benefits.

6 The last one I'll flag here is muscular
7 dystrophy. The prevalence of muscular dystrophy you see is
8 about 24 out of 100,000 children, so not high but most of
9 them are in Medicaid. And the annual treatment cost for
10 the most common form of muscular dystrophy ends up being
11 about $60,000 a year in annual spending. And so, again, a
12 place where we could see relatively significant increases
13 in spending with the launch of gene therapies.

14 Now before we move on I want to mention that
15 there are also pediatric conditions that we looked at and
16 talk about with the panel that were not gene therapies, and
17 cystic fibrosis was the most important one. There are
18 about 18,000 beneficiaries in Medicaid today with cystic
19 fibrosis, about 11,000 of them are children, and it is one
20 of the highest-spending classes in the program already.
21 And as new products continue to come to market that offer
22 significant benefits in both quality of life and life

1 expectancy for these patients, those launches have
2 continued to keep cystic fibrosis as one of the top
3 pharmacy spending drivers to date.
4 So if pivot then to adult gene and cell
5 therapies, this was also a major area of concern as we
6 talked with the panel. We heard a lot of focus on these
7 gene therapies. I think one of the key differences between
8 the adult and the pediatric gene therapies is really the
9 importance that Medicaid is going to play as a payer. So
10 for the pediatric gene therapies we can assume that
11 Medicaid will be one of the top payers for those products
12 and so may have more ability to engage with manufacturers
13 and potentially achieve some sort of outcomes-based
14 contract or supplemental rebate agreements.
15 Medicaid is likely to not be the top payer for
16 these adult conditions. Many of them will probably end up
17 in the Medicare market. But there certainly are some that
18 will be more important for Medicaid, so we highlighted a
19 few here. You see type 1 diabetes, obviously a huge
20 disease area for Medicaid beneficiaries. Again, one of the
21 big questions as we look at this is going to be exactly
22 which individuals and which patients are going to meet the

1 clinical criteria to actually be eligible for a gene
2 therapy, and it certainly will not be as big as this bar
3 shows, but the potential eligible population is quite
4 large.
5 Similarly, rheumatoid arthritis. The autoimmune
6 diseases, as a whole, have been another big spending
7 driver, historically, in the last five years or so for the
8 Medicaid program, and there are two CAR-Ts in development
9 for RA.
10 Now as you look at the prevalence here, the 346
11 patients per 100,000 beneficiaries, about 18 percent of
12 those are taking a biologic medication today, so you can
13 start to see sort of that funnel of disease progression and
14 who might actually be eligible for a gene therapy
15 eventually.
16 And then multiple sclerosis showing a somewhat
17 smaller prevalence out of the total population, but what
18 I'll flag is that this is, of course, a disease that is
19 mostly diagnosed after age 45. And so we see the
20 prevalence of beneficiaries over 45 at about 642
21 beneficiaries per 100,000, with annual spending costs of
22 about $33,000 a year.

1 And then last but perhaps the one that has
2 garnered the most attention to date is hemophilia, and
3 hemophilia is a very expensive condition, treated today
4 with factor and typically with treatment costs between
5 $300,000 and $1 million per year per beneficiary. BioMarin
6 had a highly anticipated gene therapy that was expected to
7 come out relatively soon. The FDA has asked for more time
8 in clinical trials, so that's likely to be delayed for a
9 couple of years. But it is one that could have a pretty
10 significant impact on Medicaid at such time that a product
11 is approved.
12 So beyond the gene and cell therapies, we found
13 ourselves having a lot of discussion about which of the
14 other products -- we've got lots of other products with
15 high costs, but which of them are going to be most
16 challenging to manage in the context of the tools that
17 Medicaid programs have available to them today. And there
18 was a theme that came up, which is products like oncolytics
19 as well as HIV/AIDS drugs are ones that states have
20 articulated are really difficult to limit utilization.
21 Through a variety of reasons, whether they be state
22 legislation and regulation or the predilections of the

1 Medicaid officials, they have had a really hard time being
2 able to direct utilization to one product over another and
3 put some of those controls in place.
4 Cancer is one where, obviously, breast cancer is
5 the biggest oncology area for Medicaid and the biggest
6 tumor type for Medicaid. But we've seen a multitude of
7 products in the pipeline for all of these conditions, and
8 gene therapies in the pipeline for a subset of them,
9 although I'll flag that from a gene therapy point of view
10 we've seen more clinical success in blood cancers relative
11 to solid tumors.
12 And so we'll talk in a moment, but again, some of
13 these more sensitive conditions where PDLs and other
14 mechanisms have been harder to implement was definitely a
15 theme that came up again and again in our discussion.
16 So if we go on to the next slide, the last area
17 of focus that really emerged from our conversation, and
18 hadn't been something that we had specifically called out
19 up front, was the idea of products that have gone through
20 accelerated approval at the FDA. We heard a lot of concern
21 from state Medicaid officials that they feel like they may
22 be covering products with less clinical evidence than

1 products that go through normal approval pathways.

2 Accelerated-approval drugs can use surrogate
3 endpoints in their FDA reviews, and while they are required
4 to conduct post-market trials, frequently those trials
5 aren't completed, they are completed later than expected,
6 and all the while some of the state officials articulated
7 that they feel like they're really funding manufacturers'
8 clinical trials without a lot of data about the outcomes
9 for their beneficiaries.

10 So with that we can go to the next slide. That
11 emerged as sort of an area of focus. So looking ahead,
12 we've really prioritized three drug types for further
13 discussion, and again, these are the places where the
14 members of the panel said new models are needed. Existing
15 models are not going to be sufficient to manage these
16 products and we need to focus on new model development in
17 three areas -- gene and cell therapies, regardless of
18 pediatric or adult indication, accelerated-approval drugs,
19 and drugs for sensitive populations.

20 So taking those one at a time.

21 The gene and cell therapies have a multitude of
22 challenges. That was definitely the unanimous pick for

1 where we should spend the bulk of our energy, and again, it
2 really focused on the idea that these products have very
3 high list prices.

4 And particularly in the coming years, states said
5 it's going to create budget volatility. We don't know how
6 many beneficiaries are going to be eligible for a gene
7 therapy from one year to the next, and certainly from one
8 health plan to another, we may see broad variability in
9 those costs. So being able to sort of spread those costs,
10 anticipate them, and then think about what is a reasonable
11 value-based cost relative to the long-term benefits of
12 these products, so understanding that if some of these gene
13 therapies are lasting cures, as we hope that they are,
14 these products will accrue benefits to Medicare, to
15 commercial insurers, but Medicaid may be the one that
16 ultimately ends up funding a lot of them up front.

17 On the accelerated approval products, as I
18 mentioned, the concern is really around the limited
19 evidence, and so I think we're going to be exploring models
20 that potentially create financial incentives for
21 manufacturers, either to delay a launch of those products
22 in order to gather more evidence before they come to market

1 or have some sort of outcomes-based or price reduction tied
2 to the generation of additional evidence moving forward.
3 And while we're not going to get into specifics
4 of models today, there's lots to be worked through. The
5 goal is really to say because these products have different
6 evidence coming to market, they should perhaps have some
7 sort of different payment process attached to them.
8 And then lastly, the drugs for sensitive
9 populations, this was a contentious area. Obviously, the
10 reason that these products had been hard to manage is
11 because they treat very vulnerable patients, and the desire
12 to maintain access is really important. But there was a
13 discussion that in classes like HIV, we've seen just
14 tremendous forward movement in the ability to treat
15 patients and keep people healthy. But we continue to see
16 new products launching, and year after year, HIV drug costs
17 continue to stay as a top spender. We're not seeing any
18 decline at spending, even in these relatively crowded
19 classes, and so how do we think about managing these
20 sensitive populations and classes moving forward?
21 So, with that, I will pause and ask if anyone has
22 questions.

1 CHAIR BELLA: Thank you very much. Fascinating
2 and challenging and exciting for some of the populations
3 that are going to be helped.
4 I just want to remind Commissioners that the
5 point of this was to give you an update on this first body
6 of work. In November, we will be hearing about the model
7 design. In December, we will be hearing about potential
8 effects of various models, and there will be plenty of time
9 for discussion.
10 I have no doubt we could discuss a lot of this.
11 In the time that we have left, though, I would like to just
12 see if we have any technical questions about the analysis
13 itself. We'll continue to gather the information as they
14 build on this work before we have sort of our full-blown
15 discussion about it.
16 So, are there any questions about the analysis,
17 any clarifications that anyone has for Caroline, Amy, or
18 Chris?
19 Kisha.
20 COMMISSIONER DAVIS: I'm just wondering how we
21 approach the long-term benefit, and you commented on some
22 of this in the paper. Just looking at offsets of lifetime

1 courses of treatment, when you think about something like
2 sickle cell and how that compares to that large up-front
3 cost that might come from a gene therapy, so just getting
4 specific on how we factor in those costs or how we think
5 about that, giving us some sort of framework in future
6 reports, just how to kind of consider that.
7 MS. PEARSON: Yeah. I mean, value-based
8 reimbursement as a topic writ large is going to be one that
9 we focus on in future discussions and sort of how should
10 that be calculated.
11 A key point that came up in our dialogue was the
12 importance of making sure that we don't design models that
13 inadvertently advantage patients who have high-cost
14 existing therapies over those for whom we don't have any
15 treatments today and not focusing just on new incremental
16 spending but actually focusing on the benefit to the
17 beneficiary, to the program, to society. So that is
18 definitely something that has been teed up a lot, and we
19 haven't solved for it yet, but we'll be tackling to the
20 best of our ability.
21 CHAIR BELLA: Anything else, Kisha?
22 [No response.]

1 CHAIR BELLA: Nope? Okay.
2 Other questions or comments? Fred.
3 COMMISSIONER CERISE: Just a question about the
4 panel. Remind me in terms of the makeup there, because
5 this really -- do we have an ethicist on this panel? And
6 if not, should we think about something like that?
7 I can imagine a first drug that, you know, it's a
8 $1.8 million drug for sickle cell, and if we come out and
9 say, "Okay. Here is where we draw the line," that's going
10 to be bad. So given all of the choices that -- I mean, the
11 things that we're going to have to think through, there's
12 going to be the science side.
13 There are other issues at play here that I think
14 we're going to have to pay attention to, and Kisha touched
15 on it. And I think it's something we're going to have to
16 pay attention to, because all of these, we're going to be
17 looking for ways to say, okay, how do we -- some of these
18 prices are just going to be ridiculous, and can you do
19 something to get the manufacturers, their investments back,
20 and then have some reasonable rate of return, and then what
21 are our options to be able to do that?
22 I think the one we don't want to start with is

1 something like the drug for sickle cell, you know, for
2 obvious reasons. That won't be a good place to start.
3 CHAIR BELLA: Chuck and Kit.
4 MS. PEARSON: We don't have an ethicist. We have
5 a bunch of drug-pricing scholars, a legal expert,
6 beneficiary advocates, and state officials right now.
7 COMMISSIONER CERISE: I don't know how set that
8 is, but I think it's a real concern.
9 CHAIR BELLA: Okay. Chuck, Kit, Sheldon. I'm
10 going to remind us of a couple of things. We have five
11 minutes. I'm asking you just to have any kind of technical
12 clarifications. Also, if people want to weigh in on
13 whether we should make this analysis public, that was also
14 a question teed up for us.
15 VICE CHAIR MILLIGAN: My best auctioneer voice.
16 So my question is -- and we can bring this back.
17 It doesn't need to be addressed right now. I was thinking
18 about it in the context of the vaccines and COVID. Are all
19 of the gene and cell therapies that we're talking about
20 here subject to the Drug Rebate Act or some of these
21 outside of the purview of the Drug Rebate Act? Because I
22 think that in terms of pricing, in terms of state coverage,

1 whether all of these particular gene and cell therapies fit
2 the Medicaid Drug Rebate Act or fall outside of the
3 Medicaid Drug Rebate Act is going to be an important area
4 for us to keep our eye on. So maybe that's just a comment,
5 but I want to make sure that I have a clear understanding
6 about that going forward.
7 CHAIR BELLA: Thank you, Chuck. We'll take that
8 as a comment, if you don't mind.
9 Kit and then Sheldon.
10 [No response.]
11 CHAIR BELLA: I think you're on mute, Kit.
12 COMMISSIONER GORTON: Sorry. The organizer muted
13 me.
14 I just want to say I think we should publish
15 results and answer the question that way.
16 CHAIR BELLA: Thank you.
17 Sheldon and then Darin.
18 COMMISSIONER RETCHIN: You know, I know it's
19 late, and the panel has been drawn. I want to, though,
20 endorse Fred's suggestion. Whether the report is reviewed
21 by a separate panel of ethicists, they will add so much to
22 it. And it's not so much the complement of the pipeline

1 drugs that are here today but just what's coming, the
2 onslaught. Thankfully, the technology is incredible, but I
3 think having a panel of ethicists or ethical input for how
4 we look at this and the factors is really important. And
5 the panel you've got, I think is going to be difficult for
6 them to do that. So I endorse that strongly.
7 CHAIR BELLA: Thank you, Sheldon.
8 Darin?
9 COMMISSIONER GORDON: Yeah. I support Fred's
10 suggestion. I think that would be a great addition.
11 I do think as we think about -- you said it a
12 couple times when we looked at the prevalence within
13 Medicaid. You'd say it's really not everyone that may
14 qualify for that particular therapy for a variety of
15 reasons, though we do have some experience in the past. I
16 think it's evolving.
17 Where there was a great deal of pressure to
18 provide it, it kind of gets to Fred's point. For folks
19 that maybe did meet the criteria and the evidence that
20 would support it went to the FDA, but they'd have this
21 diagnosis. Should we at least try? And you saw that
22 happen from an advocacy perspective across the country, and

1 what many would have thought would have been one number as
2 far as being eligible to access it, become a very different
3 number, much larger.
4 So I do think, you know -- and particularly as
5 you talk about the accelerated approval, I think that's
6 only going to exacerbate that, how states are going to be
7 able to set the medical criteria here.
8 So I think we have to be careful when we make
9 that comment that surely not everyone who has this
10 diagnosis would be eligible for it. I think you can say
11 that, but I think we need to let history guide us a little
12 bit there and say although we recognize there will be
13 pressure to expand coverage.
14 Thank you.
15 CHAIR BELLA: Thank you, Darin.
16 Sheldon for the last comment.
17 COMMISSIONER RETCHIN: Yeah. I just wonder if,
18 in some way or another, the solution is to have states do
19 this individually. Just keep in mind the launch prices are
20 so high that families may actually move, which they have
21 done in the past. Hemophiliacs' families actually move to
22 different states because of the cost and the lack of

1 treatment.

2 CHAIR BELLA: So just three things to wrap up.

3 If we could check on being able to get an ethicist

4 involved, whether as a panel member reviewing it. I agree

5 that I think that would be important.

6 Second, does anyone have any concerns -- not to

7 put you on the spot, but I'm going to -- with publishing

8 this information? Raise your hand if anyone has any

9 concern with that.

10 Does anyone feel like I'm putting them on the

11 spot? Raise your hand if you feel like that.

12 Okay. I think unless -- we'll give people, like,

13 a little bit of a grace period to come back and say, "Hey,

14 no," but otherwise let's assume that we're going to be able

15 to publish this information. It's really important

16 information.

17 Then the third point, I think you can see that

18 there's a lot of interest. I have unfairly constrained the

19 discussion here. So, as you think about when we have time,

20 when all of these things come together, I would just ask

21 that we make sure there's ample time to really dig into all

22 these pieces because I think there's going to be a lot that

1 the Commissioners are going to want to talk about.

2 With that, thank you all. I thank the three of
3 you. Appreciate this information and look forward to
4 hearing about the next two sessions.

5 MS. PEARSON: Thank you.

6 CHAIR BELLA: Okay. We are in the home stretch.
7 We are on our last subject. Joanne is here already to talk
8 about the Secretary's report to Congress -- it's a very
9 long line -- on reducing barriers to substance use
10 disorder, using telehealth for pediatric populations in
11 Medicaid.

12 So, Joanne, I believe what you are doing is
13 giving us context for this, and we are determining about
14 our position on commenting. Is that correct? That's what
15 you need from us?

16 MS. JEE: That's correct.

17 CHAIR BELLA: Okay. Wonderful. Take it away.

18 **### COMMENT ON SECRETARY'S REPORT TO CONGRESS ON**
19 **REDUCING BARRIERS TO SUBSTANCE USE DISORDER**
20 **SERVICES USING TELEHEALTH FOR PEDIATRIC**
21 **POPULATIONS UNDER MEDICAID**

22 * MS. JEE: Okay. So, as Melanie said, I am going

1 to be highlighting some findings from the study with the
2 very long title, which I will not repeat since Melanie did
3 it for me. Thank you. And that was a study from Secretary
4 Azar of HHS to the Congress.

5 So we'll start with a little bit of background on
6 the study. Then I'll summarize the key findings, and then
7 I'll move on to some possible areas for comment that the
8 Commissioners may want to consider and then very quickly go
9 over some next steps.

10 The impetus for this report was a mandate from
11 the SUPPORT Act, and the SUPPORT Act directed the Secretary
12 to analyze and report on best practices, barriers and
13 potential solutions, differences in use and cost, avoidable
14 inpatient admissions and readmissions, and quality and
15 satisfaction with telehealth for substance use disorder
16 services for children in Medicaid.

17 HHS used a contractor, RTI International, which
18 conducted this analysis through an environmental scan, key
19 informal interviews, and site visits. As Melanie said, the
20 purpose is to determine whether you would like to exercise
21 your right, ability, to make a comment on this report.

22 Okay. So a key overall finding in this report

1 was that there are knowledge gaps and data gaps about the
2 use of telehealth for SUD services for children in
3 Medicaid. In several instances throughout the report,
4 report authors include information pertaining to telehealth
5 and behavioral health or telehealth and general health
6 services rather than SUD services specifically, and the
7 authors do this because, as I said, the information on SUD
8 services and telehealth generally were lacking. And the
9 more general findings can be applicable to SUD.

10 All right. So the report describes information
11 on best practices and characterizes them as emerging and
12 evolving. These includes ensuring organizational readiness
13 to adopt telehealth, engaging staff on operational and
14 policy decisions, using synchronous modalities because they
15 rely on more common technologies and may have other
16 benefits such as similar revenue potential to in-person
17 visits and allow for family members to easily participate
18 in visits where that is appropriate.

19 In addition, best practices included using
20 support staff before and throughout the telehealth
21 encounter, and this includes, for example, to do outreach
22 to patients, scheduling, and intakes, and then finally

1 using telehealth in school-based programs because of the
2 access that that can create for young people.
3 There was limited information on differences
4 between telehealth and in-person visits. The information
5 that the authors described here, again, relate primarily to
6 behavioral health or general health or also to the views
7 and experiences of the experts who were interviewed.
8 On utilization, there were no studies comparing
9 the use of SUD services by children in telehealth to in-
10 person; however, the report does cite some other studies,
11 general studies, as I said, showing some variation in
12 utilization by population, depending on their care needs
13 and their location.
14 Information on cost of care was generally not
15 available, but interviewees noted that in their experience,
16 costs for telehealth were similar to in-person services.
17 Data on admissions also was limited, and here
18 authors cite studies showing some mixed results on how the
19 use of telehealth related to use of urgent care and
20 emergency department visits.
21 Information available suggests that quality for
22 telehealth is similar to quality for in-person services,

1 and that providers and patients generally appear to be
2 satisfied with telehealth services, with some variation,
3 depending on their access to technology and for patients,
4 demographics.

5 All right. The report authors noted several
6 barriers to telehealth for SUD services, and,
7 Commissioners, I think that probably most of these will be
8 familiar to you. Low provider payment was identified as a
9 concern, and the authors noted that this might be addressed
10 by policies such as implementing payment parity between
11 telehealth and in-person care.

12 Issues with technology and broadband also can be
13 barriers, both for patients and providers. For example,
14 providers might experience some challenges with
15 compatibility of their telehealth platforms to their EHRs,
16 or electronic health records.

17 Barriers relating to provider and patient
18 acceptance of telehealth were raised, and the report
19 authors noted that this might be addressed with increased
20 training for providers or through gained experience by both
21 providers and patients with telehealth.

22 Lack of a sufficient workforce and capacity

1 constraints can still be problematic, even when telehealth
2 is used. So, for example, if there is a lack of providers
3 who are trained in serving pediatric populations,
4 telehealth may ease access to them. But if there's not
5 enough and you have high demand, you still potentially face
6 some barriers.

7 Variability in state licensure and credentialing
8 rules was identified as a barrier for providers. The
9 report notes that some streamlining of those processes and
10 policies might be useful in addressing those concerns.

11 The report also noted other barriers. These
12 include consent requirements for services for children and
13 privacy rules in educational settings. In addition, the
14 report authors noted that other non-Medicaid policies and
15 activities can affect how Medicaid can use telehealth. An
16 example of this would be the Ryan Haight Act, which, just
17 as a reminder, that Act affects prescribing of controlled
18 substances via telehealth.

19 So some areas for possible comment that you may
20 wish to consider. A MACPAC letter could comment on the
21 need for additional research on the use, cost, and outcomes
22 for pediatric SUD services delivered via telehealth. I

1 think this comment could also address a more general need
2 for research on telehealth in Medicaid, if you would like.
3 Our report chapter on telehealth from 2018 noted that there
4 was a lack of research on telehealth in Medicaid, and that
5 there were some inconclusive findings on studies that were
6 available at the time.

7 The Commission could urge CMS to continue
8 assessing what type of telehealth analyses could be
9 supported with Medicaid administrative data, which is
10 reported by states into the T-MSIS system. CMS recently
11 issued the first-ever snapshot on the use of telehealth in
12 Medicaid during the COVID-19 pandemic, and to do this
13 analysis CMS relied on T-MSIS data that noted, in the data
14 caveats, to take caution in interpreting the data because
15 of data claims lag. The analysis, however, did not
16 otherwise speak to any other data quality issues.

17 You also may want to comment on the need for
18 sharing information about Medicaid approaches for using
19 telehealth for SUD services or for other services, and this
20 might include providing states technical assistance or
21 creating opportunities for state-to-state learning on
22 approaches for using telehealth.

1 And finally, Commissioners, you could acknowledge
2 the importance of addressing non-Medicaid barriers and
3 leveraging solutions outside of Medicaid policy. For
4 example, the Federal Communications Commission has numerous
5 programs to ease barriers to technology and broadband, and
6 those also could be useful in Medicaid for telehealth.
7 All right. So next steps. We seek your feedback
8 this afternoon on whether you think a comment letter is
9 warranted. If you do think a letter is warranted, we will
10 draft one based on your discussion and comments today. And
11 also if there are other topics that you think the letter
12 should include that weren't mentioned on the slides, it
13 would be helpful to hear from you on those as well.
14 That's it. Thank you.
15 CHAIR BELLA: Thank you, Joanne. I appreciate
16 you getting through all that pretty quickly.
17 All right. The question before us is pretty
18 clear. What is the will of the Commission on submitting a
19 letter, and if the will is to submit one, then providing
20 some direction on what we would like to be our main areas
21 of comment would be the next step. Does anyone have strong
22 feelings about whether to comment?

1 Pretend like this is the first session of the day
2 and you haven't been here for two days, and we're at the
3 end on a Friday night. Does anyone have any feelings about
4 -- Martha, thank you.
5 COMMISSIONER CARTER: I think we should take the
6 opportunity to comment. You know, we've been working on
7 telehealth for some time, and while we haven't done a lot
8 of work on pediatric SUD telehealth services, I think we
9 can broaden the conversation to talk about some of the
10 challenges that we see in telehealth. We've already really
11 addressed some of that, but I don't know that it hurts to
12 say some of those things again, and as Joanne said,
13 highlight the need for more research on telehealth in
14 general.
15 And we're really talking about the adolescent
16 population, aren't we, for pediatric SUD? So, you know,
17 it's a particular area of service delivery that does
18 require some additional focus and maybe some research.
19 CHAIR BELLA: Thank you, Martha. Other thoughts?
20 Kisha.
21 COMMISSIONER DAVIS: Yeah. I think, as Martha
22 said, you know, taking advantage of the opportunity to

1 write the letter and expand the conversation, and one of
2 those things to highlight is the need for broadband both
3 for the provider side and the patient side. And so that
4 technical piece really becomes an issue around access and
5 how people are able to access those services and have
6 availability.
7 I think also highlighting reimbursement rates for
8 providers, that there is still the same amount of technical
9 skill and know-how needed to conduct a visit via
10 telehealth, as is done in person, and so they shouldn't be
11 thought of as discounted visits just because it's performed
12 at a distance.
13 And then, you know, highlighting some of the
14 benefits of just being able to, you know, observe patients
15 in their natural environment, especially when it comes to
16 mental health, behavioral health, and substance abuse, and
17 recognizing, really thinking of patients as part of the
18 situation that they're in, their home environment, and how
19 that influences their care. That can really be a benefit
20 for providers to be able to observe them in that way.
21 CHAIR BELLA: Thank you, Kisha. Chuck?
22 VICE CHAIR MILLIGAN: Thanks. I just want to

1 align myself with the comments that Kisha and Martha just
2 made. I think there's value to sending a letter and I
3 think the broadband issue is something we should touch on.
4 And I think this is an opportunity also for us to comment
5 on the importance of broadband access as a response to some
6 disparities and equity issues.
7 CHAIR BELLA: Thank you, Chuck. Joanne, I don't
8 know if you can see but I see heads nodding, particularly
9 on the broadband access and disparities. Fred?
10 COMMISSIONER CERISE: Yeah, I would agree with
11 the others. I think it's worth commenting on, you know, we
12 started this session with non-emergency medical
13 transportation, and one of the top reasons for that was
14 behavioral health. And so to the extent that telehealth
15 can contribute to that cap, I think it's worth continuing
16 to focus on it. So I'd support sending it and commenting
17 on some of the non-Medicaid barriers like internet access.
18 CHAIR BELLA: Martha?
19 COMMISSIONER CARTER: I think it's also worth
20 commenting on anything we know about the value of school-
21 based health and behavioral health SUD services. Maybe
22 there isn't much, but if there isn't much then that would

1 be an area to comment on the need for further research.
2 The School-Based Health Alliance, there's a national
3 organization. They have some information. But I think
4 that would be good too.
5 MS. JEE: Yeah, and the report did address some
6 school-based models.
7 CHAIR BELLA: Anne, did you have your hand up
8 before, or did I misstate that?
9 EXECUTIVE DIRECTOR SCHWARTZ: I think I was just
10 saying “snap,” it'll be easy.
11 [Laughter.]
12 CHAIR BELLA: All right. Are there any other
13 comments or feedback for Joanne? It sounds like we will do
14 a letter, targeted in the areas we talked about. Is there
15 anything else people want to say in terms of where they
16 would like focus to be or not to be?
17 [No response.]
18 CHAIR BELLA: Joanne, do you have enough of kind
19 of the areas of interest?
20 MS. JEE: Yeah. I think I'm good to go.
21 CHAIR BELLA: Okay. We are going to open up to
22 public comment. We are going to welcome the public to

1 comment on any of the sessions this afternoon. We did have
2 one already on postpartum, but if someone didn't get a
3 chance to say something about that they are welcome. But
4 otherwise we have not yet had public comment on the DSH
5 chapter, on the high-cost specialty drugs or on this
6 subject.

7 So opening it up. If anyone would like to make a
8 comment please hit your little hand icon.

9 **### PUBLIC COMMENT**

10 * [No response.]

11 CHAIR BELLA: While we're waiting to see if
12 anyone wants to comment I'll just remind everyone, the next
13 MACPAC meeting is December 10th. It'll be December 10th
14 and 11th. It will also be virtual. I want to also thank
15 Jim and Kevin for making this virtual meeting about as good
16 as it could possibly be. I think we had no idea of all
17 that you do behind the scenes to keep us up and running and
18 to make sure that we can keep on with the business of
19 protecting and advancing the Medicaid program. So thank
20 you very much for that.

21 I see no hands, and so let me see if there are
22 any final comments or questions from any Commissioners, and

1 see if Anne has any last words, and then we'll be just
2 about done.
3 Chuck, Anything?
4 VICE CHAIR MILLIGAN: No. Thanks, Melanie.
5 CHAIR BELLA: Anne, any final words?
6 EXECUTIVE DIRECTOR SCHWARTZ: No. I think we're
7 good. Thank you.
8 CHAIR BELLA: Okay. I'm going to say on behalf
9 of all of the Commissioners I want to thank the staff, both
10 those of you we saw that presented and those of you who
11 didn't. You also haven't missed a beat, even though we
12 know these are trying times and strange times, so thank you
13 for your continued support. And you should know that the
14 Commissioners talk about this and talk about how much we
15 value you. So I'm just the mouthpiece on behalf of all of
16 us.
17 And then, Anne, a big thanks to you, obviously,
18 so thank you all. We had a lot of stuff we got through,
19 and we'll have as much, I think, in December.
20 So this concludes our October meeting. Thank
21 you, everyone, for being so engaged over the last couple of
22 days, and we'll look forward to December.

1 Have a great weekend, everyone. Thank you.

2 * [Whereupon, at 3:51 p.m. the meeting was

3 adjourned.]

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