PUBLIC MEETING

Via Go-to-Webinar

Thursday, September 24, 2020
10:35 a.m.

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

2 [10:35 a.m.]

3 CHAIR BELLA: Welcome, everyone. Thank you for
4 joining our September MACPAC meeting virtually. We will do
5 our best to make this as normal as possible and as seamless
6 as possible but certainly appreciate all that have joined.

7 We're going to start the morning talking about
8 countercyclical. This is a continuation of work that the
9 Commission has been exploring. I think we have a lot to
10 get through. So I would like to turn it over to Moira and
11 Chris so we can jump right in. Welcome.

12 **### ESTIMATING THE EFFECTS OF A PROTOTYPE**
13 **COUNTERCYCLICAL FINANCING ADJUSTMENT FOR MEDICAID**

14 * MS. FORBES: Okay. Can you all hear me?

15 CHAIR BELLA: Yes. Hi.

16 MR. BOISSONNAULT: Your slides are coming up.

17 MS. FORBES: While Jim is bringing those up and
18 handing those over to me, we're here today to talk about
19 countercyclical financing, following up on a presentation
20 from last April.

21 We had first started talking about the design
22 features of a countercyclical financing adjustment last

1 December, which was when an economic downtown was still
2 hypothetical. One of the things we had mentioned then was
3 that the GAO had developed a prototype after the last
4 recession. And so back in December, you had asked us to
5 come back in the spring with maybe some examples of what
6 the GAO model might look like under different scenarios.
7 Then before we did that, of course, in March, the pandemic
8 hit. The national emergency went into effect, and there
9 were these huge effects on the economy, and Congress acted
10 very quickly to actually put in this increase in the
11 medical assistance percentage for Medicaid spending. They
12 put in a 6.2 percentage point increase for the duration of
13 the national emergency.

14 So in April, instead of presenting something that
15 would sort of be out of date immediately, we talked in more
16 detail about policy choices and the technical
17 considerations that would need to be considered in
18 designing an automatic mechanism, and we showed how
19 different economic indicators could be used for this
20 purpose.

21 Over the summer, you saw we published a brief on
22 the effect the 6.2 percentage point FMAP increase could

1 have on states in terms of offsetting the cost of
2 additional Medicaid enrollment and what additional federal
3 support might be needed to provide a larger countercyclical
4 effect. And then when we did that, that was still early in
5 the pandemic, and very little data was available. So we
6 used the estimates of state spending and enrollment to
7 project these effects.
8 Now we're six months in, and of course, it's
9 looking like even if additional treatments for the virus
10 are identified soon, it's possible that the country may
11 still be facing an extended economic downtown. And the
12 experience of past recessions is that job growth tends to
13 lag well behind an official economic recovery.
14 So some policymakers have suggested that Congress
15 could still consider a mechanism to automatically adjust
16 the FMAP formula once certain economic conditions are met
17 or create one that wouldn't necessarily have to be tied to
18 something like a public health emergency or a national
19 disaster.
20 So although there's a countercyclical FMAP
21 adjustment still in effect, we're going to go back to some
22 of that earlier work. Chris and I looked at some of those

1 prototypes for automatic stabilizers and used some data
2 from the current situation now that we have some, to see
3 what we can learn about how well those models could work in
4 real time.
5 I just have to wait a second for my mouse to
6 catch up here.
7 MR. BOISSONNAULT: It's coming now.
8 MS. FORBES: All right. Ah, there we go.
9 Excellent.
10 So I'll recap how Medicaid financing works. I
11 know we've been over this, but there may be some folks in
12 the audience, just to catch up, focusing obviously on how
13 it functions as an automatic countercyclical program during
14 economic downturns and go over some of those policy issues
15 regarding how it could be used formally as a
16 countercyclical financing approach.
17 I'll walk through the specific prototype model
18 that was proposed by the Government Accountability Office,
19 and then Chris will walk through our estimates of the
20 effects of the formula if implemented this year. We tried
21 to see if we could implement the model using currently
22 available data. The GAO developed it using historical

1 data.

2 And finally, because Congress did act to give
3 states an increased FMAP associated with the national
4 health emergency, we looked at the effects of the automatic
5 GAO model on state share and then compared it to what they
6 actually got under the Families First Coronavirus Relief
7 Act.

8 So as we've discussed before, Medicaid is a
9 public assistance program, and demand for assistance is
10 countercyclical to economic growth. Enrollment and
11 spending increase when there's a downtown in the economic
12 cycle.

13 The program is designed to automatically offset
14 these cyclical changes in economic activity without
15 additional governmental intervention.

16 Financing this additional program cost is
17 complicated by the requirement for states to contribute a
18 fixed percentage of program expenditures. States can face
19 steep revenue declines in a downturn, but they can't run
20 deficits. They can't take on debt for program expenses.
21 The federal government can run deficits and can contribute
22 additional share but only through congressional action.

1 Another approach is to have an automatic offset
2 for cyclical changes in the economic activity through a
3 statutory countercyclical FMAP adjustment formula that
4 would account for the increased enrollment and spending and
5 make up for the decreased state revenue. This could help
6 do away with the need for one-off congressional actions.
7 Of course, creating an automatic FMAP adjustment
8 that would go into effect under specific economic
9 conditions requires a number of design decisions. There's
10 a lot of options for each element. Each choice affects the
11 timing and magnitude of changes in federal expenditures and
12 the amount of money that goes to states, so those are
13 political decisions. For example, Congress would have to
14 decide whether to provide an increase to states based on
15 national- or state-level economic conditions, whether an
16 increase should go to all states or only those that meet a
17 certain threshold level of need, whether an increase should
18 be triggered easily in order to function as a stimulus, or
19 whether an increase should be based on robust trend data in
20 order to function more as an additional stabilizer on top
21 of the FMAP formula.
22 Last April, we talked about some of those policy

1 considerations and some of the data that would be needed to
2 implement various options. You may recall we had a lot of
3 charts. We looked at GDP, sales taxes, and unemployment as
4 potential indicators; we looked at the factors that make an
5 economic measure relevant to the design of an automatic
6 FMAP adjustment, like the degree to which changes in the
7 measure correlate to changes in state revenue and changes
8 in Medicaid enrollment; and we looked at the timeliness and
9 availability of the data for trend analysis. All of those
10 are factors that go into the design.
11 As part of the 2009 stimulus bill, Congress asked
12 the GAO to analyze all those issues and provide
13 recommendations for modifying the FMAP formula to make it
14 more responsive to state Medicaid program needs during
15 future economic downturns.
16 The GAO developed a prototype formula for a
17 temporary increased FMAP, which they published in 2011,
18 which, of course, they had designed for more typical
19 recessions, which generally begin with a gradual economic
20 slowdown, not what happened this year. But it's still
21 useful for us to see how it works in practice, particularly
22 trying to obtain and use the data and also for us to have

1 something to compare the effects of this year's
2 congressional action to.
3 So, again, I'm going to walk through their
4 approach, and then Chris will talk about how we applied it
5 and what we found.
6 The GAO looked at all the options for all those
7 design decisions, and they made a number of choices to
8 actually put into the model and figured out which data to
9 use to support the choices.
10 They started by looking at the design and the
11 outcomes of the temporary FMAP increases that Congress put
12 in place in response to the 2001 and 2008 recessions, and
13 they decided that an automatic countercyclical model should
14 start and stop based on national economic conditions, that
15 it should vary based on state-level factors but allow all
16 states to get an increase, and that it should use data
17 that's available more quickly than that used in the FMAP
18 formula, so they should use something other than per capita
19 income to allow a faster response.
20 If you go back to the presentation we made in
21 April and look at some of the indicators and thresholds
22 that at the time in the discussion, seemed like the most

1 reasonable or the most workable, a lot of the choices that
2 the GAO proposes line up with what we showed, such as the
3 indicators of national economic conditions generally line
4 up with what you see at the state level as well at the
5 start of a downturn.
6 So the first design choice is what indicator to
7 use that would identify the start of an economic downturn
8 to trigger the need. That's obviously a very important
9 consideration.
10 In April, we looked at GDP, gross domestic
11 product, state sales tax collections, and unemployment, and
12 we talked about the extent to which these are reported
13 timely, that they line up with changes in state-level
14 economic changes. We said that of the three, the
15 unemployment rate is the most timely and comparable across
16 states, while it's also a good proxy of a change in demand
17 for Medicaid.
18 The GAO prototype uses unemployment data as the
19 trigger to automatically start an FMAP increase, although
20 they don't just look at the unemployment rate. They
21 compare each state's three-month average employment-to-
22 population ratio to the prior year, and they trigger an

1 FMAP increase if there's a decline over two consecutive
2 months in 26 states or more. They are carefully looking at
3 the data. The use of the three-month average allows for a
4 timely measurement while smoothing out some of the seasonal
5 changes and looking at a year-over-year trend across two
6 consecutive months, you know, allows for some trend
7 analysis. It also addresses the national- versus state-
8 level conditions issue by looking at state-level changes,
9 but they require changes in at least half the state which
10 gets you close to the national picture.
11 The next issue is how much assistance to provide
12 to states and whether this should be the same for all
13 states or whether it should vary based on state-level
14 factors. Congress has provided temporary assistance both
15 ways. In 2003 it provided all states with the same FMAP
16 increase, which was easy to implement, but it led to uneven
17 effects across states. Then in 2009, they tried something
18 different. They gave all states an across-the-board
19 federal share increase but then made an additional
20 adjustment based on unemployment, which was more targeted,
21 but then it required -- there was sort of a delay while
22 they collected the state-specific unemployment data.

1 The GAO proposal calculates a state-specific FMAP
2 increase based on two factors, increases in state
3 unemployment and reductions in total wages and salaries,
4 which are used as proxies for increases in Medicaid
5 enrollment and decreases in revenues to support Medicaid.
6 The formula is a little complicated to explain.
7 It's easier with actual numbers. So if we assume there's a
8 state where the federal match is 60 percent, which means
9 the state share is 40 percent, the GAO proposal would
10 decrease the state share by the corresponding increase in
11 the unemployment rate or decrease in state wages and
12 salaries. So if the unemployment rate went up 10 percent,
13 the state share would go down by 10 percent, and 10 percent
14 of 40 percent is 4 percentage points. So the state share
15 would go from 40 percent to 36 percent and the federal
16 share with an increase from 60 percent to 64 percent.
17 And then we add in the second part. So if the
18 state's wages decrease 10 percent, the state's share would
19 go down by 10 percent of 40 percent or 4 percentage points.
20 The state's share would go down another 4 percentage
21 points. So take another 4 percent off that down to 32
22 percent, and the federal share would go up to 68 percent.

1 So each basis is calculated independently, and they add
2 together.
3 Finally, the automatic stabilizer must also have
4 a mechanism to revert back to the regular funding formula
5 when economic conditions improve. You can tie it to some
6 of the effects, like a certain period of time or an
7 external condition like a public health emergency, or you
8 can tie it to an economic indicator.
9 The GAO proposes ending the temporary assistance
10 once fewer than half the states show a decline in their
11 employment to population ratio over two consecutive months.
12 It's basically the inverse of the trigger that would start
13 the increased federal share and actually indicate that
14 states are no longer in an economic downturn.
15 And when the Commission looked at different
16 indicators in April, we saw that states experienced high
17 unemployment for several quarters after GDP has returned to
18 pre-recession levels. So not only is unemployment a more
19 timely indicator than GDP in terms of data availability,
20 it may also be a better indicator of continuing demand for
21 Medicaid.
22 So that's a very fast overview of the GAO model,

1 which has a lot of elements, but I'll turn it over to Chris
2 who can walk through the findings when we plugged in some
3 actual 2019 and 2020 data.
4 * MR. PARK: Thanks, Moira.
5 If you could advance two slides. Thanks.
6 So using the GAO proposal as the basis for a
7 permanent countercyclical mechanism, we modeled what the
8 FMAP increases would be if the prototype formula had been
9 implemented this year. Note that when the GAO developed
10 this prototype, as Moira said, it could retrospectively
11 access the data from the quarter they were looking at for
12 the assistance period. If policymakers wanted to calculate
13 the FMAP increases at the beginning of a given quarter,
14 that is, prospectively, the calculation would need to use
15 the most recently available data, which would generally be
16 from a prior quarter.
17 Our analysis uses the most recent data that was
18 available through August. So we used state-level monthly
19 employment and unemployment data from the Bureau of Labor
20 Statistics through June 2020 and state-level quarterly
21 personal income data from the Bureau of Economic Analysis
22 through the January-to-March quarter of 2020.

1 As Moira mentioned, the GAO model would trigger
2 assistance if at least 26 states experienced a decline in
3 the average employment to population ratio in two
4 consecutive months, and the FMAP increase would go into
5 effect in the first fiscal quarter after the trigger month.
6 Looking at the data, the majority of states
7 experience a decrease in the average employment to
8 population ratio in March and April of 2020. Because the
9 trigger was met in April, this means the assistance period
10 would go into effect for the quarter beginning on July 1.
11 Next slide. Thanks.
12 The state-level unemployment data are available
13 monthly from the Bureau of Labor Statistics, and the data
14 for a particular month are typically released during the
15 third week of the following month. This means that for a
16 particular assistance quarter, there's generally a lag of
17 one quarter for the data for the unemployment assistance
18 component. For example, for the assistance period beginning
19 July 1, 2020, the most recent quarterly data for
20 unemployment was for the April and the June period, which
21 would be available in the third week of July.
22 To calculate the unemployment assistance

1 component for each state for this July to September period,
2 we used data from the April to June period as a proxy and
3 reviewed all quarters back to the second quarter of 2018 to
4 identify the baseline lowest unemployment rate.
5 Based on these data, all states would receive an
6 FMAP increase through this unemployment component, with the
7 increases ranging from about 1.3 to 8.4 percentage points.
8 Over half the states, 27, the second bar in this
9 graph, would receive an FMAP increase between 2 to 4
10 percentage points for this quarter.
11 Next slide.
12 State-level wages and salaries are a component of
13 the Bureau of Economic Analysis state quarterly personal
14 income data. These data are typically released at the end
15 of a quarter and have a lag of two quarters. So the
16 personal income data for January to March 2020 were
17 released the last week of June, and that would be the most
18 recently available data for an assistance period beginning
19 July 1.
20 To calculate the wage and salary component for
21 each state for this July to September period, we used the
22 January to March period as a proxy, looked back to the

1 first quarter of 2018 to identify the baseline highest wage
2 and salary level. Based on these data, six states would not
3 receive an FMAP increase because the data from the proxy
4 period were higher than the baseline.
5 For states receiving an FMAP increase, the
6 increase ranges were pretty small, from .002 percentage
7 points to 1.26 percentage points. Twenty-nine states, this
8 first bar -- and this includes those with no increase --
9 would receive an FMAP increase of less than .25 percentage
10 points.
11 We should note that these small increases from
12 the wage component are primarily due the lag in available
13 data, as the most recent available data includes months
14 prior to the implementation of stay-at-home orders that
15 began in March. We would expect that states would receive
16 a much larger increase in the wage and salary component in
17 the next quarter when data from April to June, when states
18 had stay-at-home orders in effect, would be applied in the
19 formula.
20 Next slide.
21 Overall, when we combine these two components for
22 the unemployment and wage and salary adjustments under the

1 GAO proposal, states would receive a total FMAP increase
2 ranging from 1.3 percentage points to 9.11 percentage
3 points for the quarter beginning July 1. Twenty-seven
4 states, the second bar there, would receive an FMAP
5 increase between 2 to 4 percentage points. These FMAP
6 increases would lead to a decrease in state spending
7 ranging from 4 percent to 21.1 percent for the quarter.
8 Weighted by states' share of Medicaid
9 expenditures, the average weighted national increase in
10 FMAP for the quarter would be about 4.53 percentage points
11 and the average weighted decrease in state spending of
12 about 10.6 percent.
13 Next slide. Go ahead and advance to the next
14 slide. Thanks.
15 To estimate the effects of the FMAP increase in
16 the GAO Model for the current economic downturn, we applied
17 the state-specific GAO FMAP increases to the model that we
18 used in our June 2020 issue brief on Considerations for
19 Countercyclical Financing Adjustments in Medicaid.
20 This model used Medicaid spending projections
21 submitted by states on the CMS-37 program budget report,
22 and enrollment projections from the Health Management

1 Associates to estimate the effect that the increase in FMAP
2 would have on states' budgets under different enrollment
3 scenarios.
4 Commissioners, please note that we changed these
5 slides from the version that you received, because we found
6 a mistake in the enrollment scenarios modeled by HMA that
7 we had put on your slides. These are the correct slides
8 and they're available on the website.
9 But in the 3 HMA scenarios, enrollment increases
10 range from about 5 million in their low projections by the
11 end of FY 2020 to about 16 million under the high scenario.
12 Because the FMAP increases under the GAO model
13 change quarter to quarter, and we do not yet have the data
14 to project the FMAP increases from October to December 2020
15 period, we only focused on fiscal year 2020 and the effects
16 due to the FMAP changes that would go into effect for this
17 quarter of July 1, which is the fourth quarter of the
18 fiscal year.
19 Next slide.
20 This slide shows the benefit spending under the
21 GAO model for the baseline, which is the original
22 projections off the CMS-37 and the various scenarios with

1 an increase in enrollment plus the GAO FMAP increase. The
2 FMAP increase under the GAO model would have decreased
3 baseline spending for states by approximately $6.7 billion,
4 or 2.7 percent.
5 Overall, the FMAP increases under the GAO model
6 would allow states to cover the cost of increased
7 enrollment under the low scenario but not under the medium
8 or high scenario. This is partly due to the fact that
9 states would see enrollment increases for two quarters,
10 April to June and July to September, but only receive an
11 FMAP increase during one quarter, July to September.
12 Next slide.
13 Nationally, the FMAP increases under the GAO
14 model would cover the enrollment increase under the low
15 scenario for FY 2020, but this is not the case for all
16 states. States would experience different decreases in
17 state spending compared to the baseline, depending on their
18 original FMAP, the amount of FMAP increase and the level of
19 the enrollment increase. With no enrollment increase, the
20 gray bars, the GAO model FMAP increase would have reduced
21 state spending for all states approximately between 1
22 percent and 4.8 percent compared to the baseline, with most

1 states, 28 states, receiving a reduction of between 2 to 4
2 percent.
3 Under the low-growth bars, the light blue bars,
4 30 states that would experience a decrease in state
5 spending compared to the baseline, while 21 states would
6 experience an increase in state spending. Under the medium
7 growth scenario, the green bars, only two states would
8 experience a decrease of less than 2 percent, and the
9 majority of states would experience an increase up to 4
10 percent. And under the high growth scenario, the dark blue
11 bars, all states would experience an increase in state
12 spending.
13 Next slide.
14 We wanted to compare the effects of the GAO model
15 to the 6 percentage point FMAP increase provided under the
16 FFCRA. Based on our analysis, the FFCRA would provide more
17 fiscal relief to states in the aggregate than the GAO model
18 for FY 2020. Under the GAO model, 42 states would receive
19 an FMAP increase lower than the 6.2 percentage points under
20 the FFCRA, and 9 states would receive an FMAP increase
21 greater than that of the FFCRA.
22 This graph focuses on the fourth quarter of 2020,

1 the July to September period, since that's the quarter
2 where both FMAP increases would be in effect. The FMAP
3 increases under the GAO model would decrease state spending
4 from 4 percent to 21.1 percent, while the FFCRA increase
5 would decrease state spending from 12.4 percent to 26.9
6 percent.
7 As you can see on this graph, the minimum
8 decrease in state spending of 12.4 percent under the FFCRA
9 is greater than the 75th percentile decrease in state
10 spending of 11.5 percent under the GAO model.
11 For the fourth quarter of fiscal year 2020, the
12 GAO model would decrease state spending on a weighted
13 average by about 10.6 percent, while the FFCRA would
14 decrease state spending on a weighted average by about 14.6
15 percent.
16 Next slide.
17 To summarize the effects of the GAO model, we
18 found the majority of states would receive between a 2 to 6
19 percentage point increase in FMAP under the GAO model for
20 the fourth quarter of 2020. The model would reduce state
21 spending for all states between 1 to 4.8 percent compared
22 to the baseline for the entire fiscal year, and would

1 generally be able to cover the enrollment increase for 30
2 states under the low enrollment growth scenario.
3 Based on our analysis, the FFCRA model provides
4 greater fiscal relief to states than the GAO model, and to
5 summarize, 42 states would receive an FMAP increase lower
6 than the 6.2 percentage points available under the FFCRA.
7 Next slide.
8 To summarize some of the pros and cons of the GAO
9 model, an automatic FMAP adjustment such as this GAO model
10 has the benefit of not depending on congressional action
11 during an economic downturn. This could potentially
12 provide assistance in a more timely manner. The GAO found
13 that would have happened during the 2008 recession. The
14 GAO formula would have started assistance in January of
15 2008, compared to the October 2008 start date under the
16 American Recovery and Reinvestment Act.
17 The GAO model also relies on the majority of
18 states demonstrating improvement in economic conditions
19 before assistance is turned off, which may ultimately
20 provide better alignment with states' fiscal situations
21 than any congressional mandate. The GAO calculated that
22 the prototype model would have provided assistance through

1 September of 2011, which would have been 15 quarters of
2 assistance had it been in place during the 2008 recession.
3 This is longer than ARRA, which ended in June 2011, and
4 only provided 11 quarters of assistance.
5 We do not know exactly when the financial
6 assistance under the FFCRA will end. It is tied to the
7 Secretary's declaration of a public health emergency. So
8 if the time for recovery extends past the end of the public
9 health emergency then the GAO model could potentially
10 provide more quarters of assistance than the FFCRA.
11 As Moira mentioned, the GAO prototype is designed
12 for typical recessions, which generally begin with a
13 gradual economic slowdown. However, the automatic triggers
14 may not respond quickly enough during these unusually quick
15 and steep economic declines, such as what has occurred
16 during the COVID-19 pandemic, due to the lags of data
17 needed to calculate the FMAP changes. In these unusual
18 cases, congressional action may still be needed to provide
19 a rapid response, even though an automatic mechanism is in
20 place.
21 Next slide.
22 And with that we'll turn it over to the

1 Commission for any questions. We would appreciate any
2 feedback you have on how to proceed with future work. We
3 could publish this analysis with a thoughtful discussion of
4 the design issues raised in some of the earlier memos and
5 Commission meetings, or more fully develop the analysis to
6 support a recommendation to adopt a automatic
7 countercyclical formula. Thank you.
8 CHAIR BELLA: Thank you, Chris and Moira. We're
9 going to open it up to discussion. I think I'd like to
10 stay on sort of the merits of the adjustment more so than
11 sort of the comparisons to FFCRA. I think the comparisons
12 are really helpful. For me, that highlights how you might
13 think about how things could work together, if we did have
14 an automatic trigger and yet we needed something more
15 timely to come through by Congress in a situation like
16 this.
17 But let me first ask, are there any technical
18 questions of Chris or Moira, based on the analysis? Tom,
19 on the analysis, and the Darin, I saw your hand, and Kit
20 and Sheldon. But first question is on the analysis. Tom?
21 COMMISSIONER BARKER: So just, Chris and Moira,
22 real quick, and I'm sorry if I missed this. Do the GAO

1 recommendations have a maintenance of effort requirement?
2 So like FFCRA in 2008 and 2001, FMAP increase had an MOE
3 requirement. Does GAO have one?
4 MS. FORBES: I can look quickly. I don't think
5 they addressed that. I think they were just responding to
6 the question of how would the math of FMAP adjustment work,
7 not what would you wrap around that.
8 COMMISSIONER BARKER: Okay.
9 CHAIR BELLA: Kit, is your question technical or
10 is it a comment? If it's technical, please go ahead.
11 Actually, yeah.
12 COMMISSIONER GORTON: So a couple of technical
13 questions. Based on the memo you sent and then this
14 morning, am I correct in understanding that the GAO model
15 and the model that you talked about last time don't include
16 any adjustments for potential changes in medical expenses?
17 So, for example, in the current issue we have an increase
18 in COVID-related expenditures but then we have this massive
19 decrease in more discretionary care, and I just want to
20 make sure I'm clear that there's really no way to factor
21 those things into the models. And then when you answer
22 that I have one other question.

1 MR. PARK: Sure. We did not factor in any
2 potential changes for this particular pandemic, in terms of
3 increased costs related to COVID-19 related treatments or
4 decreases in utilization due to stay-at-home orders. So we
5 took the 2020 projections and essentially calculated a
6 spending per enrollee measurement for the different
7 enrollment groups, and then just multiplied that by the
8 estimated enrollment increases.
9 COMMISSIONER GORTON: Okay. Thank you. And then
10 my second question is, in this analysis, I'm assuming that
11 you didn't have the opportunity to take it to a level where
12 you could say the GAO model could produce the following
13 disparate effects on racial and ethnic minorities. And is
14 there a way, understanding that it would be an
15 approximation based on proxies, is there a way to sort of
16 say well, okay, if we do it this way, based on the way FMAP
17 is distributed across the states and how the demographics
18 of the states vary, here's what happens if you use the
19 formula the way it was set up.
20 I'll stop with that. That's my point. Am I
21 right that it didn't do -- that you haven't done that, and
22 would it be possible, or would you at least be willing to

1 think about a way to do that going forward?

2 MR. PARK: We did not. We just looked at

3 spending per eligibility group at a high level, so like

4 children, adults, the disabled group, aged, and the new

5 adult group. So we didn't necessarily get down to the

6 specific demographics under each of those eligibility

7 groups, in terms of race or ethnicity. So we could

8 potentially do that. Oh, sorry. Go ahead.

9 MS. FORBES: I was going to say, I mean, one

10 element of the GAO formula, though, is wage and salary, and

11 so to the extent that there's a disproportionate effect on

12 wages and salaries among different ethnic groups, that will

13 show up in the GAO formula. Correct?

14 MR. PARK: Correct, or unemployment as well, if,

15 you know, it affects unemployment in such a way that it

16 could set a larger change in unemployment for a particular

17 state. But one thing we maybe would have difficulty doing

18 is trying to figure out how that would lead to either

19 changes in utilization or spending for different

20 eligibility groups under an economic downturn or this

21 current pandemic. If, you know, utilization changes more

22 for one racial group than another, I'm not sure if we would

1 be able to predict that.

2 CHAIR BELLA: I think it's a really important
3 point, and Kit, I thank you for raising it. We need to be
4 asking ourselves this on all of our work, and I just ask
5 that we go back and think about that, as we think about
6 indicators or impacts. But I do think we're going to be
7 applying that lens to everything we do, but Kit, I
8 appreciate you raising it this morning in this issue.

9 Darin and then Sheldon.

10 COMMISSIONER GORDON: Thanks. Thanks for all
11 this. A couple of questions. So does the Bureau of
12 Economic Analysis, where do they get the wage information
13 from?

14 MR. PARK: I would have to double-check to be
15 certain, but I believe they do a survey of states, of
16 people in the states, to identify what their wages and
17 salaries are, as the basis of the data.

18 COMMISSIONER GORDON: I was curious whether or
19 not they were using wage file information, I mean, because
20 it's always a question for those states who don't have
21 income taxes, where some of that information comes from.
22 So I was curious on that front.

1 Also, in your analysis, and I don't know if this
2 holds true in states across the country, but one of the
3 things we had seen, and I know it does happen in some
4 states, for sure, when an economic downturn happens, you
5 know, you don't immediately see the increases in the rolls,
6 but when it does happen, the recovery, as the economy
7 starts to recover, there's a longer tail on how long
8 [inaudible] Medicaid and retained coverage. But thinking
9 about whether or not that ending mechanism that GAO is
10 contemplating, how does that track with actually the
11 increased rolls that Medicaid is experiencing, you know,
12 from that downturn? Because again, I suspect it's longer,
13 but just don't know how those two track. I don't know if
14 you do either, at this point.
15 MR. PARK: We can take a look at that. One thing
16 that's difficult to tease out is how much of ongoing
17 enrollment changes are reflecting the economic downturn
18 versus general increases in enrollment that just happen
19 naturally over time.
20 COMMISSIONER GORDON: Right. Right. And I'm
21 sure that's even clouded more by the MOE in those prior
22 periods to be able to tease that out. But I do think it's

1 something we need to think about.

2 And then third, do we have any sense -- the whole
3 time when I read the memo and listened to the presentation
4 the question that kept rising, do we have any sense, does
5 GAO explain how they arrived at the adjustment mechanisms,
6 the calibration of that? You know, for every change here
7 we're going to make a change on match here. I mean, is
8 that supported anywhere? Do they detail that out?

9 MR. PARK: They do go into a little bit of their
10 analysis in greater detail as to why they think kind of the
11 ratios they applied are valid in terms of a 1 percent
12 enrollment increase generally corresponds to a 1 percent
13 increase in spending. So they do give a lot more
14 supporting documentation to that.

15 COMMISSIONER GORDON: The reason I was asking is
16 tracking that compared to what we're still, you know, just
17 your analysis, seeing where states are still making
18 substantial cuts in their Medicaid programs, even with the
19 higher match rate makes me wonder if that's calibrated
20 correctly. So I appreciate it.

21 CHAIR BELLA: Okay. We are probably going to run
22 a few minutes over on this issue. There are a few people

1 who would like to speak. I would encourage Commissioners
2 to also be including in your comments your feelings about a
3 recommendation, because that's really what we're trying to
4 drive to here is to get some more understanding of where
5 the Commission is on that.
6 So Sheldon, and then I think, Stacey, I saw your
7 hand, and then Toby, and then Chuck.
8 COMMISSIONER RETCHIN: Can you hear me?
9 CHAIR BELLA: Yes.
10 COMMISSIONER RETCHIN: Okay. Moira and Chris, I
11 really appreciate the work. I've been in favor of a
12 different formula for FMAP during these periods since I
13 joined. And I understand, you know, the goal is to have a
14 thermostat that is not too sensitive but just sensitive
15 enough on both the nose and the tail. And I think that the
16 GAO approach is worthwhile and I would support doing
17 something from the Commission to support that.
18 I've got a couple of questions, though, on the
19 technical side. One is, the pandemic presents a different
20 type of recession, and one difference are the amount of
21 furloughs. Can you tell me how are furloughs view in terms
22 of unemployment figures?

1 MR. PARK: That, I think, I would need to go a
2 little bit further into the BLS's methodology. I know
3 they've been working on it, in terms of how they include
4 that in the unemployment numbers, because I believe we've
5 seen some of the news articles saying that, you know,
6 certain populations may or may not have been counted as
7 unemployed during the particular year. But that was more
8 on the CPS number, so I don't know exactly when they go
9 down to the state unemployment data, exactly how they're
10 handling that, but I can look into that a little bit more.
11 COMMISSIONER RETCHIN: Okay. Just to emphasize
12 or underscore that. That's a very important area, because
13 it's no small number. In April, for example, there were 14
14 million American workers who were furloughed, so that will
15 definitely play a role, especially in something like a
16 pandemic.
17 And then only just technically, when you were
18 talking about the fact that wage and salary and the
19 unemployment were actually additive, but aren't they done
20 in -- wouldn't they be done in series? So if there was a
21 10 percent change in unemployment that would equal a 10
22 percent reduction in the state contribution to the FMAP.

1 Then would the wage and salary reduction in the state
2 contribution be on that or would it be on its base, say
3 from 40 percent as opposed to the 36 percent? Does that
4 make sense?
5 MR. PARK: Yeah. They're calculated separately,
6 so they would be both calculated based on the original
7 state share of 40 percent.
8 COMMISSIONER RETCHIN: Oh, is that right? Okay.
9 Thanks.
10 CHAIR BELLA: Toby. Sorry, sorry. Stacey, then
11 Toby. I got myself out of order. Stacey, please.
12 COMMISSIONER LAMPKIN: Thank you, and thanks,
13 Moira and Chris. I really especially appreciate what this
14 tells us about real-time tracking and the lags in the data
15 and the effect they would have on the formula.
16 I also really appreciated your description of the
17 GAO retroactive look at the 2008 recession and how that
18 would have compared.
19 I'm very sympathetic and interested in a
20 potential recommendation for this kind of methodology, but
21 the piece that I feel like I would still like to understand
22 a little bit better, if they are available and if it's

1 possible to do, is if we were to look over, say, the last
2 30 years, how often this methodology has actually triggered
3 an enhanced FMAP and how does that compare to times that
4 Congress felt like it was necessary to step in and do
5 something. So how sensitive is that trigger if you kind of
6 look out over at a more typical, if there is such a thing,
7 economic period? That would be useful to me to understand.
8 I don't know if that's a possibility.
9 MR. PARK: Sure. I'd have to go back to the
10 original GAO paper, but I do think they did kind of look at
11 this for maybe not 30 years but going back to maybe like
12 2000 or even to the 1990s. But we could do something
13 similar to see how many times that you suggested going back
14 historically to maybe like the 1990s to see if this formula
15 would trigger an FMAP increase and how it matches up to
16 congressional action.
17 CHAIR BELLA: Toby and then Chuck.
18 COMMISSIONER DOUGLAS: Thank you, Moira and
19 Chris. Great analysis.
20 First, in terms of whether we should be coming up
21 with recommendations and presenting the work, I definitely
22 think we need to publish. This is very thoughtful.

1 In terms of recommendations, I definitely see
2 value around triggers because of states' inability or
3 waiting for some type of legislative action.
4 The area where I would ask more questions -- and,
5 Chris or Moira, if you can talk about it -- this issue on
6 revenue. Clearly, the biggest question is, is it hitting
7 the right level of FMAP increase to account for just
8 overall the state's revenue and shifting and policy
9 priorities and other budgets, and why is GAO solely focused
10 on wages and salaries versus looking at sales tax and other
11 types of revenue sources? Because the big question to me
12 would be, Is it hitting the right level of increase based
13 on what's going on overall in the state?
14 MR. PARK: We could certainly talk to GAO about
15 what went into their thinking about exact measures.
16 I know one thing Moira mentioned in earlier
17 presentations is sales tax can be a tricky measure because
18 of how states report collections, not all states have the
19 same level of sales taxes. So it's not clear. When you
20 see changes, is it a reflection of state-level policy of
21 changing the sales tax, or is it a reflection of economic
22 downturns and things like that? So there is a little bit

1 more fluctuation in sales tax and exactly when states are
2 collecting and reporting that information.
3 CHAIR BELLA: Chuck and then Bill and then Craig.
4 VICE CHAIR MILLIGAN: Thank you very much.
5 Really good work.
6 So I think based on how our discussions go over
7 time on this topic, I'm kind of inclined to make a
8 recommendation. I do think that countercyclical is a
9 better starting place for Congress to work off of. I mean,
10 even if something like this was adopted, Congress would
11 still weigh in and adjust or go downward as they see fit,
12 but I think this is a better base.
13 I have one question, and it gets to how this
14 would get scored if it actually turned into legislation.
15 My assumption is that it would get scored off of just
16 normal FMAP rules and not get scored off of historically
17 what's happened in recessions with the 6.2 percent this
18 year and in the 2008 recession. So I wanted to get a sense
19 of whether the GAO version ever got any estimate in terms
20 of a score, and I want to confirm my assumption that if
21 this was offered as legislation, CBO would have to do its
22 best guess at scoring it. So that was my question.

1 MS. FORBES: Well, the GAO proposal wasn't
2 introduced as legislation, so it wouldn't have been scored,
3 but we do have a note that if the Commission is interested
4 in moving forward that we do need to follow up with CBO and
5 have a conversation with them about how they would score
6 it. I don't know that they will give us a score to bring
7 back to the next meeting, but we would at least have a
8 sense of “would this have to get a number?” and we would at
9 least have some information the next time we came back.
10 VICE CHAIR MILLIGAN: Okay. Just one quick
11 follow-up, and then I'll stop. My assumption is it's
12 likely to be a big number then because it's going to be
13 against the baseline rules and not the ad hoc adjustments
14 that get made, like the Families First Act this year. So I
15 just want to sensitize all of us to that possibility.
16 CHAIR BELLA: Okay. Thank you, Chuck.
17 Bill, then Fred, then Peter.
18 COMMISSIONER SCANLON: Well, first, let me say a
19 quick response to Chuck. I'm not sure it would be a big
20 number because CBO's score is based upon what they project,
21 and if this was 2009 and they had perfect foresight and
22 there was a 10-year projection, the score would have been

1 zero because there would have been no recessions.

2 I mean, I think it's going to be an incredible
3 challenge for CBO to say over the next 10 years, this is
4 what we expect is going to happen in terms of the business
5 cycle because people virtually have never been very good at
6 projecting a business cycle, so there's that.

7 I want to say also I think this is incredibly
8 useful information, and I'm very supportive of a
9 recommendation. I'll go back to what Melanie said at the
10 very outset. I think the contrast here or the comparison
11 here shouldn't be less about COVID and sort of -- and the
12 FFCRA and more about the historical problem of we've needed
13 more timely adjustments of the FMAP to deal with recessions
14 repeatedly.

15 And it's true that Congress in the past has acted
16 sometimes not that quickly, but in the case of COVID sort
17 of very quickly and potentially has acted sort of more
18 "generously" -- I'll use the word -- and -- but they always
19 have that option of adding on something, whereas an
20 automatic sort of adjustment would be sure that sort of
21 relief is coming sort of when the economic conditions
22 change kind of as quickly as reasonably as possible.

1 I like the GAO approach in, one, that it's
2 automatic, two, that it's targeted. It's got rules for
3 phase-out. I have some questions about the phase-out in
4 terms of whether or not when one is in a longer recession,
5 sort of multi-years, whether the phase-out needs to be sort
6 of delayed in some ways, given that we haven't restored
7 economic activity as much as it was sort of before the
8 start of a recession.
9 I also want to underscore the idea that GAO used
10 employment in some places as the measure as opposed to
11 unemployment, and this gets not quite to what Sheldon was
12 talking about in terms of furloughs, but it gets to the
13 more traditionally discussed issue of the discouraged
14 worker, that unemployment is people that are looking for a
15 job and haven't been able to find one. That doesn't
16 include people that have just given up because there are no
17 jobs out there. So employment tells us exactly what the
18 level of employed activity is and can actually probably be
19 a better measure to use for both the trigger and for the
20 targeting.
21 Again, I'm very much in favor of us doing a
22 recommendation here because I think it's been an

1 historically important problem and again not tying it too
2 much to COVID because hopefully COVID will become history.
3 I don't want us to lose the memory of it. There's a need
4 to do this, regardless, for the future.
5 CHAIR BELLA: Thank you, Bill.
6 Fred and Peter, and then we're going to wrap this
7 one up.
8 COMMISSIONER CERISE: Okay. Thanks.
9 I have a technical question and then a comment,
10 but my question is kind of as Bill was indicating. On the
11 trigger to turn off the enhanced FMAP, in the GAO model,
12 it's that you're no longer seeing a decline. So if you see
13 a steady decline and then it just flattens out, it doesn't
14 come back, as long as it's not declining, that's going to
15 turn off the enhanced FMAP? Is that correct?
16 MR. PARK: That's correct. It's basically the
17 opposite of the trigger to start the adjustment. It kind
18 of depends on how it moves along with the baseline since
19 it's comparing to the prior year. So as long as 26 states
20 don't show that improvement in that employment to
21 population ratio, it will keep going. So it may go on for
22 a while, and it has to be two consecutive months. So it's

1 possible that you could hit one month where the ratios are
2 better, but if it doesn't have that two-consecutive-month
3 period, then it wouldn't necessarily turn off.
4 And then the other thing to mention is that the
5 FMAP increase would extend to the beginning of the fiscal
6 quarter -- or to the end of the fiscal quarter when the
7 trigger was met. So if it was met in April, the FMAP
8 increases would go on until June.
9 COMMISSIONER CERISE: It's not a decline, but
10 it's a reduction in comparison to the baseline, or it's
11 actual quarter to quarter?
12 MR. PARK: To the prior year. They're always
13 looking in terms of an increase or decrease in the rolling
14 three-month average of employment to population ratio
15 compared to the prior year.
16 COMMISSIONER CERISE: And my comment is just to
17 echo what some of the others have said. I think it makes
18 sense to have something in place before you need Congress
19 to act and make it up in the moment. So I think it's good
20 to have something thoughtful in place that will trigger
21 under the right circumstances. So I would favor that.
22 CHAIR BELLA: Thank you, Fred.

1 Peter?

2 COMMISSIONER SZILAGYI: Yeah. I just want to
3 briefly weigh in and support both a publication -- Chris
4 and Moira, I thought this was beautifully presented and
5 very elegant and nicely done, and a publication would be
6 important. And I've always felt the need for an automatic
7 countercyclical financing arrangement and just to point out
8 that obviously it doesn't stop Congress from acting.

9 I also want to point out that we always expected
10 a pandemic to come. We just didn't expect a coronavirus
11 pandemic. So an influenza pandemic is coming. We just
12 don't know which year. So I do think that we have to sort
13 of think about these countercyclical measures as not only
14 dealing with the typical recession but future pandemics
15 because I expect, even in my lifetime, we're going to have
16 multiple pandemics, unfortunately, to deal with.

17 CHAIR BELLA: Well, on that rosy projection into
18 the future, Peter -- Moira and Chris, thank you for this
19 work.

20 I am very supportive of a recommendation. This
21 is something that has been talked about for many years, and
22 I would love to see us actually act on it and put something

1 forward.

2 There are a couple of follow-up things that you

3 may or may not be able to drill into. Do you have what you

4 need from us in terms of the desire of the Commission and

5 what you might bring back to us either next month or in

6 December that we would be working toward for a March

7 recommendation?

8 MS. FORBES: Yep. Think so.

9 MR. PARK: Yep.

10 CHAIR BELLA: All right. Thank you both very

11 much. Really timely and really great work.

12 We are now going to turn it to a couple of COVID-

13 related topics, the first one looking at funding for

14 providers that have been affected by the pandemic.

15 Michelle and Rob are going to lead us through this session.

16 We are running a little bit late, but we tend to

17 make up time. This is an important topic. So don't feel

18 rushed, but we'll see if we can make up a little bit of

19 time on this one and the next one, but certainly want to

20 make sure we get to the heart of all that you have to

21 share.

22 So thank you for being here, and I'll turn it

1 back over to you.

2 ### RELIEF FUNDING FOR MEDICAID PROVIDERS AFFECTED BY

3 **THE COVID-19 PANDEMIC**

4 * MS. MILLERICK: Thank you, Melanie. Good

5 morning.

6 Today Rob and I are going to provide an update on

7 federal relief funding for Medicaid providers affected by

8 the COVID-19 pandemic.

9 Just waiting for the mouse to click over.

10 [Pause.]

11 MR. BOISSONNAULT: Let's go with you pronouncing

12 "next" for the time being.

13 MS. MILLERICK: Okay. Thanks, Jim.

14 Next, please.

15 First, we will review available data on the

16 effects of the COVID-19 pandemic on provider finances with

17 a particular focus on the experience of safety net

18 providers. Then we will discuss the distribution of the

19 federal provider relief funding to date, with a focus on

20 the provider relief fund created by the CARES Act.

21 In April, the Commission sent two letters raising

22 several concerns about initial distributions of provider

1 relief funding, so we will examine available data about the
2 extent to which the Commission's prior concerns have been
3 addressed.
4 In addition, we will discuss Medicaid payment
5 authorities that states are using to help ensure the
6 stability of Medicaid providers as well as other options
7 for provider relief funding during the pandemic.
8 We welcome Commission feedback on how this work
9 can inform our future work on Medicaid provider payment,
10 and so we will conclude by talking about potential next
11 steps for work in this area.
12 Next, please.
13 The novel COVID-19 pandemic has created financial
14 strains for many health care providers because of the
15 increased cost of preventing the spread of COVID-19 and
16 treating patients with virus-related illnesses. At the
17 same time, disruptions to the health care delivery system
18 has resulted in steep declines in revenue.
19 Some providers have been able to offset some lost
20 revenue from in-person visits by increasing the use of
21 telehealth services, but total visits appear to remain
22 below pre-pandemic levels.

1 Next slide, please.
2 To get a sense for how overall health spending
3 has changed, we took a look at monthly health care spending
4 by sector reported by the Bureau of Economic Analysis and
5 how this changed since January 2020.
6 As you can see in this figure, health spending
7 declined sharply for most sectors in March and April when
8 many states imposed stay-at-home orders. Spending appears
9 to have rebounded to some degree for many provider types
10 beginning in May when some stay-at-home orders were lifted.
11 As you can see, nursing home care, which is the
12 solid light blue line at the top of the figure, appears to
13 be an exception to this trend, where spending on nursing
14 home care increased slightly during initial months of the
15 pandemic, but has since declined as other sectors
16 rebounded.
17 Overall, nursing facility occupancy rates have
18 fallen approximately 10 percent since the start of the
19 pandemic and are expected to remain low for the foreseeable
20 future.
21 Safety net providers that serve a high share of
22 Medicaid and uninsured patients are particularly vulnerable

1 to the effects of the pandemic for several reasons. First,
2 prior to the pandemic, many Medicaid providers had lower
3 operating margins than providers serving a higher share of
4 commercially insured patients. Second, Medicaid providers
5 serve populations that have been disproportionately
6 affected by the COVID-19 pandemic, including people of
7 color and individuals in need of long-term services and
8 supports. And finally, Medicaid providers by nature are
9 relying on payments from states whose budgets may be
10 increasingly strained.
11 Further, the most recent available data on
12 outpatient utilization suggests that visits by Medicaid
13 enrollees have not recovered as much as other payers,
14 including commercial and Medicare. One reason may be
15 because many Medicaid enrollees are children, and the data
16 show that visit volume for pediatrics has declined more
17 than adult volume compared to pre-pandemic levels.
18 The CARES Act and other federal legislation has
19 provided funding for health care providers related to the
20 COVID-19 pandemic through a number of vehicles. In
21 particular, the CARES Act created a $100 billion provider
22 relief fund that was later increased to $175 billion by the

1 Paycheck Protection Program and Health Care Enhancement
2 Act.
3 The statute provides the Secretary of Health and
4 Human Services with broad authority to determine which
5 providers are eligible for funding and how much funding
6 providers will receive. To date, HHS has allocated $122.9
7 billion through a variety of different distributions.
8 Initial distributions from the Provider Relief
9 Fund in Phase 1 prioritized making payments quickly over
10 providing funds in a targeted manner. Overall, a total of
11 $50 billion was allocated to Medicare-enrolled providers in
12 Phase 1 based on their net patient revenue.
13 Subsequently, HHS has made a series of targeted
14 funding distributions totaling approximately $57.9 billion
15 for safety net hospitals, nursing facilities, rural and
16 tribal providers, as well as funds for hospitals who have
17 received a high number of COVID-19 admissions.
18 In June, HHS announced a Phase 2 general
19 distribution of $15 billion for Medicaid and CHIP providers
20 who are not enrolled in Medicare and therefore were not
21 eligible for Phase 1. Applications for Phase 2 funding
22 were initially due in July, but the application window was

1 extended several times and recently closed on September
2 13th.
3 As of August 25th, $76.9 billion has been
4 distributed to providers who attested to the terms and
5 conditions to accept relief funding.
6 There is very limited data available about
7 provider relief funding that has been spent to date, but
8 now I'm going to turn it over to Rob to share some of our
9 preliminary findings about the extent to which funding has
10 been targeted to safety net providers.
11 * MR. NELB: Great. Thanks, Michelle.
12 So, first, we're going to look at the Phase 2
13 general distribution which went to Medicaid and CHIP
14 providers that are not involved in Medicare.
15 One of the challenges in making payments to these
16 providers is the fact that the federal government doesn't
17 have complete provider enrollment information on Medicaid
18 providers because Medicaid is administered by the states.
19 To address these challenges, HHS asked states to
20 provide a list of Medicaid-enrolled providers and then
21 compared that information to information available on T-
22 MSIS and the list of Medicare-enrolled providers that we

1 see funded in the first distribution.
2 Overall, HHS estimated that about 38 percent of
3 Medicaid and CHIP providers were potentially eligible for
4 this phase 2 general distribution. These include many
5 home- and community-based service providers, dentists, and
6 pediatricians that serve a high share of Medicaid patients,
7 but are often not enrolled in Medicare because Medicare
8 doesn't cover all of these services.
9 Unlike the initial Medicare distributions, which
10 were made automatically to providers based on
11 administrative data, in the Phase 2 general distribution,
12 providers needed to apply and submit detailed financial
13 information in order to prove that they are eligible.
14 We don't yet have complete information on all the
15 providers that applied as of September 13th, the deadline,
16 but according to some preliminary estimates from HRSA, the
17 application rate has been low.
18 First, looking at the tax identification numbers
19 of provider organizations that were identified as
20 potentially eligible, it looks like only about 14.8 percent
21 had applied as of August 30th.
22 It's important to note that some of the providers

1 on HRSA's list that were identified as potentially eligible
2 may not in fact be eligible for a variety of reasons, but
3 at the same time, we also see that spending on the Phase 2
4 distribution has been lower than expected.
5 As of September 11th, only $2.2 billion of the
6 $15 billion allocated had been paid to Medicaid and CHIP
7 providers.
8 So this next slide looks at the distribution of
9 relief funding to hospitals that did get paid using some
10 estimates that we developed using available data in
11 Medicare cost reports.
12 Here, we have the amount of funding to deemed DSH
13 hospitals, which are statutorily required to receive DSH
14 payments based on the high share of Medicaid and low-income
15 patients. In the left column, we show funding under the
16 general distribution, which was equal to 2 percent of
17 providers' net patient revenue. Because deemed DSH
18 hospitals often have lower margins than other types of
19 hospitals, deemed DSH hospitals received relatively less
20 funding when compared to hospitals' operating expenses.
21 However, subsequent targeted distributions from
22 the relief fund resulted in relatively more funding per

1 deemed DSH hospitals in the aggregate. Overall, we
2 estimate that they received funding equal to about 6.8
3 percent of their operating costs, which is higher than that
4 of other providers.
5 One last note on this slide is that of all the
6 different types of hospitals that we examined, rural
7 hospitals seemed to receive relatively more than other
8 types, and this is primarily due to the targeted funding
9 that was directed towards them.
10 So moving on, another way to examine relief
11 funding is by comparing the total amounts of payments that
12 providers received to the losses that they experienced
13 early on in the pandemic. MedPAC's preliminary analyses of
14 these issues suggest that relief funding combined with some
15 of the additional Medicare payment changes have been
16 sufficient to offset several months of losses in the
17 aggregate for several types of providers.
18 Specifically, MedPAC estimates that hospitals
19 have received funding sufficient to offset about three to
20 five months of April-level losses, and that nursing
21 facilities have received funding able to offset about eight
22 months of losses in the aggregate.

1 There's not as much data on the financial status
2 of physicians and other clinicians, but according to
3 MedPAC's estimates, more than half of lost revenue for
4 clinicians has been offset by the relief funding.
5 It's really important to note that these analyses
6 are averages, and that the experiences of specific types of
7 providers may vary.
8 Unfortunately, though, it's a bit too early to
9 examine relief funding at the provider level because we
10 don't yet have complete provider-level financial data, and
11 in addition, HHS has not made provider relief data
12 available at the provider level in a format that enables
13 analysis.
14 So in addition to the federal relief funds,
15 states are using a variety of existing Medicaid payment
16 authorities to help support Medicaid providers during this
17 pandemic.
18 In fee-for-service, there's a lot of different
19 options that states can use, including advanced or interim
20 payments to address cash flow issues and increases to base
21 or supplemental payments to help offset some of the
22 increased costs of care during the pandemic.

1 In managed care, states have fewer options, but
2 they can direct managed care plans to pay providers
3 according to specific rates or methods.
4 One limitation of all these payment options is
5 that Medicaid payments generally must be tied to
6 utilization of Medicaid services, which makes it difficult
7 to use Medicaid funding as a vehicle to help offset lost
8 revenue from declines in utilization like those that many
9 providers experienced early in the pandemic.
10 One exception is an option known as a "retainer
11 payment," which is an additional payment intended to ensure
12 access to a provider during a temporary drop in
13 utilization. Currently, CMS only allows retainer payments
14 for HCBS providers, and many states have taken up this
15 option.
16 Some states have also requested the ability to
17 make retainer payments for other types of providers, but
18 CMS has not yet approved these requests.
19 Lastly, I just want to note that states and local
20 governments can also use grant funding provided by the
21 CARES Act to make additional payments to health care
22 providers. Overall, about $150 billion in grants were

1 authorized for expenses related to the public health
2 emergency. This includes many costs that are not health-
3 related. As of June 30th, about $36 billion of this
4 funding had been spent, and based on a review by the
5 National Conference of State Legislators, at least 11
6 states have directed approximately $855 million in targeted
7 relief payments to health care providers.
8 Because CARES Act grants are not subject to
9 Medicaid rules, states can use this funding to pay for non-
10 Medicaid costs, as well as the cost of care for uninsured
11 individuals that can't normally be covered by Medicaid.
12 That concludes our presentation for today. We
13 welcome your feedback for future work in this area. As I
14 mentioned, the data is pretty limited, but we do plan to
15 continue to monitor these programs as more data become
16 available. We also have some work underway looking at how
17 hospitals and nursing facilities have been affected, and we
18 could look more closely at the experience of other provider
19 types if data are available.
20 Finally, if there is Commissioner interest, we
21 can further explore the barriers and opportunities to using
22 existing Medicaid payment authorities to help ensure the

1 stability of safety net providers, and we can consider
2 whether there's any new authorities that might be needed.
3 So thanks and I look forward to your questions.
4 CHAIR BELLA: Thank you, Rob, thank you,
5 Michelle.
6 I'm looking for hands. Sheldon and then Peter,
7 then Kathy and Chuck. Sheldon.
8 COMMISSIONER RETCHIN: Yeah, thanks, Rob and
9 Michelle. That's a very important focus, and the report
10 was really illuminating.
11 I just want to point out something that's -- I
12 don't know where we'll be talking about this later, but the
13 relief funds to a long-term-care facility and the 10
14 percent drop in the number of residents I think has not
15 returned. I don't know -- I'm sure all Commissioners
16 realize this, but more than 40 percent of deaths due to
17 COVID have been in long-term-care facilities.
18 Put another way, about 80,000 residents of long-
19 term-care facilities have expired, so that about 6 percent
20 -- it's about 6 percent that have not have only gotten the
21 infection, but have actually died. So I don't know whether
22 that explains -- it explains a fair amount of those that

1 have not [inaudible].

2 CHAIR BELLA: Peter.

3 COMMISSIONER SZILAGYI: Thanks, Rob and Michelle,
4 for a very nice presentation. I have two questions. One
5 has to do with the issue of delay in obtaining Medicaid
6 enrollees. Are there ways in the future to make that a
7 factor or process or develop some sort of a mechanism
8 whereby that could be obtained quickly? And then my other
9 question is: I do favor looking more into provider-level
10 reimbursement, and I was just wondering what are the data
11 exactly that we need to be able to analyze that better.

12 MR. NELB: Sure. I can take a stab at that. So
13 the T-MSIS data that the federal government collects from
14 states ideally would have, you know, information on
15 providers that are enrolled in Medicaid, and HHS did use
16 that data in identifying the eligible providers. And most
17 of the providers identified by the states sort of matched
18 with T-MSIS, but some didn't. So I think in terms of data
19 opportunities, there may be ways to better improve that T-
20 MSIS file.

21 But there may just be kind of an operational
22 challenge there where the states are the ones that have

1 that relationship with providers and are sort of more on
2 the ground, and so having the federal government distribute
3 the funding versus the states may have also been a sort of
4 barrier there.
5 In terms of your other question about specific
6 types of providers, you know, we'll do the best with
7 whatever data we can find. I think in your feedback it's
8 helpful if there's particular types of providers you'd like
9 to look at, we can explore what data is available and bring
10 back to you what we can.
11 COMMISSIONER SZILAGYI: Again, I was thinking
12 about primary care providers, in particular, family
13 medicine, pediatric, primary care providers, which serve a
14 very large proportion -- I mean, which, you know, obviously
15 serve all of the Medicaid enrollees.
16 CHAIR BELLA: Thank you, Peter. Kathy and then
17 Chuck and then Tricia and Toby and Kit and Fred. Kathy.
18 COMMISSIONER WENO: Yeah, thank you so much for
19 this, especially the inclusion of the dental providers in
20 this. This is something that has been of great interest to
21 me. You know, in most states for a fair amount of this
22 quarantine period, dentists were required to close and only

1 did emergency treatment, so a lot of staff lost their jobs.
2 A lot of financial loss for dental practices. And, you
3 know, obviously Phase 1, with dentists not being Medicare
4 providers, they were pretty much shut out of any sort of
5 relief.
6 With Phase 2, dentists that were not Medicaid
7 providers were allowed to get some of the funding, and I
8 was wondering if there was any way to know, you know, what
9 proportion of dentists were applying for that that were
10 just Medicaid providers versus non-Medicaid providers.
11 MR. NELB: Yeah, according to some of the
12 preliminary data, about a third of -- you're right that all
13 dentists are eligible for that Phase 2 distribution. We
14 looked at the Medicaid-specific part, and about a little
15 more than a third of dentists nationwide seem to be part of
16 that Medicaid portion. But, presumably, the other
17 dentists, you know, could have applied through the other
18 mechanism.
19 COMMISSIONER WENO: Okay. Thank you.
20 CHAIR BELLA: Chuck and then Tricia.
21 VICE CHAIR MILLIGAN: Thank you. Thanks for the
22 presentation and catching us up on all this. I have a

1 comment, and then I do have a suggestion about the future
2 work and analysis.
3 The comment is that I'm really concerned that
4 there's a second phase of provider distress that we're
5 going to run into, which is when the enhanced FMAP ends,
6 which could end as early as the end of December, states are
7 likely to find themselves in a lot more fiscal distress
8 because of the loss of the enhanced FMAP, and the response
9 might be cutting provider rates and exacerbating some of
10 the provider revenue stress, and that would have
11 implications on access and capacity.
12 So I don't know the methodological way to get at
13 this, but I think it's going to be important to try to
14 track provider availability and provider revenue stress
15 kind of beyond the CARES Act-related funding as we prepare
16 for likely state responses to cost containment kind of
17 coming out of the enhanced FMAP. And, again, I don't know
18 how to track that provider participation or access or
19 utilization, but I think there's going to be more stress in
20 the system to come.
21 Thank you.
22 CHAIR BELLA: Tricia, then Toby.

1 COMMISSIONER BROOKS: Yes, thank you. I want to
2 echo Peter's comments about drilling down on primary care
3 providers. We know that health care for kids has not
4 rebounded at the same rate as other providers, and there
5 are huge concerns over immunizations and one outbreak,
6 possibly another outbreak. So I definitely want to echo
7 that, as well as behavioral health. As we know, there's an
8 increased need there.
9 My question is that based on the preference list
10 we had, I think the deadline for applying for the grants
11 has passed. Do we have any idea how many applications are
12 in the process? Because it's sort of disturbing that so
13 little of that fund has been actually distributed.
14 MR. NELB: Yeah, we don't yet have the final
15 data, but we'll continue to monitor it and can get it to
16 you. I think looking at the -- as Michelle mentioned,
17 because the initial deadline was in July, most of the
18 applicants submitted in July-August. So it's sort of
19 unlikely that the last couple weeks of September, you know,
20 made a big difference in the total application rate.
21 CHAIR BELLA: Anything else, Tricia?
22 COMMISSIONER BROOKS: I just wanted to follow up

1 on that. I mean, it seems to me -- I know that we heard
2 from the pediatric community that, you know, they were
3 asked to submit data very rapidly and, you know, may have
4 had difficulty in doing that. I wonder if it also would be
5 in order for the Commission to recommend that it be
6 reopened for application.
7 CHAIR BELLA: Do we know -- I'm sorry. Do we
8 have a good sense of why people aren't applying?
9 MR. NELB: We don't. I think one of the
10 challenges is just the complexity of the application
11 process, but then another challenge is sort of figuring out
12 exactly who's eligible and who's not, because many
13 providers are sort of part of larger organizations that
14 maybe applied through the first phase or other ways that --
15 again, that list of potentially eligible providers may be a
16 bit off. And then it -- yeah, I think in addition there's
17 also other relief funding that providers have been
18 receiving from the Paycheck Protection Program and other
19 pieces, and so there may be some concern about sort of the
20 accounting of how these different funds come together and
21 maybe concern about providers with sort of managing some of
22 the different paperwork. But these are just sort of

1 guesses right now, and that's something we can definitely
2 look into more.
3 CHAIR BELLA: Okay. Toby and then Kit and then
4 Fred.
5 COMMISSIONER DOUGLAS: I definitely would agree
6 that we should do some more --
7 CHAIR BELLA: Toby, we're having a hard time
8 hearing you.
9 COMMISSIONER DOUGLAS: Can you hear me now?
10 CHAIR BELLA: Yes.
11 COMMISSIONER DOUGLAS: Okay. I definitely think
12 we should do further analysis on specific provider types.
13 I do also want to just build on what Chuck's saying about
14 the significant implications long-term on providers given
15 just the change in how we know all individuals, including
16 Medicaid, are going to be receiving services, and this
17 intersection with the ability of Medicaid providers to take
18 on sub-capitation or global risk payments. So whether in
19 this body of work or in a different one, I do think we
20 should be assessing what are the challenges and ways that
21 payment, whether it's investments or others, can move
22 providers to taking on risk-based payments where they're

1 able to then have the infrastructure to do telehealth and
2 other modalities, or else we're just going to have this
3 continual downward cycle impacting providers, whether it's
4 with rate cuts or their inability to get reimbursed for new
5 modalities or take on risk.
6 CHAIR BELLA: Thank you, Toby. I want to remind
7 all of us that it's more helpful, it's most helpful to
8 these guys if we can be very specific about additional
9 analysis we want to be doing. So I think, you know, we all
10 love analysis, but let's -- in your comments, try to please
11 be very specific about what you think we want to see if
12 they could learn more about. And, Toby, this is in
13 relation -- this is not a dig on you. It's just saying you
14 said we want -- yes, we should keep doing analysis, and
15 it's sort of like, "Of what?" And so you did get more
16 specific at the end. I'm just reminding --
17 COMMISSIONER DOUGLAS: You can dig me. That's
18 okay.
19 CHAIR BELLA: Yeah. Kit and then Fred.
20 COMMISSIONER GORTON: Okay. So two very specific
21 questions for future analysis, the first being: Can you
22 look into whether or not the state budget processes

1 potentially were one of the barriers, particularly in
2 states that do biennial budgeting? I'd be interested in
3 whether -- you know, in many states you can get federal
4 money, but it then has to be appropriated. And I would be
5 interested in knowing whether that caused any of the
6 difficulty here, particularly in the biennial states.
7 And then the second question is I'd be interested
8 in hearing about Puerto Rico and the territories in terms
9 of what help did they get, how did it relate to the
10 impacts, or did we just assume that they get their annual
11 grant and they were done.
12 CHAIR BELLA: You guys have any comment on that
13 now or will you just take that back?
14 MR. NELB: We can take that back. I believe the
15 providers in the territories were eligible for relief
16 funding, but I will double-check that.
17 CHAIR BELLA: Anne?
18 EXECUTIVE DIRECTOR SCHWARTZ: Yeah, I was just
19 going to say that the mechanism of the CARES Act goes
20 directly from the federal government to the providers and
21 doesn't go through the states and doesn't require a match,
22 just to clarify that. In fact, there was some suggestion

1 that a quicker way to do it would have been to give chunks
2 of money to the states to distribute, and the legal ruling
3 on that within the department was that they couldn't do
4 that.
5 CHAIR BELLA: Thank you. Fred.
6 COMMISSIONER CERISE: Yeah, it might have been
7 that, or they push out a lot of money fast, and so, Rob and
8 Michelle, I'm wondering if you've looked at some of the
9 regulatory guidance that's coming out. You know, even last
10 weekend, there's new guidance and the rules are changing as
11 it seems like we're trying to catch up with the
12 distribution. And so, specifically, you know, one of the
13 things I've seen over the past week or so is some large
14 systems starting to change course on expenditures like, you
15 know, instating COVID bonuses, paying for time that was
16 previously furloughed. These are systems that had laid off
17 people and are reinstating contributions to pension plans
18 and things like that, and it feels like there's kind of a
19 spend-it-or-lose-it mentality that may be going on right
20 now, and I'm not sure -- you know, because I know the rules
21 have changed around -- you've got to show cause, you've got
22 to show lost revenue. Are you going to be eligible based

1 on both of those things? And with the regulatory guidance
2 shifting on that, it seems like they're maybe creating some
3 unintended consequences there. And so if that's something
4 that you could take a look at, I think it would be helpful.
5 CHAIR BELLA: I see heads nodding. Okay. Do I
6 see any other hands from Commissioners? Then I have a
7 couple of last comments. No. Okay.
8 I do think a couple things. One, kind of what we
9 could keep looking at on the data front. I do think Toby's
10 point about what can we do to set up providers to have more
11 value-based or up-front payments is an important one.
12 There's been lots of -- there have been several provider
13 practices that are in value or capitated arrangements
14 talking about how that has gotten them through this and how
15 it allowed them to make investments and sort of retain some
16 of that infrastructure. So I don't know that there's
17 anything that we can analyze there. I think keeping that
18 in mind as to how we proceed-- you know, if there's
19 anything to learn from that, I think that would be
20 important.
21 I also think if there is anything to learn about
22 confirming what some of the barriers have been, that might

1 influence whether we would want to do something like Tricia
2 suggested about suggesting that we reopen or extend any of
3 the deadlines that have passed. Again, realizing that all
4 of this stuff may not be available.

5 And then I don't -- no one has mentioned it, but
6 I don't want to lose sight of a really important piece of
7 what you raise about the authorities and is there value to
8 the Commission looking at what can be done with existing
9 authorities or where states might need new authorities.
10 And I guess I would say that personally I don't feel like I
11 have enough knowledge of what the states think they need.
12 Certainly I've heard the most about retainer payments and
13 opening that up to other provider types. But I would ask,
14 as you all talk regularly with NAMD and NGA and Advancing
15 States and others, I would ask that we keep this question
16 in mind, and we're trying to gather information about where
17 we think the states might benefit from the Commission
18 weighing in on any type of policy recommendations regarding
19 Medicaid authority. And I don't know if there's anything
20 you want to say to that now. I think that's an important
21 piece that I don't want to let slip.

22 Okay. Michelle, I also forgot to say at the

1 outset welcome. Welcome to MACPAC, and thank you for your
2 comments, both you and Rob today.
3 MS. MILLERICK: Thank you.
4 CHAIR BELLA: So we are done with this session.
5 We have one more before lunch, which is Joanne is going to
6 update us on Medicaid's response to COVID, so it's another
7 COVID, and then I'll just let the folks in the public know
8 we'll be taking public comment at the end of this session
9 for everything we talked about this morning. So if you do
10 have a comment, there will be an opportunity for you to
11 address the Commission at the end of this presentation.
12 So, Joanne, welcome. I don't see you yet.
13 Ah, welcome. There you are.
14 **### UPDATE ON MEDICAID'S RESPONSE TO COVID-19**
15 * MS. JEE: Here I am. Okay. So you guys can see
16 and hear me, and that's a good thing. Let me just click on
17 the slides. All right.
18 In this session I'm going to provide you all with
19 a quick overview and updates on Medicaid's response to
20 COVID, and it's me making the presentation, but I wanted to
21 be sure to say that Kacey, Kayla, and Erin were big
22 contributors to the memo, and so I just wanted to make sure

1 that you all knew that.

2 Okay. So the first thing I'll do for you this
3 morning is just provide a very quick recap on MACPAC's work
4 so far in Medicaid's response to COVID. Then I'm going to
5 highlight some information that we heard from states
6 regarding their experience in responding to COVID,
7 particularly with respect to telehealth, substance use
8 disorder treatment, and home and community-based services.
9 And as you recall, those were areas that sort of emerged
10 early as priorities, both for CMS and the states. I'm
11 going to just do some very quick updates on nursing
12 facilities and then provide a little bit of information on
13 racial and ethnic disparities.

14 Okay. So at the April Commission meeting you
15 will recall that staff presented on the flexibilities that
16 states were using in their response to COVID. At the time,
17 states were very busy submitting and trying to win approval
18 for their state plan amendments, various waivers, and
19 Appendix K modifications for home and community-based
20 services. Again, we talked about the priorities that
21 seemed to emerge for both CMS and states. And we talked
22 about the federal funds that were available to support

1 states and providers, and those were the 6.2 percentage
2 point increase to the FMAP and the provider relief funds,
3 which you were just discussing.
4 During that meeting, Commissioners, you raised
5 the question of whether certain flexibilities that came to
6 be during the pandemic ought to be retained after the
7 emergency or made permanent. Building on your discussion
8 in April, we sent a few letters with respect to the
9 provider relief fund and one in August to the Secretary
10 regarding the public health emergency, in that letter you
11 emphasized the need for early notification on whether, you
12 know, when the PHE, the public health emergency would end
13 or whether it would be extended, and the need for guidance
14 to states on expectations and requirement for the return to
15 normal operations.
16 We also put together a catalog of state
17 telehealth policy changes in response to COVID, and all of
18 these materials are available on MACPAC webpage on
19 Medicaid's response to COVID, which is also new.
20 Okay. So moving on to telehealth, as you know,
21 states quickly expanded their use of telehealth at the
22 onset of the pandemic. These expansions occurred across

1 specialties, provider types, and modalities, and based on
2 information coming from state so far, the use of telehealth
3 has been received favorably, and in particular, this would
4 be the use telephonic telehealth as well as tele behavioral
5 health.

6 We are beginning to get some information from
7 states, as I said, and the state anecdotes indicate that
8 the use of telephone telehealth and tele behavioral health
9 services and the individuals using those services made up
10 very large shares of the overall increase in use of
11 telehealth. States are beginning to think about how they
12 want to use telehealth in the future, once the PHE ends,
13 including a couple of states, New York and Ohio, that have
14 taken some steps already to make certain of their
15 flexibilities permanent. Other states, North Carolina
16 comes to mind, are looking at their available data to
17 understand what those data say about what makes the most
18 sense for them and where it would be most beneficial to
19 retain telehealth flexibilities.

20 For states that do wish to retain telehealth
21 flexibilities after the emergency there are a number of
22 considerations that could affect the state, beneficiary,

1 and provider experience with the use of telehealth. They
2 are listed on your slide, but for example, these include
3 equitable access to telehealth, including broadband and
4 technologies, privacy concerns, and the limitations of
5 telehealth, you know, what telehealth can and cannot
6 accomplish.
7 So moving on to substance use disorder treatment,
8 or SUD, I'll just sort of hang on the telehealth thread for
9 a little bit longer. States really leveraged telehealth
10 technologies, as I said, to maintain access to substance
11 use disorder treatment as well as medications for opioid
12 use disorder, or MOUD. And again, the reports from states
13 are that there is a high degree of satisfaction with using
14 telehealth for these services. Anecdotally, we heard that
15 one state said that the no-show rates for telehealth visits
16 was lower than for visits in person, and that some
17 beneficiaries actually feel more comfortable using
18 telehealth for their SUD services than they are using in-
19 person visits.
20 Most states are also allowing opioid treatment
21 programs, or OTPs, to provide take-home doses, and you will
22 recall that typically take-home doses are very tightly

1 regulated, but during the PHE, OTPs are able to provide
2 longer take-home doses.
3 And there are, again, numerous considerations for
4 states wishing to retain these flexibilities for these
5 services. I think it's important to note that a lot of
6 these relate to policies that are external to Medicaid.
7 Certainly they affect Medicaid, but they are things such as
8 the Drug Enforcement Administration, or the DEA's rules
9 related to prescribing, related to telehealth, and then
10 there are SAMHSA rules with respect to OTPs, take-home
11 doses.
12 Moving on to LTSS, long-term services and
13 supports, states are using a variety of authorities to
14 maintain access to LTSS during the PHE. Most of those end
15 with the PHE, or in close proximity to the end of the PHE.
16 However, Appendix K, which I just want to flag for you,
17 they last a little bit longer. They are effective for one
18 year past the implementation date but no longer than March
19 2021. So there's a little bit more time for states to
20 learn and analyze data on how those flexibilities within
21 the Appendix K's worked out for them and beneficiaries, and
22 that can inform which of those flexibilities they want to

1 retain going forward.

2 There is some interest that we're hearing about
3 in terms of which flexibility they want to retain. For
4 example, we heard from Washington that they are working
5 with CMS on extending their flexibility to use beneficiary
6 self-attestation, income and assets and level of care of
7 requirements for eligibility for home and community-based
8 services. And their goal in doing that, really, is just to
9 connect individuals with those services a little bit more
10 quickly and not have to wait for a final eligibility
11 determination. They thought this was especially important
12 for people who were waiting for discharge from the
13 hospital.

14 And again, retainer payments were another area
15 where states might be interested in either extending
16 flexibility or expanding flexibility. And you heard a
17 little bit about that from Rob and Michelle.

18 All right. So on the nursing facility update, it
19 continues to be an area of focus for CMS. There's a lot of
20 activity. It seems like every day there seems to be
21 something new with respect to nursing facilities. Since
22 April, I'll just give you a couple of examples of what has

1 occurred since April. CMS has started posting nursing
2 facility data regarding the effects of COVID on the Nursing
3 Home Compare website, and those are data that they are
4 required to submit -- that they submit to CDC. They've
5 also resumed routine nursing facility inspections for
6 quality and safety, and they've begun that distribution of
7 provider relief funds.
8 So over time we hope to learn more about racial
9 and ethnic disparities for Medicaid beneficiaries and their
10 experience with COVID-19. But there are some CDC data that
11 show that the rate of cases and hospitalizations are
12 greater in communities of color than they are for white
13 people. And this slide here provides you with some of
14 those data points. CMS does have some data on
15 beneficiaries who are dually eligible for Medicare and
16 Medicaid, and those data show that across racial groups
17 individuals who are dually eligible are more likely to have
18 COVID than Medicare-only beneficiaries. And this slide
19 also provides a data point here which is that among black
20 beneficiaries there were more COVID cases among dual
21 eligible than individuals who were just Medicare only.
22 That data, I think, has probably been updated on

1 the CMS website since we put these together, but CMS is
2 continuing to update that.
3 Okay. So that's the update. It was quick, but I
4 look forward to any questions you might have and your
5 discussion.
6 CHAIR BELLA: Okay. Thank you, Joanne. I want
7 to just put one thing on the table in case other
8 Commissioners want to comment on that while they're talking
9 as well. And then I saw Brian and Martha, and I'm sure
10 there are more.
11 It was important for the Commission to put out
12 that letter to the Secretary about the extension of the
13 public health emergency, and in particular, I mean, we
14 called attention to the need for ample notice but we also
15 called attention to things that are going to have to be
16 restarted and unwound. And one of those things that I
17 worry about is the eligibility redetermination and the
18 process for doing that, the amount of time for doing that,
19 the impact that's going to have on beneficiaries and also
20 on states as they try to dial that back up.
21 And so I want to put on the table that that's
22 something I'd like to talk about. It would be nice to

1 understand what CMS is planning with regard to guidance to
2 states on how to do that or what guardrails are going to be
3 in place to ensure that that comes back on properly. It
4 feels like that's going to be a pretty big undertaking.
5 So the point is I don't want to lose sight of the
6 things we raised in that letter, and one of those in
7 particular being eligibility redeterminations. Joanne,
8 you're welcome to comment on that now or we can move to the
9 other Commissioners.
10 MS. JEE: Sure. I'll just quickly say that we
11 know that CMS is working on guidance and that they've been
12 in touch with states. We don't know the contents or the
13 timing for that guidance, and we are in touch with CMS so
14 as we learn more -- we'll try to learn more. And also to
15 say that we do hear from states that this is a big concern,
16 and they are worried about sort of how this plays out for
17 them and their ability to do all of this, the
18 redeterminations.
19 CHAIR BELLA: Yeah, I think this is an area for
20 the Commission, you know, one of those cases where we say
21 to ourselves, is this something that we kind of make a
22 statement on now, about the importance of this, or is it

1 something we wait until guidance comes out and then we make
2 a comment on that? So it's not just this. There are other
3 issues. But that's sort of where my head is in thinking
4 about what's the appropriate role and where can we have the
5 most impact to preserve access and also to help the states
6 where they might need some additional guidance.
7 I will admit I got everybody's hands out of
8 order, except I know Brian and then Martha. I saw Chuck
9 and Peter. So if I miss you -- okay, picking you all back
10 up. All right. Thank you. Brian.
11 COMMISSIONER BURWELL: I have a small comment on
12 annual redetermination. I'll let people know on the LTSS
13 area for HCBS services redeterminations not only have to be
14 made for financial eligibility but functional eligibility,
15 you know, whether people meet the functional criteria for
16 LTSS benefits. And I know in a couple of states the
17 guidance from the states to the local case managers has
18 been we would prefer to have the functional assessment done
19 in person, but if there is any reason why that might pose a
20 risk to either the assessor or the recipient, if they've
21 had COVID exposure, et cetera, we will accept telehealth
22 assessments, virtual assessments.

1 My question to Joanne is, in the previous
2 presentation there was no data on provider relief funding
3 to HCBS, so I'm assuming due to lack of data. Are there
4 reporting requirements from states where Appendix K
5 approvals, for example? Would CMS get any data on retainer
6 agreements to HCBS providers as a result of state
7 reporting?
8 MS. JEE: You know, I'm not really sure. I don't
9 remember off the top of my head, but I can certainly look
10 that up for you and get back to you on that one.
11 COMMISSIONER BURWELL: Okay. Thanks.
12 CHAIR BELLA: Thanks, Brian. Martha, and then
13 Chuck.
14 COMMISSIONER CARTER: Yeah, thanks for this
15 presentation. I wanted to highlight the importance of
16 telephonic telehealth and perhaps ask that we can track
17 that as a -- track it separately from, you know, telehealth
18 that's audio and visual. I think in areas where there's
19 low broadband access that telephone access really levels
20 the playing field and provides a lot of access. And I
21 think there's some controversy about continuing solely
22 telephonic visits.

1 I'm hearing anecdotally that it's been really
2 wonderful. It lends itself to visits where there's
3 generally more conversation and consultation, like
4 contraceptive counseling and intake for infertility workup,
5 things like that, that really involve a lot of
6 conversation, in addition to SUD and behavioral health.
7 So again, can we kind of look at telephonic in a
8 little separate way than just lumping it together with all
9 telehealth?
10 CHAIR BELLA: Thank you, Martha. Chuck and then
11 Peter.
12 VICE CHAIR MILLIGAN: Thanks, Melanie, and thank
13 you, Joanne. So let me just pick up on the redetermination
14 comment, Melanie, that you made. I'm not quite sure of the
15 right way to proceed but the public health emergency
16 currently would end at the end of October, or, you know, a
17 week before the end of October, and the continuous coverage
18 part of the MOE would end at the end of October. So if a
19 state is moving towards restarting redeterminations and
20 trying to make them effective November 1st, you know,
21 that's five weeks out and we're not going to be meeting
22 again until right before that.

1 So I do think there's an issue, and I know there
2 are a couple of states that are thinking about restarting
3 it immediately, and they would be ramping up their
4 administrative and operational process to send notices and
5 whatnot. So I do think flagging that issue, Melanie, is a
6 really important thing, and to the extent that we're in
7 touch with CMS, getting that guidance out soon is going to
8 be important, because if states are going to have some
9 requirements around that based on CMS that, and they're
10 planning to act November 1st, when the PHE ends and the
11 continuous coverage maintenance of effort ends, you know,
12 now's the time.
13 The comment I wanted to make was back in the
14 telehealth area, and it's really about Medicare, not
15 Medicaid, insofar as dual eligible are reliant on Medicare
16 for delivery of their primary and specialty care from
17 physicians. And so, Joanne, as we track telehealth, and if
18 we're going to track it separately, per Martha's comments,
19 I would like to just make sure that we're paying attention
20 to what Medicare does and where any federal legislation,
21 any CMS [inaudible] that it has some regulatory discretion
22 here. Because I do think for dual eligible who are

1 receiving HCBS and who are home-bound, telehealth expansion
2 on the Medicare side has been a really critical means of
3 providing access to care and a way of creating a meaningful
4 alternative to nursing facilities, where we have seen a
5 high mortality rate from COVID.
6 So I just want to make sure that we don't lose
7 sight of the Medicare implications of telehealth as a key
8 component of care for dual eligible. So that was my
9 comment.
10 CHAIR BELLA: Okay. Thank you.
11 Peter and then Kisha.
12 COMMISSIONER SZILAGYI: Thank you, Joanne. Great
13 presentation.
14 Is it okay if I talk about telehealth? I feel
15 like we're bouncing back between redetermination and
16 telehealth, and those are the two key topics. Is that
17 okay?
18 CHAIR BELLA: Yes.
19 COMMISSIONER SZILAGYI: So a few key comments on
20 telehealth, and some of this overlaps with what Martha
21 said.
22 Joanne, I'm really happy we did a chapter on

1 telehealth prior to the pandemic, which was a really strong
2 chapter.
3 I just want to emphasize that telehealth, tele-
4 video visits, and tele-telephonic visits have actually
5 transformed and saved primary care, both in the pediatric
6 world and in the adult world, to a reasonable extent.
7 There's an interesting discussion in the
8 pediatric world that more and more visits are going to be
9 desired by parents to be using telehealth, and that
10 includes regular checkups, well child visits, which is
11 almost half of all visits. There may be combinations of
12 visits where you do a telehealth visit and then have them
13 come in for a vaccine to your clinics, all those various
14 combinations.
15 There's more and more papers that I'm seeing
16 about the quality of care on telehealth and that it can be
17 equal to in-person visits, although you certainly can't do
18 certain things on telehealth that you can do otherwise.
19 I know of multiple papers that came out of
20 Rochester where I used to be. There used to be a concern
21 by health plans and others that if you get into the world
22 of telehealth and fund it, there will be something called

1 "drift," drift being defined as overutilization of
2 telehealth or telephonic. And we actually have some data
3 to show that that didn't happen for an inner-city Medicaid
4 population, that opening up and paying for telehealth did
5 not yield to drift.
6 So I would favor really looking into as much
7 quantitative data, not just qualitative like in New York
8 and Ohio, but to try to really see what are states doing.
9 I don't know whether this would be on our website or a
10 brief or some sort of really, really continuing to track
11 this issue of telehealth because I feel that this is going
12 to become a potential transformation of care for the
13 Medicaid population.
14 One last point -- two last points. Many Medicaid
15 beneficiaries work. So when I go to the doctor, I don't
16 get loss in pay because I go to the doctor, but a
17 tremendous number of Medicaid beneficiaries, parents or
18 adults, they work. They don't get paid when they go to the
19 doctor. Telehealth is a more efficient way to deliver care
20 because you don't have all the travel and wait in waiting
21 rooms. So there is less cost for the Medicaid population.
22 The last comment is I do in-person visits, I do

1 telehealth visits, and I do tele-telephone visits with
2 Medicaid beneficiaries. And they all work pretty well,
3 quite well.
4 CHAIR BELLA: Thank you, Peter.
5 Kisha, then Fred, then Darin.
6 COMMISSIONER DAVIS: Thanks.
7 We've talked quite a bit about telehealth. So I
8 don't have to repeat many of those points, and I'll echo a
9 lot of what Peter has said regarding how much telehealth
10 video and audio has really just helped to keep primary care
11 afloat and really strengthen that connection between
12 primary care providers and their patients.
13 Medicare has been very clear or clearer on what
14 they will and will not cover by a telehealth and the
15 requirements for annual wellness visits and transitional
16 care management, and the same has not been true on
17 Medicaid. And there is a lot of variability amongst states
18 on what they will pay, how much they will pay, and I would
19 be really curious to see some correlation amongst state
20 uptick of telehealth and the reimbursement rates with the
21 use of telehealth in those states.
22 And calling particular attention to the community

1 health centers, even in Medicare, the payment rate for
2 telehealth at community health centers is lower than their
3 typical PPS rate, and so looking at what that looks like
4 for Medicaid for telehealth at community health centers,
5 it's a great resource for health centers to be able to use,
6 especially in volume. And they are often being -- staffing
7 resources have been shifted to focus on testing, and so as
8 much as we can help them to be able to take advantage of
9 telehealth, it's great for their populations.
10 Then I do just want to call out an appreciation
11 for the data that we have on the race and ethnic data
12 related to Medicaid's response. I want to make sure that
13 we are continuing to look at this, continuing to bring it
14 up, as we continue to see the disparity there and thinking
15 about how Medicaid can be part of the solution for
16 narrowing those gaps.
17 CHAIR BELLA: Great.
18 Joanne, do you have any response? Is there
19 anything you want to say about what we do and don't know or
20 what we -- kind of level-set expectations on what we might
21 be able to bring back?
22 MS. JEE: Yeah. I think there's a real question

1 about the telehealth data and Medicaid, and it seems like
2 states are really tracking the use of telehealth during the
3 public health emergency. So I'm hopeful that there's going
4 to be more complete data, but on a broader national level,
5 I just don't know what that looks like yet. So that might
6 be a bit of a limiting factor in terms of what we can do in
7 the future.

8 Then just to Kisha's point about the variability,
9 I think that Medicare has just one single set of rules,
10 federal rules, and with the state variation, I think even
11 where states started pre-pandemic and then where they are
12 now in the midst of the pandemic, the policies are still
13 highly variable across the states. And then I think even
14 once they move post-pandemic to the policies that they
15 retain, I expect that there will still be a lot of
16 variation. So I think that's sort of the nature of the
17 Medicaid program. That makes it hard to study.

18 CHAIR BELLA: Fred, then Darin, then Tricia, and
19 we're going to be making our way to public comment as well
20 here shortly.

21 COMMISSIONER CERISE: Yeah. Just to pile on,
22 that's unfortunate, and I saw in your brief that most of

1 the telehealth flexibility, the states already have. And
2 so it's not as if you've got to go ask permission and then
3 get tracked.
4 I do worry a bit. We've used telehealth quite a
5 bit, and it's been successful, like Peter said, in places
6 where you knew it should work and prompted people to just
7 do it.
8 I am concerned about the lack of data. I am
9 concerned about telehealth as a stand-alone kind of fee-
10 for-service modality. I know, Peter, you mentioned to look
11 at this. I think in structured areas, there's less
12 opportunity for abuse, but there is potential there. And
13 having data, as people really move into this, having some
14 good data, it really makes sense as part of a global
15 payment methodology where you really sort of take out the
16 incentives to overuse. If there's any cases where that's
17 happening, it would be interesting to see because that
18 really helps transform delivery system as opposed to kind
19 of just paying for those individual visits again, one by
20 one, through telehealth instead of making people come to
21 the office. So I'd be interested to see if anybody has
22 made that jump as well, but again, another plea for data.

1 There are areas. Like our OB practice, they're
2 doing a quarter of their prenatal visits by telephone now.
3 That's a time-limited episode that you can track outcomes
4 for and tell if it's useful or not and where it doesn't
5 incentivize overuse because you've got a set number of
6 interventions that you would do, which I think is probably
7 a more safe deployment.
8 So, anyway, if people are doing anything with
9 moving from just fee-for-service to global payments with
10 that and then in the fee-for-service world, just taking a
11 look at what Peter has already talked about, and that is
12 potential for overutilization.
13 CHAIR BELLA: Darin and then Tricia.
14 COMMISSIONER GORDON: So a lot of my comments
15 have already been made, but just picking up on Fred and
16 Peter's point, I think when we do look at utilization
17 and/or received or reutilization telehealth, I mean, it
18 needs to be in the context of what it's replacing. Is it
19 high-value services, or is it low-value services? I think
20 that's relevant in that discussion because I don't think
21 you can look at it in a silo and really be able to walk
22 away with the conclusion, good or bad, if we don't look at

1 it in context.

2 I think others have -- I remember reading a
3 Health Affairs article where they were looking, at least
4 asking that question. I don't know if anybody has gone
5 deep enough on that at this point.

6 But something else that Fred said was something I
7 wanted to highlight. We talk about in the briefing paper
8 that Medicaid already had a lot of these authorities to do
9 some of these things around telehealth. This is a
10 question, Joanne. Maybe I am misremembering or just
11 completely, just flat out wrong.

12 I did believe that there was some relief at the
13 federal level with regards to HIPAA as it related to
14 certain activities that really did open up greater use and
15 options around telehealth. Is that correct?

16 MS. JEE: So they didn't actually change HIPAA.
17 What happened was they exercised the authority on
18 enforcement basically, and so the HIPAA rules are still in
19 place. But providers are able to use non-HIPAA-compliant
20 platforms right now without fear of enforcement action, I
21 guess.

22 COMMISSIONER GORDON: Right. Okay. So I wasn't

1 exactly right, but I was directionally. There is something
2 there.
3 And I think that's really an important area
4 because I do think some of the incredible increase that we
5 have seen, some element of that is tied to that lack of
6 enforcement provision, and I just think it's important to
7 understand, given the fact that at some point that could be
8 -- and I presumably assume, I should say -- would be pulled
9 back, and what kind of impact that would have.
10 I don't know, Joanne, how we would be able to get
11 at that, but there's some element of what's occurring today
12 that could be tied to or related to the relaxing of
13 environment around that at this point.
14 CHAIR BELLA: All right. Joanne, I'd just ask
15 you to think about that.
16 I have Tricia, and then did I miss anyone? And
17 if I did and it's about telehealth, I would say I think
18 that sentiment has become clear. I want to be respectful
19 of getting to the public comment as well, but I also don't
20 want to cut anyone else off. So is there anyone after
21 Tricia who I may have missed?
22 [No response.]

1 CHAIR BELLA: Okay. So we will do Tricia, and
2 then we will open it up for public comment. Then we will
3 take a quick break for lunch and whatever else.
4 Tricia?
5 COMMISSIONER BROOKS: Thank you.
6 I just wanted to go back to the renewal issue and
7 throw my weight behind reiterating this to CMS in some
8 form.
9 I don't think all states have stopped renewals,
10 Chuck. I do know that some are continuing to process them.
11 They just can't disenroll people who were at least -- came
12 back as looking ineligible. So there's a provision in
13 Medicaid regs that requires that an individual be
14 considered for any category of Medicaid before an adverse
15 action takes place, and to me, even if a state had already
16 done a renewal, had found information that suggested the
17 person wasn't eligible, they still have a responsibility to
18 review it at the time that action would be taken. I think
19 that needs to be reinforced in any guidance that CMS puts
20 out.
21 Then the second piece of this is that there's got
22 to be a sane way to re-phase these back in because if

1 states try to do this in one fell swoop, they're going to
2 end up overwhelming their eligibility workers, and then
3 consumers aren't going to be able to reach someone to get
4 the assistance they need to understand what they need to do
5 to prove that they remain eligible. So I think those are
6 two major points to reinforce.
7 CHAIR BELLA: Thank you, Tricia.
8 Joanne, thank you for this update. I know we are
9 going to be relying on you and the team for updates
10 periodically, and so I think you've gotten a good flavor of
11 kind of the areas of interest. And we understand there are
12 limitations to what you may be able to bring back to us,
13 but I think you know what we would like to see, and where
14 there's a way to be building sort of that, that would be
15 great. Otherwise we'll continue to have you level-set our
16 expectations about what's out there. So thank you for
17 that.
18 We are now going to turn to public comment, and
19 the way this is going to work is our MC from Go To Webinar
20 will work with the public who raise their hands and will
21 unmute that mic and introduce the person making a comment.
22 And I would ask that folks who are making comments, please

1 identify your organization so that we understand who you're
2 representing, but we are now ready for public comment.
3 ### PUBLIC COMMENT
4 * MS. HUGHES: We have a comment from Stuart
5 Gordon.
6 Stuart, you have been unmuted, and you may ask
7 your question.
8 MR. GORDON: Thank you. I actually have comments
9 on two different presentations.
10 First of all, I am with the National Association
11 of State Mental Health Program Directors. We represent all
12 of the mental health directors in the 50 states and in the
13 territories.
14 I wanted to make sure you all understood that
15 very, very few behavioral health providers are able to get
16 payment through the payment portal, so few in fact that the
17 Assistant Secretary McCance-Katz reached out to the mental
18 health directors and the substance use directors a few
19 weeks ago and asked for them to collect TINs of behavioral
20 health providers in case a different methodology was
21 developed.
22 The portal was pre-populated with the TINs of

1 Medicaid providers after the outreach to the Medicaid
2 agencies, and many behavioral health providers are not
3 enrolled in the Medicaid program.
4 There was an option for them to access the
5 portal, but it required an extended interaction with HRSA.
6 Some of those providers that aren't enrolled in the program
7 are employees of providers that are enrolled in the
8 program, so that employees of CMHCs, FQHCs, hospitals, but
9 they're not directly enrolled. They were not able to
10 access payment through the portal.
11 The second comment is on the audio-only
12 telehealth. CMS's argument for not covering, not having
13 the statutory authority for covering audio-only telehealth
14 at the moment is the language in 1395(m)(1)(M) is a
15 straightforward allocation of authority and demonstrations
16 in Hawaii and Alaska for asynchronous telecommunications.
17 CMS is reading that as an exception. Many, many
18 years ago, I was a bill drafter in statutory canons and
19 statutory construction, would argue -- and the Supreme
20 Court has argued -- that that's not an exception. It's a
21 direct grant of authority, and it should not be read as an
22 exception. So I'd urge you to consult your attorneys on

1 that issue.

2 Thank you.

3 MS. HUGHES: Our next comment or question is from
4 Jim Roberts.

5 Jim, you are self-muted. If you'd click your
6 microphone icon and unmute your line, you can ask your
7 question.

8 MR. ROBERTS: Yeah. Thank you.

9 My name is Jim Roberts. I work for the Alaska
10 Native Tribal Health Consortium. We're an organization
11 that comanages the Alaska Native Medical Center that
12 provides care to over 175,000 Alaska Natives in the state
13 of Alaska. So thank you for allowing me to make a comment.

14 Just a couple of points on the things that you
15 discussed this morning. First off was the CMS guidance on
16 eligibility determination and redetermination, and it
17 sounded like CMS was working on something. There was some
18 discussion about whether to wait until the guidance came
19 out or maybe weighing in before, and I would recommend that
20 you do. I would recommend that you weigh in before the
21 guidance is issued in hopes that you could influence the
22 outcome. So that was my point there.

1 But the guidance that's been issued by CMS under
2 the public health emergency does provide broad flexibility
3 to use electronic means for eligibility determination and
4 redetermination, and unfortunately, not all the states are
5 implementing that. In our case, that's certainly the
6 situation.
7 We think that additional guidance is needed from
8 CMS to let the states know that they can accept other types
9 of document products like DocuSign, et cetera. That's a
10 product that I've purchased homes with, cars with. It's a
11 broadly accepted legal kind of product. I know there are
12 similar products that are out there.
13 But the challenge is that not all the states are
14 willing to utilize that, and I think additional guidance
15 from CMS that would permit that would be certainly helpful.
16 We're in a situation where we continue to shelter
17 in place with many of our workers. Our eligibility
18 determination workers are working from home, and it's very
19 difficult when a live signature is needed, a wet signature
20 is needed on the new application. I'd just encourage you
21 to do that.
22 The second item is with regard to telehealth and

1 the use of telephone technology. In Alaska, we have
2 certainly the broadband issue that was discussed this
3 morning, and I think more should be done to continue to
4 make permanent the use of telephone technology. In fact,
5 where we may not even have cellular service or telephone
6 lines, we use two-way radios with our community health aid
7 providers, our midlevel providers that work in the Alaska
8 Native villages, communicating by two-way radio or by
9 telephone back to a village-based clinic. So that's a very
10 effective medium use.
11 I just wanted to comment you for the discussion,
12 and thank you for the opportunity to provide my comment on
13 the things you talked about today. Thanks.
14 CHAIR BELLA: Thank you very much.
15 MS. HUGHES: Ronnie Coleman, you have been
16 unmuted, and you may make your comment.
17 MR. COLEMAN: Thank you very much. I appreciate
18 your time. My name is Ronnie Coleman. I'm Government
19 Relations director for Benevis. We do nonclinical support
20 for dental practices around the country. So, collectively,
21 our practices are the largest Medicaid dental practices in
22 the country, and we're about 15, 16 states.

1 I wanted to make a couple points, one having to
2 do with the challenges associated with COVID. Obviously,
3 we're not seeing as many patients as we normally would. I
4 think someone mentioned earlier that pediatric patients are
5 coming back a little bit slower than adults, and I'm
6 thinking they were talking about physical health. But that
7 is kind of the way it's working with the pediatric dental
8 as well.
9 Our practices on average are about at 70 percent
10 of normal. Some of that is our fault because a lot of our
11 hygiene would normally be done in an open-bay setting, and
12 we've had to invest in ways to create safe barriers for
13 infection control. We're just rolling that out.
14 But either way, the other real challenge and I
15 think enduring challenge that we have right now is PPE.
16 It's not just access to it, but it's the cost. Our people
17 have said that PPE is contributing about $15 or more per
18 patient on average, and we can't bill for it, as you know.
19 We can't bill for supplies. But on a commercial dental
20 side, increasingly, private insurance companies are paying
21 providers for PPE, anywhere from $7 to $10, some $15, and
22 yet Medicaid dental providers who are making 70 cents on

1 the dollar are still stuck with the entire PPE bill. So
2 that is a real challenge.
3 Some states have looked at how they can help. I
4 know that Washington State has gone out of their way likely
5 using state dollars to help cover PPE for Medicaid dental
6 providers. I know that in West Virginia, they increased
7 certain codes and their reimbursement rates for dentists to
8 cover increased costs associated with infection control,
9 and there might be one or two other states.
10 Unfortunately, we don't serve any of those
11 states, but it's something that needs to be considered.
12 I know HHS says, "Well, states, why don't you
13 increase rates to help providers?" Well, we know that
14 states are not in a position to do that, especially without
15 additional FMAP and/or state and local funding. So that's
16 one point.
17 The other point had to do with value-based
18 payments. You guys mentioned that earlier. I just wanted
19 to mention that we've been trying to urge state Medicaid
20 programs and some of the dental payers to consider this for
21 years, going back to when CMS had their incubator project
22 to try to encourage value-based experiments in states. But

1 what we found is a lot of the states, number one, they
2 don't want to do the heavy lifting associated with doing
3 that, and number two, we've been working with payers like
4 DentaQuest and Avesis, the dental benefit administrators.
5 DentaQuest is probably the farthest along. We're
6 actually in a capitated arrangement with them in Texas, and
7 we're one of the largest Medicaid dental providers down
8 there. I suspect the largest one might be involved as
9 well, but it's a very useful tool. It gives the state cost
10 visibility. It makes us more of a partner because we have
11 patient assignment, because they have dental homes down
12 there. It's just a really good idea, and they actually
13 helped sustain us through this crisis. They kept making
14 the capitation payments, and what we have to do is make
15 sure that we are making sure that our patients are coming
16 in at higher numbers to meet our obligations over the next
17 several months.
18 So, anyway, those are the two main points I
19 wanted to mention. I appreciate your consideration, and
20 thanks for all that you do.
21 CHAIR BELLA: Thank you very much.
22 It looks like that was the last public comment.

1 Is that right?

2 MS. HUGHES: That's correct.

3 CHAIR BELLA: All right. I appreciate everyone

4 sticking with us virtually. I know it's not the easiest

5 thing to do.

6 We're running a little bit behind. We're going

7 to come back at 1:05. So we're going to give you a 20-

8 minute break. I'm sorry it's not more, but we've got a lot

9 of stuff to do this afternoon. So if everyone could please

10 come back at 1:05, we'll get started with the state

11 recovery, and Chuck is going to lead us through that

12 session.

13 See you all in a little bit.

14 * [Whereupon, at 12:45 p.m., the meeting was

15 recessed, to reconvene at 1:05 p.m., this same day.]

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1 AFTERNOON SESSION

2 [1:09 p.m.]

3 CHAIR BELLA: It has come to our attention that
4 there was one person that wanted to make a public comment
5 that was unable to do so, that we missed in the public
6 comment session, and so Anne has shared that comment with
7 the Commissioners. But if you'd like to share that, Anne,
8 with everyone, just sort of publicly, so it gets on the
9 record, while we're waiting for everyone else to join, that
10 would be a good thing to do.

11 * EXECUTIVE DIRECTOR SCHWARTZ: Okay. Sure this is
12 from Camille Dobson at ADvancing States. She says,
13 "Regarding the provider relief fund, our providers receive
14 contradictory and sometimes misleading information on who
15 qualified for payments. This is especially important for
16 providers that may have had a very small Medicare book of
17 business. And the provider relief fund communications for
18 that agency, were that if you'd gotten any payment from the
19 earlier rounds, you were no longer eligible.

20 "There are a number of HCBS providers who do not
21 directly enroll with the state, especially those that
22 operate under organized health care delivery systems or

1 those providers who provide certified public expenditures
2 to the state.
3 "Finally, there are a number of providers who
4 deliver services under self-directed programs. They do not
5 have a Medicaid enrollment with the state but rather a
6 contractual relationship with the financial management
7 services agencies. HHS finally, after pressure, advised
8 that these agencies could apply on behalf of the self-
9 directed providers but needed to attest that those
10 providers would be spending those payments on COVID-related
11 expenses, and a number of them were not willing to take
12 that risk."
13 Then she also had comments on Medicaid and COVID.
14 "As Joanne said, a number of states were interested in
15 maintaining the flexibilities they received under 1135 or
16 Appendix K waivers. Right now, states have to go one by
17 one with CMS through those specifics, and it would be
18 really helpful if CMS could put out some blanket guidance
19 that specified which flexibilities could be incorporated
20 into permanent authorities or under 1915(c)waivers in order
21 to speed up that process with the looming public health
22 emergency ending soon."

1 CHAIR BELLA: Okay. Thank you. And, Camille, if
2 you're still listening, thank you. I'm sorry we missed
3 that in the public comment period.
4 Kit, I think you had something, based on the
5 public comment, and then we're going to turn it to Chuck
6 and we're going to turn estate recovery.
7 COMMISSIONER GORTON: Yes. So I just wanted to
8 thank a minute to thank the people who participated in the
9 public comment period. What we heard in the telehealth
10 section is that some things were happening maybe better
11 than used to happen in the past, when we relied only on
12 face-to-face, and I would just say the Commission is no
13 different. We're learning to function in this new
14 environment. And to actually hear directly from someone
15 who is serving tribal populations in Alaska, for me is just
16 a phenomenally valuable thing.
17 And so I think it's really great that people are
18 participating in the webinar across the country, and we
19 really value all of their input, and I just wanted to thank
20 them for doing that.
21 CHAIR BELLA: Thank you. Thanks, Kit, for
22 raising that.

1 CHAIR BELLA: Okay, Chuck, I'm going to turn it
2 to you to kick us off with this session.
3 **### UPDATE ON MEDICAID ESTATE RECOVERY ANALYSES**
4 * VICE CHAIR MILLIGAN: Thank you and welcome to
5 the afternoon portion of the first day. The first topic
6 we're going to be taking on is an update on Medicaid estate
7 recovery. We haven't spent much time in this area and it
8 does affect a lot of individuals who use long-term services
9 and supports. Kristal and Tamara, it's all yours.
10 * MS. HUSON: Great. Thank you. Good afternoon,
11 Commissioners. Kristal and I are pleased to be here today
12 to provide an update on our work on Medicaid estate
13 recovery.
14 Next slide please.
15 So this slide gives an overview of what we'll be
16 presenting on today. We'll remind you of prior MACPAC work
17 on estate recovery as well as some background on the topic.
18 We will then highlight data from the review of state plans,
19 aggregate estate recovery collections, state surveys, and
20 stakeholder interviews. We will then finish with a
21 discussion of various policy options.
22 Next slide please.

1 So a little bit about prior MACPAC work. In
2 November of 2015, MACPAC published an issue brief of
3 Medicaid's new adult group and estate recovery. That issue
4 brief raised policy questions about the potential effects
5 on enrollment in Medicaid expansion states and about if
6 state recovery rules conflict with the intent of a modified
7 adjusted gross income rule.
8 Then, last December, Kristal presented at the
9 Commission meeting on this topic. She provided initial
10 background on estate recovery programs, data, and a set of
11 policy considerations and policy options. Commissioners
12 requested updated data and raised questions about whether
13 estate recovery has a chilling effect on access to long-
14 term services and supports. So we are here today to
15 provide some updated information.
16 Next slide please.
17 So just to jog your memories, since the inception
18 of Medicaid states have been permitted to recover assets
19 from the estates of certain beneficiaries as reimbursement
20 for the care provided to them, and in 1993, the Omnibus
21 Budget Reconciliation Act, or OBRA, made estate recovery
22 mandatory for three categories of beneficiaries: first,

1 individuals who were expected to be permanently
2 institutionalized; second, individuals who received
3 Medicaid when they were 55 or older; and third, individuals
4 with long-term care insurance policies under certain
5 circumstances.
6 Next slide please.
7 So beneficiaries who received Medicaid when they
8 were age 55 or older, OBRA specified the benefits for which
9 states are required to seek recovery, and these include
10 amounts at least equal to benefits paid on their behalf for
11 nursing facility services; home- and community-based
12 services; and related hospital services and prescription
13 drugs provided during a stay in a nursing facility or while
14 receiving HCBS.
15 And when benefits are covered under managed care,
16 states are required to seek recovery for some or all of the
17 premiums paid for individuals that would have been subject
18 to state recovery under fee-for-service. States also have
19 the option to seek recovery for any other items for
20 services under their state plan.
21 Next slide please.
22 So OBRA required states to attempt to recover, at

1 a minimum, all property and assets that passed to heirs
2 under state probate laws. There are, however, some
3 exemptions. The states must exempt or defer recovery if a
4 beneficiary has a surviving spouse, a child who is under
5 age 21, or a child of any age who is blind or disabled.
6 States are also required to designate a cost-effectiveness
7 threshold. Finally, states must establish procedures for
8 waiving estate recovery requirements due to hardship, based
9 on criteria established by the Secretary of Health and
10 Human Services. Finally, CMS has provided examples states
11 should consider, but does not require states to use them.
12 And with that I'm going to pass it over to
13 Kristal.
14 * DR. VARDAMAN: Thank you, Tamara.
15 As Tamara mentioned, states have some flexibility
16 in how they implement estate recovery. To gain insight
17 into state policies we reviewed state plans for 38 states
18 and the District of Columbia, that were online or which we
19 received directly from states. We plan to continue to
20 collect these in the event of a chapter to have as complete
21 as national a picture as possible.
22 We found that most states do not use their

1 authority to place liens on beneficiaries' property. For
2 example, liens under the Tax Equity and Fiscal
3 Responsibility Act of 1982 were only used by 15 states.
4 In contrast, most states seek recovery for state
5 plan services other than those required for individuals age
6 55 or older. Of the 25 states that did so, 21 pursued
7 recovery for all state plan services. Fewer states pursue
8 recovery for other optional populations and services. You
9 can find more details in your materials.
10 Information on hardship waivers in state plans is
11 not standardized so it's difficult to make comparisons
12 across states. However, we found in our review that many
13 states use CMS sample criteria such as considering if the
14 asset is the sole income-producing asset of the heir.
15 States also have defined their own criteria. For example,
16 Mississippi will waive recovery if the assets in the estate
17 are less than $5,000, and there's no prepaid burial
18 contract or other money set aside for the burial of the
19 deceased.
20 Similarly, state approaches to cost effectiveness
21 thresholds vary substantially. Ten of the states we
22 reviewed pursue any estate where the amount of recovery

1 exceeds the cost of pursuing recovery. Other states use
2 thresholds such as $500 or $1,000. Georgia has the highest
3 estate recovery cost-effectiveness threshold at $25,000.
4 In December, we presented information on
5 aggregate estate collections, which are reported on the
6 CMS-64 expenditure reports through fiscal year 2018. We
7 are now able to provide updated information for fiscal year
8 2019. In fiscal year 2019, Medicaid programs reported
9 collecting approximately $733 million from beneficiary
10 estates. Five states accounted for nearly 40 percent of
11 all recoveries.
12 Recoveries as a proportion of national Medicaid
13 fee-for-service LTSS spending was under 1 percent for each
14 year. It would likely be lower if managed care costs were
15 able to be included.
16 As we noted in December, we could not find any
17 recent publications on the average size of recovered
18 estates. The only figure available was about $8,000, and
19 that was based on a survey for 2003. We decided to seek
20 updated figures directly from a sample of states that
21 represented a range of aggregate collections and estate
22 recovery policies, and included states with and without

1 MLTSS. We asked states to provide information for three
2 years, if possible. We asked states about the number and
3 size of recovered estates, the number of hardship waiver
4 applications reviewed and granted, and program
5 administration costs.
6 We have received six responses so far, and expect
7 to receive more in the coming weeks. States have been very
8 responsive to our inquiry but some just needed some
9 additional time to respond. Among the states responding to
10 our survey so far there has been a wide range in the number
11 of estates recovered, and the average recovery amount, as
12 you can see on the slide. In general, states that
13 recovered from fewer estates had higher average recovery
14 amounts. Variation in the cost-effectiveness thresholds
15 may be one factor that explains this.
16 For example, Alaska has a small number of
17 collections and the highest average recovery amount among
18 the responding states, and maintains a cost-effectiveness
19 threshold of $10,000.
20 In terms of the range of recoveries, we found
21 very minimal amounts at the low end, sometimes a few
22 centers or dollars. An estate recovery contractor we spoke

1 with suggested that minimal recovery amounts could include
2 funds from personal needs accounts held by nursing
3 facilities, which must return any remaining funds after a
4 resident's death.
5 Large recoveries could include home equity or
6 funds remaining in special needs trusts. The largest
7 recovery amount among the states that have responded so far
8 was nearly $400,000.
9 In the materials we also include some information
10 summarizing research on wealth held by older adults, which
11 we can include in a potential chapter. This demonstrates
12 the modest assets held by individuals at risk of using
13 LTSS, which is even more true for Black and Hispanic
14 adults. We included that to confirm that the modest
15 recoveries we're seeing reflects limited assets available
16 for recovery rather than states' relative success in being
17 able to recover those assets.
18 Regarding hardship waivers and administrative
19 costs, only three of the six states were able to provide us
20 with that information. The maximum number of hardship
21 waivers in a single state in a year was 41. Administrative
22 costs were generally under 10 percent of recoveries. We

1 should note that some states use third-party contractors to
2 administer estate recovery, which is typically done on a
3 contingency fee basis where they retain a percentage of
4 recoveries.

5 In December, Commissioners questioned whether
6 estate recovery could deter people from seeking Medicaid
7 coverage. Estate recovery's potential chilling effect has
8 come up in the past, once as a potential barrier to
9 enrollment in the Medicare Savings Programs. Congress
10 subsequently moved in MIPPA to prohibit recovery for the
11 cost-sharing assistance provided through the MSPs.

12 It also came up as a potential deterrent to
13 Medicaid enrollment for the new adult group in expansion
14 states, and some states moved to remove recovery for that
15 population.

16 In this context, we sought insight from states
17 and interviews with an eldercare attorney and a beneficiary
18 advocate. One state said they could not measure any
19 potential chilling effect of estate recovery. The elder
20 law attorney and advocate both said that some people do
21 forego Medicaid due to concerns about estate recovery.
22 However, the elder law attorney noted that given the

1 limited options available to cover LTSS, individuals may
2 end up on Medicaid despite their initial reservations as
3 their needs become more urgent.
4 On the next few slides I'll outline a few policy
5 options. Before that we just wanted to note that there are
6 a variety of viewpoints on estate recovery and thus a range
7 of policy options. Some of the options we're presenting
8 would increase standardization of estate recovery across
9 states and others would grant states with additional
10 flexibility. We're going to start with the more
11 significant changes and end on the more modest changes.
12 The first policy option is to eliminate recovery
13 or to limit the assets subject to estate recovery. This
14 would require congressional action. Both of these actions
15 would standardize estate recovery policies across states.
16 Eliminating estate recovery completely would remove a
17 source of revenue for states but would have little effect
18 on Medicaid spending, given that the estate recovery as a
19 proportion of LTSS spending is so small. It could have
20 significant effects, however, on heirs, for whom it would
21 provide protection from potential economic hardship.
22 Limiting the assets subject to estate recovery

1 could take several forms. For example, one option could be
2 to set the federal cost-effectiveness threshold that would
3 exempt particularly small estates from recovery.
4 Alternatively, certain assets that are not
5 counted in eligibility determination could be excluded from
6 estate recovery. An elder care attorney told us about
7 circumstances where an income-producing asset like a
8 family-owned store was excluded from eligibility
9 determination but was later pursued in estate recovery.
10 Congress could determine the treatment of different types
11 of assets to, for example, treat income-producing assets
12 different than home equity.
13 The next option is to revert estate recovery back
14 to a state option, as it was prior to OBRA. That would
15 require congressional action as well. We expect that some
16 states might opt out if recovery was optional. This might
17 be influenced by the size of their collections or if they
18 view estate recovery as a program integrity tool.
19 In our survey we did ask states whether they
20 would be interested in ending estate recovery were it made
21 an option. One state said that some stakeholders and
22 legislators might be interested but that budget constraints

1 would make it difficult to forego that revenue. Two other
2 states have said they will likely continue to pursue estate
3 recovery. Other states either didn't answer or told us
4 they weren't able to speak to that question. And again,
5 we'll continue to ask states about this as our outreach
6 continues.

7 The next option relates to states with managed
8 LTSS. Currently, if a state elects to pursue recovery for
9 all Medicaid services they must pursue recovery for the
10 total capitation payment. If a state only pursues recovery
11 for some state plan services, they must pursue recovery for
12 the portion of the capitation payment attributed to those
13 services. This means that the estates of beneficiaries who
14 use small amounts of care may be pursued for more than what
15 was spent on their care. For those institutionalized or
16 using a lot of care, recovery could be less than what was
17 spent.

18 This policy is currently outlined in the Medicaid
19 manual, so we believe changes could be made through
20 regulatory or sub-regulatory action. In order to implement
21 this change, states need to have information on the cost of
22 care from the plans, similar to what fee-for-service states

1 use to determine the potential recovery amount. And we did
2 hear from one state that they were interested in this
3 policy option.
4 The last policy option is to establish federal
5 standards for hardship waivers. OBRA mandated that states
6 establish hardship waiver programs based on criteria
7 outlined by the Secretary. And as Tamara noted, CMS
8 suggests but does not require that states consider certain
9 criteria. The Commission could recommend that CMS set
10 minimum standards for hardship waivers, which appears to be
11 within the Secretary's authority and in keeping with
12 congressional intent. This could address some equity
13 concerns, although variation in state probate laws may
14 prevent complete standardization.
15 As you discuss this information, staff are
16 interested in hearing whether the Commission wants to make
17 recommendations in the March 2021 report to Congress, and
18 what additional information would be required to support
19 your deliberations. For example, we could interview some
20 additional federal and state officials as well as advocates
21 regarding interest in and the feasibility of policy options
22 that the Commission is considering. We would anticipate

1 bringing themes from those interviews and any additional
2 survey results in December, along with draft recommendation
3 language and information on the cost implications. In
4 January we could present a draft chapter, and at that time
5 you could vote on recommendations.
6 And with that we'll turn it back to the Vice
7 Chair. Thank you.
8 VICE CHAIR MILLIGAN: Thank you both very much
9 for your presentations.
10 I see Kit and I see Brian. Let me just tee it up
11 first by -- as the Commissioners kind of weigh in here and
12 ask questions, it would good to get a sense of whether
13 you're interested in thinking about potential options and
14 recommendations down the road, and to the extent that
15 you've got thoughts already along those lines, to help
16 articulate that for the group as a whole. So it would be
17 helpful just to take our temperature about that.
18 I do see Kit and I do see Brian, so, Kit, let's
19 go to you first, and then Kisha.
20 COMMISSIONER GORTON: Thank you. A comment
21 first, and then I'm going to answer Chuck's question
22 directly. The comment is I'm a little worried about our

1 use of the term "chilling effect." It has a built-in value
2 judgment, and I don't think we're in the business of making
3 value judgments. At some level families are making
4 choices, and making choices is okay. If you disagree with
5 their choices -- I mean, we don't understand what informs
6 their choices. And while some people might choose to do
7 something else, cost sharing in health care could be said
8 to have a chilling effect on people's use of discretionary
9 services.

10 We do it anyway because there are important
11 reasons to do it, and so I just think we should be careful
12 about that language, particularly since to me it would seem
13 to signal a predisposition towards a value judgment.

14 With respect to Chuck's questions, I would not be
15 supportive of eliminating estate recoveries, and I know the
16 memo felt at least a little bit to me like it was
17 minimizing what the recoveries -- but I don't remember a
18 state I've ever worked in where $733 million was a minimal
19 set of recoveries, and I note that you had at least one of
20 your states respond that the amount of money they get will
21 make people feel badly about giving it up. And I
22 personally don't feel bad about recovering money that was

1 spent on a person's care, so I would not be supportive of
2 the first policy proposal.
3 The second one, to put it back as a state option,
4 I think what we're seeing is the states are functioning
5 like it's a state option now anyway, and I would be very
6 comfortable supporting it going back to being a state
7 option.
8 The third option, you know, that strikes me as
9 being reasonable. Again, it comes down to making value
10 judgments, and should we be telling states what they can do
11 or not? But as long as we had it as an option where they
12 could choose to recover less than the full capitation
13 amount, I think I could probably get my head behind that.
14 The fourth option, which goes back to sort of
15 federalizing and centralizing the policy decisionmaking,
16 I'm not going to be able to be supportive of it. Medicaid
17 is a state-administered program. We give the state lots of
18 options. Every one of us could spend 20 minutes listing
19 the ways that there are inequities between states in how
20 they administer their programs. I think this is just
21 another one of them. The layer of probate on top of it
22 just makes it all the more necessary that we give states

1 the flexibility to do what they want and not try and put on
2 a uniform standard that, you know, we dreamed up or that
3 somebody -- you know, some group of interest groups inside
4 the Beltway dreamed up. So that would be my response to
5 Chuck's question.
6 VICE CHAIR MILLIGAN: Thank you, Kit. Brian?
7 COMMISSIONER BURWELL: So this is a topic I
8 actually know something about because I've done multiple
9 studies of this in my earlier years, mostly for ASPE. And
10 I could talk for a long time, but I'll try to keep it
11 short.
12 I commend Kristal and Tamara for a very good
13 chapter, but from my point of view, it's only a start, and
14 there is a lot that is not addressed in this chapter about
15 Medicaid estate recovery, which should.
16 It's very complex. You could say that it's not
17 just related to Medicaid rules about assets but probate, et
18 cetera. And it's totally, completely interwoven with
19 Medicaid eligibility for LTSS up front and how assets are
20 treated at both the front end and the back end. You can't
21 have money -- you can't recover assets at the back end if
22 they're able to be sheltered at the front end. So the two

1 are inextricably linked. And because these are assets,
2 they're treated entirely differently. You know, like a
3 basic rule is income is treated individually, assets are
4 treated jointly for married couples. So that adds another
5 layer of complexity.
6 There are references to probate. I don't know if
7 people -- everyone's aware most states only recover from
8 probate, assets that go into probate. Most assets don't
9 pass through probate. What's the best way to keep assets
10 exempt from probate? It's to have a will. So any assets
11 which are transferred after death through a will are not
12 subject to probate. So that is part of the reason -- there
13 are some states that try to recover assets beyond a
14 probated estate, but that gets very complicated in regard
15 to state laws. So that's the first issue. It's a very
16 complex topic.
17 Second, it's a very political topic because it
18 has to do with -- the largest source of recovery is always
19 the home, which is exempt up front as long as the person
20 expresses an intent to return home, so it could be a home
21 still in the person's estate upon their death. So there's
22 a lot of politics around taking away people's homes, as you

1 can tell from the Atlantic Monthly article. A lot of
2 people don't want to deal with this from a political
3 standpoint.
4 However, my third point is this is a very
5 important topic from a Medicaid policy point of view
6 because it is fundamentally about what Medicaid is in
7 regard to a means-tested program, and so it's a program
8 integrity. So how much money at the end of somebody's life
9 should somebody be allowed to pass on to their heirs? Or
10 what responsibility do they have to repay states and
11 Medicaid for the costs that they have incurred during their
12 lifetime? There's a lot of different points of view about
13 that equity issue. You could certainly make arguments
14 about -- equity arguments about should a family be allowed
15 to inherit an $800,000 house rather than using that
16 $800,000 to provide dental coverage to TANF kids or
17 something like that. It's a tradeoff.
18 I guarantee you that the $773 million that's
19 currently collected is just the tip of the iceberg of what
20 could be collected if states aggressively had better
21 knowledge about how to go about this and ran good programs.
22 But a final problem I want to point out in the

1 incentives of states to operate good estate recovery
2 programs. It's considered a relatively minor component of
3 state Medicaid operations. There are not resources. There
4 are very few staff who don't understand the legalities of
5 how to go about this. And the incentives are states have
6 to pay for estate recovery costs, but they have to pay back
7 the federal government the federal share. So, you know, a
8 state with a 60 percent FMAP has to give back 60 percent of
9 their recoveries to CMS. That's not a good return on their
10 investment. So that's another reason.
11 The last point I want to make at this point is
12 that if we're going to do work on this, you have to take
13 into account the role of elder law attorneys in both the
14 up-front application process and in estate recoveries.
15 It's a huge industry, as I'm sure everybody's gotten
16 pamphlets, you know, "Come to our free dinner, and we'll
17 tell you how to protect your home from Medicaid." There
18 are literally hundreds if not thousands of attorneys whose
19 sole source of revenue is protecting inheritances for
20 children. And an example of that was, you know, in
21 Massachusetts, there are specialized eligibility offices
22 for LTSS because it's such a different type of eligibility

1 that counts assets. I asked the head of the offices, how
2 many of your LTSS applications are submitted by attorneys?
3 Her answer was 100 percent. So they're a big part of this
4 policy equation, and I think, you know, we need to include
5 them in any kind of research that we've done.
6 So those are my comments thus far.
7 VICE CHAIR MILLIGAN: Thank you, Brian. I have
8 Kisha and I saw Sheldon next.
9 COMMISSIONER DAVIS: Thanks. Thanks, Kristal and
10 Tamara. This is a really important topic, and I really
11 appreciate the analysis that you've done.
12 Piggybacking a little bit on what Brian was
13 saying, I do think it's worth exploring this area,
14 exploring recommendations, and -- policy recommendations in
15 that area. It would be really helpful for me to hear more
16 from beneficiaries and elder care attorneys but not
17 necessarily lumping them in together, because I think that,
18 as Brian mentioned, there can be different motives there,
19 and also looking at it as an equity piece. So those folks
20 who have the means to be able to hire an attorney who can
21 help them hide their assets versus those who don't and how
22 that plays out in some of this.

1 And then also hearing more from the states just
2 on the complexity of the recovery efforts, and is the juice
3 worth the squeeze a lot of times in what they have to do to
4 really be able to recover meaningful assets.
5 VICE CHAIR MILLIGAN: Thank you, Kisha.
6 Sheldon, then I have Darin.
7 COMMISSIONER RETCHIN: Thanks, and I really
8 appreciated this report. Just to double back on one issue,
9 I don't think it's $733 million annually. It's $733
10 million over five years. Isn't that right? So it's about
11 $120 million per year, 130. Looking at the appendix,
12 that's the way I interpret it, because, otherwise, you
13 can't get to a half a percent. Anyway, but you could just
14 look in Appendix A. I think that's cumulative over five
15 years. So it is a small amount.
16 Here is where I am, though. I'll have a little
17 different perspective maybe than Brian and maybe more like
18 Kisha, but it's disturbing to me -- and we all know this
19 happens -- that asset transfers are protected for those who
20 can afford and have the insight to go get an estate
21 planning attorney who creates an irrevocable trust. And
22 then the disenfranchised, more vulnerable populations, oh,

1 by the way, underrepresented minority populations, may not
2 have access to the same protections, and they have even a
3 smaller veneer of protection in terms of the estate. So
4 that's bothersome to me, and I don't know how to solve it
5 with any of the options, but leaving intact -- I'm not
6 scared of the industry that is doing this, but it's just
7 something that I'm concerned about.
8 Thanks.
9 VICE CHAIR MILLIGAN: Thanks, Sheldon. Darin,
10 and if there's anybody else who wants to get in the queue,
11 if you could raise your hand. Darin.
12 COMMISSIONER GORDON: Thanks. I agree with the
13 comments Kisha and Sheldon made. I also want to align
14 myself with Kit. I do agree that leaving this as a state
15 option is something we should strongly consider just
16 because of the variability state to state and, again, you
17 know, for a practical sense, it does appear that states are
18 functioning that way, anyway, and that was my experience
19 back when I was at the state and talking to other states, a
20 lot of variability out there.
21 I do believe, Kristal and Tamara, that, you know,
22 collecting -- you know, you said other states are still

1 working on pulling the information together. I think
2 having a broader perspective will be helpful, and that's
3 coming to some conclusions here. I mean, this is a good
4 sampling. It's helpful. I do believe it's somewhat
5 telling that other states need a lot of time to pull that
6 stuff together as far as, you know, how big a role that
7 this plays within the organizations. But, again, I just
8 align myself with Kit, and I think the points that Sheldon
9 and Kisha make are well founded. I don't know how to solve
10 for it, but I think those are important.
11 VICE CHAIR MILLIGAN: I'm going to have comments,
12 but, Melanie, I want to make sure that I go last. Melanie?
13 CHAIR BELLA: Yeah, I just wanted to go back to
14 your first question, Chuck, which is, like, for all of us
15 to express interest in a recommendation, and I just want to
16 put my name in the hat for a recommendation. I would like
17 to very strongly endorse what Sheldon and Kisha said in
18 terms of this is an equity issue. It's an equity issue for
19 the population. It's also just strange the way we would
20 treat different things on the back end than we treat them
21 on the front end, but mostly it is the ability -- if you
22 have the ability to shelter your assets, you can. So I'm

1 worried about the people that don't have that ability. And
2 when you look at the collections -- and, Darin, whether the
3 states are functionally acting like it's their option, for
4 the people that have no other means to get protection from
5 that, if the states even have the opportunity to do that,
6 it doesn't seem to be furthering the goals of the program.
7 And so I guess I just want to go on record,
8 Chuck, to say that I'd be very supportive of the
9 recommendation. I'm not sure how much more we would need
10 in order to do something like saying make it optional. I
11 don't know that we're going to get a bunch of extra data
12 that's going to help us. I don't think there's a monetary
13 threshold here over which we'd be saying we're not
14 comfortable making it optional. So I would push us to
15 determine, like, what exactly else do we need to know
16 quantitatively as [inaudible].
17 That's it, Chuck, for me.
18 VICE CHAIR MILLIGAN: Yeah, it's okay. I saw
19 Brian raise his hand. I want to make sure that anybody who
20 wants to have a first bite gets a first bite, and then I'll
21 come to you, Brian, and then I'll wrap. Is there anybody
22 else?

1 DR. VARDAMAN: Chuck, can I just hop in and
2 clarify?
3 VICE CHAIR MILLIGAN: Yes.
4 DR. VARDAMAN: There was a question about the
5 recovery amounts, and, Sheldon, we can follow up with you
6 on that one. What I'm seeing is there was a range of $622
7 million to about $733 million. That's fiscal year 2015 to
8 2019.
9 VICE CHAIR MILLIGAN: Okay. Thanks, Kristal.
10 Sheldon, did you want to respond? Were you
11 waving?
12 COMMISSIONER RETCHIN: But, Kristal, that's in
13 the aggregate, right, not per year?
14 DR. VARDAMAN: That is the aggregate across all
15 states for that --
16 COMMISSIONER RETCHIN: Yeah, yeah -- for the
17 single year? Okay. All right.
18 VICE CHAIR MILLIGAN: Okay. Thank you. Brian,
19 and then I'll close, and then we'll move on. Brian?
20 COMMISSIONER BURWELL: I'm personally of the
21 opinion that the problem with Medicaid estate recovery is
22 that it just had bad policies associated -- it's not a bad

1 idea, but it's bad policies, so several people have
2 mentioned it's not equitable, that, you know, people with
3 fewer assets don't have the resources to hire attorneys
4 while more wealthy people can. So I think that there could
5 be changes made to policy to protect people with less
6 wealth and target people with more wealth. I mean, we live
7 in a society where -- of extreme wealth maldistribution the
8 top 10 percent of the country owns 77 percent of all the
9 wealth and 90 percent have only 23 percent. So obviously
10 we could do a lot more to protect people with minimal
11 amounts of money and target people with more amounts of
12 money. So the existing policy landscape is just mixed up.
13 So, I mean, there's a real opportunity to make this better,
14 but it's not going to be easy. So I just want to make that
15 point.
16 VICE CHAIR MILLIGAN: Thank you, Brian.
17 So in the interest of time, I want to strongly
18 align myself with the recommendation down the road to make
19 this optional. I think the states that want to pursue
20 collection and have been successful could retain the
21 option.
22 I want to, I think, make two comments I haven't

1 heard yet. One is that I think there's a separate equity
2 position or point that I haven't heard, which is
3 individuals who use Medicare, individuals who use Social
4 Security benefits, individuals who use other federal
5 programs don't find themselves with this kind of risk. And
6 I think to the extent that in Medicaid the difficulty
7 transferring assets to the next generation, it might
8 perpetuate poverty. And I think there's a fundamental
9 stigma and inequity around thinking of this as a way of
10 financing a program by recycling dollars back that, you
11 know, I don't see in Medicare, I don't see in other
12 programs, I don't see for higher-income people who are
13 using other public resources.
14 So I think there's a different equity issue, not
15 just who can afford an elder law attorney and who can't,
16 but why is Medicaid uniquely subject to this risk in terms
17 of helping lift the next generation potentially out of
18 poverty?
19 The second comment I want to make is -- and,
20 Kristal, this is something that I think if we can find some
21 data, I would want to see the data or an estimate, which is
22 the amount of money that is not collected, if states, in

1 fact, are treating it functionally like it's optional, I
2 could have concerns that states have risk with HHS OIG
3 coming in behind and having a finding of the state not
4 properly administering federal law and recoupment type
5 risks.

6 So I would want to have a sense of like that
7 scale, if we -- if there's any way to estimate it, and I
8 see, Anne, you -- so my comment is I'm very aligned to the
9 optional piece for other reasons that I won't go into right
10 now in the interest of time.

11 Anne, did you want to comment about that data
12 point I raised?

13 EXECUTIVE DIRECTOR SCHWARTZ: Well, I just wanted
14 to ask if you had a suggestion about how we might do that
15 because it's not easy to get an estimate of things that
16 didn't happen. You would have to know how much money
17 people had in their estates which otherwise wouldn't be
18 reported. It's not being collected.

19 So if you had a thought, a clever way to get at
20 that or like a proxy for that, I just wanted to see if you
21 had any thoughts on that, and if you have thoughts later,
22 you can, of course, let us know.

1 DR. VARDAMAN: We have been reviewing --

2 VICE CHAIR MILLIGAN: Go ahead, Kristal.

3 DR. VARDAMAN: We have been looking for
4 information that's out there in the literature on assets
5 held by the elderly. We can dig around and look for some
6 more sources of information. Some of the challenges are
7 also around not knowing other creditors that might be in
8 place that might have a higher priority than Medicaid. So
9 that even if people have assets, there might be other
10 obligations to that money before Medicaid gets to it.

11 VICE CHAIR MILLIGAN: And, Anne, the only thought
12 I had was just checking with states to see if they had made
13 those estimates, but I agree. It's not likely to be very
14 precise or very available.

15 Kristal, Tamara, do you have what you need from
16 us in terms of feedback or next steps? Do you have any
17 questions before we move on to the next item?

18 DR. VARDAMAN: No. I think we have what we need.

19 VICE CHAIR MILLIGAN: Are you good?

20 DR. VARDAMAN: We'll be back to you all in
21 December.

22 VICE CHAIR MILLIGAN: Okay, great. Thank you

1 very much.

2 Melanie, back to you.

3 CHAIR BELLA: Thank you, Chuck. Thanks,

4 everyone.

5 The next session that we have is about drug

6 rebates and medications for opioid use disorder. I hope I

7 don't jinx this session by saying that this should be a

8 pretty straightforward discussion about a classic sort of

9 unintended consequence, where I think it's something

10 important to call to our attention, though.

11 So Erin and Chris are going to lead us through

12 that, and then we'll have a bit of a discussion. I turn it

13 to you guys.

14 **### MEDICAID DRUG REBATES AND MEDICATIONS USED FOR**

15 **OPIOID USE DISORDER**

16 * MS. McMULLEN: Thanks, Melanie.

17 So in 2018, Congress passed the SUPPORT Act to

18 help address the nation's opioid epidemic, and as part of

19 that legislation, Congress mandated that Medicaid programs

20 cover all forms of medications used for treatment of opioid

21 use disorder, or MOUD, for a five-year period.

22 In passing this legislation, MOUD was

1 unintentionally excluded from the definition of a covered
2 outpatient drug. As a result, MOUDs will no longer be
3 eligible for the statutory Medicaid drug rebates for the
4 next five fiscal years beginning on October 1st.
5 Additionally, states will no longer be required
6 to include MOUDs in drug utilization review, or DUR
7 programs, and MOUDs will be excluded from the 340B drug
8 pricing program.
9 So in today's presentation, we'll provide a brief
10 background on the SUPPORT Act and the Medicaid Drug Rebate
11 Program. Next, we'll discuss issues associated with this
12 provision of the SUPPORT Act and potential solutions the
13 Commission may want to consider, to include MOUDs in the
14 definition of a covered outpatient drug in the Medicaid
15 Drug Rebate Program.
16 So really quickly, I mentioned that in 2018,
17 Congress through the SUPPORT Act explicitly required all
18 state Medicaid programs to pay for all MOUDs for a five-
19 year period beginning on October 1st of this year.
20 As a reminder, there's currently three drugs that
21 have been approved by the FDA for the treatment of opioid
22 use disorder. That's methadone, buprenorphine, and

1 naltrexone. Some of these medications are available in a
2 variety of formulations, such as oral tablets, extended
3 relief injections, as well as implantable devices. Some of
4 these formulations are also available in generic form.
5 Prior to the SUPPORT Act, all states and the
6 District of Columbia paid for some form of buprenorphine
7 and naltrexone; however, Medicaid programs were not
8 obligated to cover methadone when used to treat opioid use
9 disorder, but the majority of states did. Therefore, this
10 provision in the SUPPORT Act will primarily increase
11 coverage of methadone when it's used to treat opioid use
12 disorder in opioid treatment programs.
13 Now I'll hand it over to Chris to discuss the
14 Medicaid Drug Rebate Program.
15 * MR. PARK: Thanks, Erin.
16 Just as a quick reminder, prescription drugs are
17 an optional benefit that all states have elected to
18 provide. Coverage is authorized under Section 1905(a)(12)
19 of the Social Security Act.
20 Under the Medicaid Drug Rebate Program, or MDRP,
21 a drug manufacturer must enter into a rebate agreement in
22 order for states to receive federal funding for the use of

1 the manufacturer's products. In exchange for the rebate,
2 state Medicaid programs must generally cover all of the
3 participating manufacturer's drug. Currently, that is,
4 before the SUPPORT Act, most forms of MOUD are considered
5 covered outpatient drugs. Certain forms of MOUD may not be
6 considered a covered outpatient drug if it is provided as
7 part of another service and paid under a bundled payment.
8 For example, methadone dispensed through an opioid
9 treatment program is often paid for as a bundled service
10 and is, thus, not a covered outpatient drug under the MDRP.
11 Next slide.
12 The statutory definition of covered outpatient
13 drug is identified in Section 1927(k)(2) of the Act and
14 specifically references drugs that are treated as
15 prescribed drugs for purposes of Section 1905(a)(12).
16 The technical issue with the SUPPORT Act comes in
17 that. MOUDs will now be covered as a distinct mandatory
18 benefit under a new paragraph, under Section 1905(a)(29).
19 Although MOUDs could potentially be covered under
20 either benefit, it is the opinion of the General Counsel of
21 CMS that coverage under the mandatory benefit takes
22 precedence over the optional drug benefit. Therefore,

1 beginning October 1st, when the SUPPORT Act provision takes
2 place, MOUDs will no longer meet the definition of covered
3 outpatient drug and therefore will be excluded from the
4 MDRB.
5 As Erin mentioned in the beginning, this creates
6 a few issues. First, MOUDs will not be eligible to receive
7 statutory rebates. Preliminary CMS projections estimated
8 that the Medicaid program could lose approximately $3
9 billion in rebates over the five-year time period.
10 CMS has indicated that states may negotiate their
11 own rebates; however, it's not clear that states will be
12 able to make up for the loss in the statutory rebates.
13 Second, because drug utilization review programs
14 are authorized under the MDRP and applied to cover
15 outpatient drugs, these activities will no longer be
16 required for MOUDs. States will have the ability to
17 implement certain processes under general amount, duration
18 of script provisions; however, states will not be required
19 to conduct specific DUR activities for MOUDs.
20 Finally, while this is not exclusively a Medicaid
21 issue, this also affects the status of MOUDs in the 340B
22 drug pricing program. The definition of covered drug for

1 the 340B program links back to the Medicaid definition of
2 covered outpatient drug. This means that MOUDs will no
3 longer meet the definition of covered drug for the 340B
4 program, and 340B entities will not be able to purchase
5 these drugs at the discounted 340B price.
6 Next slide.
7 Nothing in the legislative history suggests that
8 it was congressional intent to exclude MOUDs from the MDRP,
9 and we have confirmed this in conversations with
10 congressional staff. Rather, this provision in the SUPPORT
11 Act was intended to increase access to MOUD by making it a
12 mandatory benefit.
13 Please note that since we put this session
14 together, a fix for this issue was included in the
15 Continuing Resolution passed by the House on Tuesday. So
16 the Commission may not need to act. However, if this fix
17 does not make it into law, the Commission may want to
18 consider making a recommendation to Congress to make MOUDs
19 covered outpatient drug. Specifically, the Commission
20 could recommend a change in the definition of covered
21 outpatient drug to cross-reference coverage of MOUDs in
22 1905(a)(29) of the Act, and this change could also be made

1 retroactive back to October 1st.

2 With that, I will turn it back over to the

3 Commission.

4 CHAIR BELLA: Thank you, Chris and Erin.

5 Can I just get my head straight on? So it's in

6 the legislation. We don't know if that goes anywhere. So

7 our options would be wait and see what happens, and then we

8 could come back in October in a future meeting and see if

9 we need to make recommendation. I suppose another option

10 could be we send a letter endorsing it and calling

11 attention to it to make sure it doesn't inadvertently get

12 dropped. Is there anything short of making a

13 recommendation or taking a wait-and-see approach that we

14 should deliberate on right now?

15 MR. PARK: I think Anne wants to make --

16 CHAIR BELLA: Yeah. Anne, I don't know if you

17 have a comment on that.

18 EXECUTIVE DIRECTOR SCHWARTZ: I think we'll know

19 by the end of this week about whether we have to do

20 anything or not. I would not vote for -- I would not --

21 well, "vote" is the wrong word. I would not suggest that

22 we pull a letter together tonight and try to get that

1 perfect if it's going to happen, anyway. But I think sort
2 of the fallback is if this doesn't get into the CR -- and
3 the politics around the CR aren't going to be around this
4 provision. They're going to be around other things. If it
5 somehow drops out, then we could come back and either do a
6 letter to the Hill or vote on a formal recommendation in
7 October. That would be fine, and in fact, it may resolve
8 itself by the end of the week.
9 CHAIR BELLA: Yeah. I'm just thinking that
10 usually the things that no one -- that have no opposition
11 and that are small tend to be the ones that drop out
12 inadvertently. So that's what I was thinking ahead to.
13 EXECUTIVE DIRECTOR SCHWARTZ: The only thing I
14 would say on that is in talking with Hill staff, as we do
15 every time we have a meeting we brief them, that we were
16 told that the four corners, both sides of the aisle, House
17 and Senate, are all in on this, and it's just whether
18 there's some politics going on that's unrelated to this
19 that is above their pay grade.
20 CHAIR BELLA: Okay. Thank you.
21 Let's open it up for comments or questions.
22 Stacey and then Martha.

1 COMMISSIONER LAMPKIN: I just have a quick, just
2 clarifying question. Would the fix that's in the House
3 bill essentially return things to the way they were before,
4 which was that if it's on methadone or something in a
5 bundled payment, it still would not be considered an
6 outpatient drug? But if it's separately delivered and paid
7 for, it would?
8 MR. PARK: That's correct. Right now, it would
9 basically say that MOUDs covered under 1905(a)(29) would
10 essentially be treated as being covered under (a)(12), but
11 if they don't meet the other requirements of the statutory
12 definition, they would not be covered outpatient drugs.
13 CHAIR BELLA: Stacey, anything else?
14 [No response.]
15 CHAIR BELLA: Okay. Martha?
16 COMMISSIONER CARTER: Thanks.
17 I think the Commission has been on record of how
18 important we think programs to treat opioid use disorder
19 are, and so I think that we need to track this carefully
20 and be prepared and perhaps have the staff ready to go with
21 a letter or whatever they think is the best approach if for
22 some reason this issue drops out of the current

1 legislation.

2 I think the 340B program is particularly
3 important as people move through addiction treatment and
4 start to be able to work again, and we know probably only
5 about half of people in addiction programs are currently
6 employed, that we don't want to put up any barriers for
7 people to be able to continue to get their medication as
8 they perhaps drop off Medicaid and move to some employment
9 perhaps without benefits.

10 So I think it's hugely important, and we need to
11 track it carefully.

12 CHAIR BELLA: Thank you, Martha.

13 Other Commissioners? Tom.

14 COMMISSIONER BARKER: Not to delay this further,
15 I agree with everything everyone said. I think Anne and
16 Martha have the best approach. Let's just wait and see
17 what happens over the next couple of days, and if it drops
18 out of the Senate version, then we should do a letter.

19 CHAIR BELLA: Thank you, Tom.

20 Anyone else?

21 [No response.]

22 CHAIR BELLA: All right. So I think that will be

1 our approach. We will watch carefully to see what happens
2 over the next couple days and then be prepared to jump in
3 if we need to, if for some reason it doesn't make it in
4 there.
5 Thank you, Chris and Erin. I think, Erin, you're
6 staying, right? You're staying with us.
7 We're going to move into a session on behavioral
8 health and talk about behavioral health and Medicaid,
9 looking at the Commission's work plan and some initial
10 analysis. Melinda and Erin are going to lead us in that
11 session. Welcome.
12 **### BEHAVIORAL HEALTH IN MEDICAID: WORK PLAN AND**
13 **INITIAL ANALYSES**
14 * MS. ROACH: Great. Thank you.
15 Next slide, please.
16 There are two parts to our presentation this
17 afternoon. First, we'll provide an update on our
18 behavioral health work plan and a timeline for the
19 Commission to discuss the different components of this
20 work.
21 The work plan includes time in the spring for us
22 to develop policy options, with the goal of including

1 recommendations in the Commission's June report.

2 In the second part of our presentation, Erin will
3 discuss findings from an analysis of federal survey data
4 used to estimate the prevalence of mental illness among
5 non- institutionalized adults, comparing the experience of
6 Medicaid enrollees to those with other sources of coverage.
7 The analysis also examines the prevalence of co-occurring
8 conditions among adults with mental illness, their
9 involvement with the criminal justice system, and their
10 reported access to mental health treatment. We'll close by
11 discussing how this analysis can inform the Commission's
12 work going forward.

13 Next slide.

14 The Commission's most recent behavioral health
15 work focused largely on access to substance use disorder
16 treatment for adults, and they included two reports to
17 Congress required by the SUPPORT Act. The four projects
18 outlined in your meeting materials broadened the
19 Commission's work, to include a focus on mental health.
20 They include projects on access to behavioral health
21 services for adults and children; electronic health record,
22 or EHR use, among behavioral health providers; and

1 application of federal mental health parity rules to
2 Medicaid and CHIP.
3 Next slide.
4 The first project focuses on access to mental
5 health services for adults. It will examine what mental
6 health services states cover for adults, what Medicaid
7 authorities they use to provide those services, and whether
8 federal policy changes are needed to improve access.
9 To consider these questions, we've done an
10 analysis of adults with mental health conditions, which
11 you'll hear about in the second half of this presentation.
12 At the Commission's October meeting, we'll come back to
13 present findings from an analysis of state coverage
14 policies and specialty mental health provider participation
15 in Medicaid. Also, at the October meeting, we'll be joined
16 by two states and a beneficiary representative for a panel
17 discussion on challenges and opportunities related to
18 mental health access among adults in Medicaid.
19 Next slide, please.
20 The next project examines access to mental health
21 and substance use disorder services for children. It seeks
22 to address whether children enrolled in Medicaid or CHIP

1 can access the behavioral health services they need, what
2 authorities states are using, in addition to the early and
3 periodic screening, diagnostic, and treatment, or EPSDT
4 benefit, to provide access to a continuum of evidence-based
5 behavioral health services for children, and whether
6 federal policy changes are needed to improve access for
7 this population.
8 At the December meeting, we'll present two
9 analyses designed to address these questions, one looking
10 at the prevalence of behavioral health conditions among
11 children in Medicaid and CHIP versus those with other forms
12 of coverage and the rates at which they receive treatment
13 and another examining the availability of behavioral health
14 services for children enrolled in Medicaid or CHIP.
15 At the December meeting, we'll also convene a
16 panel with states and a beneficiary representative to
17 further examine issues related to behavioral health
18 screening and treatment for children.
19 Next slide.
20 The next project focuses on EHR use among
21 behavioral health providers as a means to improve care
22 coordination for patients with substance use disorder and

1 mental health conditions, many of whom have serious
2 comorbidities and receive fragmented care. Building on the
3 Commission's previous work on behavioral health
4 integration, the project will examine how the HITECH Act
5 increased use of certified EHR technology and what federal
6 mechanisms behavioral health providers can use to promote
7 EHR interoperability.
8 At the Commission's meeting in December, we'll
9 provide an overview of the HITECH Act and federal Medicaid
10 policies that could increase use of EHRs among behavioral
11 health facilities. We'll also discuss trends in EHR use
12 before and after the HITECH Act and identify state policy
13 levers to strengthen adoption among behavioral health
14 providers that aren't eligible for Medicaid incentive
15 payments.
16 We're expecting HHS to release a proposed rule to
17 align 42 CFR Part 2 in HIPAA as required by the CARES Act.
18 This may increase EHR adoption among behavioral health
19 providers who will no longer have to segment substance use
20 disorder treatment records, something we'll consider in the
21 course of this work.
22 Next slide.

1 The final project focuses on application of
2 Mental Health Parity and Addiction Equity Act of 2008 to
3 Medicaid and CHIP. It will examine barriers to
4 implementation, how state plan compliance is assessed,
5 whether parity requirements have improved access, and
6 whether federal policy changes for state compliance or
7 otherwise further the objectives of mental health parity.
8 To answer these questions, in January, we will
9 present findings from interviews with state officials,
10 health plans, and beneficiary representatives in Hawaii,
11 Maryland, and Oregon. That presentation will also
12 highlight findings from interviews we conducted with
13 officials at CMS and national organizations such as the
14 National Health Law Program and the National Association of
15 Insurance Commissioners.
16 Next slide.
17 As we move ahead, it would be helpful to hear
18 whether Commissioners have comments on the proposed
19 approach for electing information to support these four
20 projects, know of particular experts or stakeholders we
21 should be reaching out to, or are aware of particular
22 nuances or issues of concern. We'll have time to get your

1 thoughts on these questions following Erin's presentation
2 on our analysis of adults with mental illness.
3 And with that, I'll turn it over to Erin.
4 * MS. McMULLEN: Thanks, Melinda. So for this
5 analysis we contracted with the State Health Access Data
6 Assistance Center at the University of Minnesota to analyze
7 the national survey on drug use and health, which is a
8 federal survey conducted annual in all 50 states and the
9 District of Columbia. It provides information on self-
10 reported alcohol and drug use, mental health, and other
11 health-related issues among non-institutionalized
12 individuals in the U.S. This means that the survey does
13 not include individuals residing in inpatient psychiatric
14 facilities, jails, or prison.
15 For adult respondents, the survey captures mental
16 health conditions based on their severity, not specific
17 diagnoses. So for the purposes of our analysis and today's
18 presentation we are going to report information in three
19 categories. That's any mental illness, mild to moderate
20 mental illness, and serious mental illness. Where
21 possible, we're going to draw distinctions between these
22 three categories when estimating prevalence, the occurrence

1 of co-occurring conditions, and the rates at which
2 individuals received treatment.
3 Our first slide looks at prevalence of mental
4 illness among non-institutionalized adults. As you can
5 see, in 2018, 21 percent of the non-institutionalized
6 population ages 18 to 64 had a mental health condition.
7 And the percentage of adults with any mental illness was
8 higher for those enrolled in Medicaid when compared to
9 adults with private coverage as well as those without
10 insurance. In part, this may be due to the fact that many
11 individuals qualified for Medicaid on the basis of a
12 disability, including those with serious mental illness.
13 In your meeting materials there are some
14 additional demographics breakdown related to prevalence
15 that I just wanted to bring to your attention. Generally,
16 we found, across all racial and ethnic categories, with the
17 exception of those who identified as American Indian,
18 Alaska Native, Native Hawaiian, or Pacific Islander, adults
19 who are enrolled in Medicaid are more likely to have a
20 mental illness when compared to those with private
21 coverage. As demographic information is incorporated into
22 a potential draft chapter, we'll plan on further discussing

1 racial disparities among individuals with mental health
2 conditions.
3 The next slide has some very high-level
4 information around lifetime rates of co-occurring
5 conditions among adults with past year mental illness.
6 Your meeting materials delve into some deeper details
7 around specific illnesses. But as you can see, in 2018,
8 non-institutionalized adults with any mental illness who
9 were enrolled in Medicaid reported having a co-occurring
10 condition over the course of their lifetime at higher rates
11 than adults with mental illness with private coverage.
12 Beneficiaries also had higher rates of co-occurring
13 conditions when compared to adults who were uninsured.
14 Across all coverage categories, these rates were higher for
15 adults with serious mental illness when compared to adults
16 with mild to moderate conditions. Generally, beneficiaries
17 with serious mental illness reported higher rates of co-
18 occurring conditions than Medicaid beneficiaries with mild
19 to moderate mental illness.
20 We also found that beneficiaries with mental
21 health conditions, regardless of the severity of their
22 illness, received treatment at similar rates of their peers

1 with private coverage. However, a deeper look at the data
2 revealed that Medicaid beneficiaries received treatment in
3 different settings than those with private coverage.
4 Specifically, we found that beneficiaries with any mental
5 illness were nearly three times more likely to receive
6 treatment in a specialty outpatient mental health center or
7 day treatment program than those with private coverage, but
8 they were less likely to receive treatment in a private
9 therapist's office.
10 Even though beneficiaries received some form of
11 treatment at similar rates of those with private insurance,
12 we did find that beneficiaries with any mental illness were
13 more likely to report that they needed but did not receive
14 mental health treatment in the past year.
15 We also found a higher use of inpatient mental
16 health services among Medicaid beneficiaries with any
17 mental illness when compared to their privately insured
18 peers. Beneficiaries with any mental illness were nearly
19 four times as likely to receive inpatient treatment for
20 their mental health condition as those with private
21 coverage, and compared to those with private coverage,
22 beneficiaries with mild to moderate mental illness were

1 nearly five times as likely to receive inpatient treatment
2 for their mental health condition. Finally those with
3 serious mental illness were more than twice as likely to
4 receive treatment in an inpatient setting.
5 So as I mentioned earlier, the National Survey on
6 Drug Use and Health doesn't capture populations that are
7 institutionalized, including individuals in jail and
8 prison. However, the survey does have some variables that
9 can be used to estimate whether individuals have come into
10 contact with the criminal justice system. So we were able
11 to make a few observations that are included on this slide.
12 In 2018, we found that non-institutionalized
13 adults with any mental illness who were enrolled in
14 Medicaid were almost twice as likely to report that they
15 had been arrested or booked for breaking the law when
16 compared to adults with any mental illness with private
17 coverage. We also found that rates of involvement with the
18 criminal justice system were higher among adults with past-
19 year serious mental illness when compared to adults with
20 mild to moderate conditions. Finally, adults with any
21 mental illness who were enrolled in Medicaid were more than
22 three times as likely to report that they were on probation

1 or parole in the past year when compared to those with
2 private coverage.
3 So before we wrap up our presentation, I just
4 wanted to take a minute to connect some of the findings
5 from this analysis with the work plan that Melinda just
6 described. So the significant percentage of Medicaid
7 beneficiaries reporting unmet need for mental health
8 treatment, combined with higher rates of inpatient
9 treatment among beneficiaries suggests the need to identify
10 coverage gaps and other barriers that may limit access to
11 community-based treatment.
12 As Melinda noted, in October we'll present a 50-
13 state overview of mental health service coverage and an
14 analysis of specialty mental health provider participation
15 in Medicaid to support further exploration of these issues.
16 That meeting will also include the perspectives of two
17 states and a beneficiary representative to gain additional
18 insight into factors that affect access to community mental
19 health services.
20 In addition, the mental health and physical
21 health care needs of beneficiaries with mental health
22 conditions and their higher rates of treatment in specialty

1 mental health settings highlights the value of improved
2 care coordination for this population. In this report
3 cycle, we'll focus on improving coordination through
4 behavioral health provider adoption of electronic health
5 records, and we'll go deeper into that at the December
6 meeting.
7 Finally, given the prevalence of mental health
8 conditions among justice-involved populations, including
9 Medicaid beneficiaries under community supervision, the
10 Commission may also want to condition additional analyses
11 focused on that population.
12 So that concludes our presentation and we're
13 happy to answer any questions you have at this time.
14 CHAIR BELLA: Thank you both. Really important
15 work, and it's great that you're bringing this in front of
16 us today. If it's not too hard, can we go back to Slide 8
17 that Melinda used, just so we have the questions in front
18 of us?
19 Peter, Martha, and I think I saw another hand
20 too, Chuck. We'll start with you, Peter.
21 COMMISSIONER SZILAGYI: Okay, two. First of all,
22 two excellent presentations, Erin and Melinda. Actually,

1 Erin partly answered some of my questions that I had while
2 Melinda was presenting. This was about child behavioral
3 health. And I think the pandemic has heightened the
4 importance of examining behavioral health issues among the
5 pediatric and adolescent populations. I don't have clear
6 national data, but we are hearing lots of reports, local
7 reports, about very serious adolescent mental health
8 concerns that have been triggered or potentially caused by
9 the pandemic, and this is partly because of social
10 isolation and other factors. So I think that's a really
11 important point.

12 I'm glad when Erin presented on the adult
13 behavior health that you had that slide where you compared
14 access in Medicaid versus commercial, and I was going to
15 make that suggestion that for the pediatric population I
16 think we absolutely have to do that. When I was very
17 involved with leaders in a Medicaid managed care program in
18 upstate New York we made the kind of commitment early on in
19 my leadership that every quality measure we present we
20 would compare the Medicaid to the commercial population,
21 whenever we had that data.

22 And the third point I was going to make is the

1 sub-populations within the pediatric population, and Erin,
2 you mentioned this, but the foster care population and the
3 incarcerated populations are two groups that have extremely
4 high mental health problems. And so as an example, for the
5 juvenile incarcerated population the access post-
6 incarceration to mental health, to receive mental health.
7 So those are my three points. Thank you. Excellent
8 presentation and I like this plan.
9 CHAIR BELLA: Thanks, Peter. Martha?
10 COMMISSIONER CARTER: Thank you, guys. You
11 mentioned a need for better care coordination for people
12 with mental health issues and co-occurring medical needs.
13 I'd like to think about going a step further and looking at
14 barriers and facilitators to truly integrating medical care
15 with behavioral and/or health care. I think care
16 coordination starts to get at what we need but I think
17 there's good evidence to show that truly integrated
18 behavioral health is very effective. So I wanted to pose
19 that question.
20 You asked for new analysis and here's one, a
21 little down in the weeds. I'm hearing from community
22 health centers, across the country really, that states are

1 reimbursing poorly or not at all at times for group
2 counseling. This is a proven method for substance use
3 disorder and other behavioral health issues. And frankly,
4 this may actually be happening for other Medicaid providers
5 as well as the FQHCs. So I'd like to take a little dive
6 into that and see what's happening with reimbursement for
7 group counseling.

8 Third, just to revisit something that we started
9 earlier, is how states are sort of dealing with, paying for
10 peer support counselors and other providers that are not
11 traditional Medicaid providers, because those are
12 important, especially in substance use disorder. We
13 touched on that earlier, but I don't want to lose track of
14 that one. Thanks.

15 CHAIR BELLA: Thank you, Martha. Chuck and then
16 Kit.

17 VICE CHAIR MILLIGAN: Really good presentation.
18 I had three comments as well. The first two I think are
19 work plan related and both of them are about the CARES Act,
20 implications for part two. I do think that one of the
21 issues I would be curious to track is whether this changes
22 for state MMISs or state system design work. So not just

1 the EHR side but the state side, around how data is
2 compartmentalized, how data is made available and used,
3 data warehouses and data analytics. I'm curious about some
4 of those elements.
5 The second is I'm curious as potentially part two
6 substance use disorder data moves more towards a HIPAA
7 model, whether we can monitor the implications for things
8 like value-based contracting and rolling the cost of those
9 services into some of those at-risk contracts that
10 providers typically, historically have been reluctant to
11 have financial risk for something they can't see and they
12 don't have awareness about. And also things like, you
13 know, patient-centered medical homes.
14 So I think how the potential privacy changes
15 affect risk models and care delivery models for PCMH and
16 value-based contracts, so I'm interested in seeing if we
17 can kind of build that into how we track that.
18 The third comment, Erin, I think touches in more
19 of what you presented. Individuals with chronic illness
20 tend not to get as many preventive services. Their lives
21 are very complicated. They don't go in for a lot of
22 routine preventive care, you know, whether it's

1 colonoscopies or mammograms or whatever. But I think with
2 mental illness it's even more pronounced and that there's
3 very low utilization of preventive services because of just
4 the complexity of dealing with the behavioral health
5 diagnoses.
6 And so I think as we look at implications of
7 behavioral health if there's a way to compare individuals'
8 behavioral health and their utilization of preventive
9 services on the physical side, I think that would be an
10 important way of shedding light on the need to build care
11 delivery models around that population for preventive care.
12 Thank you.
13 CHAIR BELLA: Thank you, Chuck. Kit then Leanna,
14 then Sheldon.
15 COMMISSIONER GORTON: So I really focused on that
16 one slide, and if you can pull it up that would be great,
17 the five-to-one inpatient. Next one, maybe. Is there one
18 after that with numbers? Yes, that one.
19 So when I looked at this I thought, well, you
20 know, why would we hypothesize that it would be this way?
21 And number one could be institutional bias in Medicaid,
22 which is that we tend to better fund institutional services

1 rather than non-institutional services. Hypothesis number
2 two would be access, right. The people in Medicaid don't
3 have as much access to the outpatient services as to the
4 inpatient services, so inpatient is the only option
5 available to them. And then hypothesis number three would
6 be, you know, Medicaid population has other risk and acuity
7 factors, social determinants of health, co-occurring
8 illnesses, all of those things, which just make them harder
9 to treat as outpatients than as inpatients.
10 My guess is that it's all of the above, in some
11 combination, and then probably other things. I think it
12 would be useful in terms of helping us figure out whether
13 there are things that are addressable by federal Medicaid
14 policy to see if we can sort out, you know, sort of
15 relative weight. It may be hard to do a quantitative
16 analysis but maybe the people that you're talking to in the
17 field can qualitatively say this is a bigger problem than
18 that is.
19 I think it would be useful in terms of making
20 observations or recommendations about what might be done
21 differently in the future to be able to say here's what
22 drives this. There's obviously a cost driver as well, so

1 in terms of cost-effectiveness program, here's what drives
2 this and here's what we might be able to do to address it.
3 Thanks.
4 CHAIR BELLA: Thank you, Kit. Leanna?
5 COMMISSIONER GEORGE: One of the things I wanted
6 to maybe sort of just take a look at is the access to
7 services for an individual that has developmental
8 disability as well as a mental health challenge. I know,
9 personal experience, a friend of mine has a child that
10 falls in that category and they searched for four years to
11 find a place that could treat her. They had to go out of
12 state for that. I'm sure she's not the only one.
13 CHAIR BELLA: Did you say four years?
14 COMMISSIONER GEORGE: Yeah. They looked like
15 three or four years. They finally found the treatment that
16 she needed, but there was nowhere in North Carolina if you
17 have any combination of needs, behavioral health or mental
18 health, and her developmental disability.
19 CHAIR BELLA: Thank you. Sheldon and then
20 Tricia.
21 COMMISSIONER RETCHIN: Yeah, I just wanted to
22 underscore something I had mentioned by email last night to

1 Erin, and, by the way, it's a great report and I'm very
2 supportive of the work plan. But this is of any area of
3 access and unmet needs. I do think this is the best
4 example of supply and demand. So I looked at the workforce
5 gaps by region from HRSA, and the gaps in some of the
6 mental health providers are absolutely astonishing and only
7 going to get worse by 2030. But there are remarkable
8 variations according to state, and especially region.
9 There seem to be plenty of mental health providers in the
10 Northeast, and very few in the South and Southeast.
11 And the importance of that is that in the
12 Southeast, the Southeast has the most restrictive scope of
13 practice laws in the country so it squeezes out those that
14 might be providing mental health, aside from psychiatrists,
15 who have very low Medicaid participation rates.
16 So I guess my request is that in the work plan we
17 build in some assessment of the workforce needs and scope
18 of practice as important issues to address. Thanks.
19 CHAIR BELLA: Thanks, Sheldon. Tricia?
20 COMMISSIONER BROOKS: Yeah. Our provider
21 colleagues may know more about this than I do, but as I
22 understand it there can be issues for young children, even

1 under EPSDT, if there's not been a specific diagnosis, in
2 terms of coverage with Medicaid, that a diagnosis is
3 required and that some providers are reluctant to label a
4 two-year-old with a specific diagnosis that it takes them
5 to the next level of care. So I think it would be helpful
6 to explore that a bit as well.
7 CHAIR BELLA: Thanks, Tricia. Darin?
8 COMMISSIONER GORDON: First, to Tricia's plan, I
9 think that is worth looking at. We understood that there
10 was some confusion in the provider community in that
11 regard, so whether it's real or perceived that's been an
12 issue over the years.
13 To Chuck's point about -- I'm sorry, or Sheldon's
14 point, about the Southeast, and this may be true elsewhere,
15 it's not just scope of practice that may be challenging. I
16 know in some states that there are provisions that had the
17 effect of blocking out some providers from participating in
18 Medicaid. For example, may require that all providers
19 provide case management services, which, you know, you
20 typically see in some of the private-based commercial
21 providers. So there are other things beyond scope of
22 practice that I think do have somewhat of a limiting effect

1 to participation, that needs to be considered.

2 To your question on are there particular experts
3 or stakeholders we should consult, I'll just throw a name
4 out there for you guys to maybe at least talk to. Out of
5 all the folks that have been involved Medicaid, from a
6 Medicaid director perspective, there's only one that I know
7 of that their structure -- they had complete responsibility
8 for not just Medicaid but also behavioral health in their
9 state, and that was Tom Betlach in Arizona. I guess Jami
10 has that responsibility now. But I think that just gave
11 them -- you know, that's a very unique position to where
12 they are managing both sides and can see where some of the
13 challenges are. And I think either of them may give a
14 different perspective than maybe just someone that's purely
15 sitting in the Medicaid director seat without that added
16 responsibility.

17 CHAIR BELLA: Thanks, Darin. Other comments?

18 [No response.]

19 CHAIR BELLA: Melinda, let me also say welcome to
20 you, since you've joined I think since we were last all
21 together. Do you, Erin and Melinda, have what you need
22 from us? I think you're hearing overwhelming support for

1 this, the style in which you presented this and allowed us
2 to comment or mapped out where things are going is great.
3 And so is there anything else, any follow-up questions you
4 have on any comments that were made or anything else you
5 need from us at this point?
6 MS. McMULLEN: I don't think so. I think you
7 guys give us a lot of great feedback to think about as we
8 move forward.
9 CHAIR BELLA: All right. Thank you very much.
10 We are moving into our last session, and
11 following this session we'll take public comments on the
12 things we discussed this afternoon.
13 Anne is actually going to lead us in this
14 session, and we're going to be talking about data sources
15 and racial and ethnic disparities in Medicaid and CHIP.
16 So, Anne, I will hand it to you.
17 **### FEDERAL DATA SOURCES FOR ANALYZING RACIAL AND**
18 **ETHNIC DISPARITIES IN MEDICAID AND CHIP**
19 * EXECUTIVE DIRECTOR SCHWARTZ: Thanks, Melanie.
20 In July, the Commission announced in an email
21 blast that we would be looking at how MACPAC could
22 contribute to combating institutional racism and addressing

1 racial disparities in health care and health outcomes. As
2 part of that work, we'll be updating our prior work, and we
3 have an extensive back catalog looking across various
4 different services and populations that includes a look at
5 disparities.

6 We'll also be conducting new analyses and you've
7 heard that in several presentations today of how we will be
8 weaving it into our work across all of our different issue
9 areas. We'll also be doing dedicated work to draw
10 attention to Medicaid policies that result in differences
11 in access or experiences in care for people of color and
12 try to think about and possibly make recommendations and
13 options for change.

14 So today's presentation is just the beginning of
15 a dedicated look at that, and you'll be hearing more from
16 our team as we go forward.

17 I also just want to thank Chris, Martha, and
18 Kayla for their help in putting this together. I couldn't
19 have done it without them. It really reflects more their
20 expertise than mine, and also Cal Ernst who was a research
21 assistant for us over the summer who did a number of the
22 tables that were in the paper.

1 Okay. So today I'm going to talk about federal
2 data standards, administrative data, survey data, and some
3 high-level options for data improvement. I want to make
4 sure to acknowledge the fact that there are data gaps that
5 I'll talk about in a moment. That does not need to keep us
6 from taking action, but obviously addressing data
7 limitations would put us in a better position to identify,
8 to monitor, track, and to benchmark going forward.
9 So in terms of data standards at the Federal
10 level, the most recent standards coming out of the Office
11 of Management and Budget that apply across the federal
12 government were set in 1997, and they govern several
13 aspects of how data on race and ethnicity are collected for
14 the purposes of federal surveys and federal programs:
15 first, that race and ethnicity are to be self-identified;
16 that there's a two-part question separating race and
17 ethnicity; and that also individuals have the ability to
18 select more than one category.
19 In 2010, this was specifically applied to HHS
20 under Section 4302 of the ACA along with creating standards
21 related to sex, primary language, and disability status.
22 From everything we can tell, HHS was actually applying the

1 standards for race and ethnicity before then, but probably
2 less so on some of these other data elements.
3 The ACA also set requirements for continuing
4 evaluation and reports to Congress on collecting this data
5 across HHS programs and specifically to Medicaid and CHIP:
6 one report four years after enactment which came out in
7 2014 and which MACPAC commented on in early 2015; another
8 report was due four years thereafter, in 2018. No report
9 has been issued to date, and despite multiple calls and
10 emails and inquiries, we haven't been able to identify the
11 status of that work from the department.
12 So in terms of specifics, these are the five
13 minimum categories for race listed on the slide, and I just
14 want to note that more granular categories may be used if
15 they can be aggregated into these five. So, for example, a
16 survey may collect information under the Asian category
17 also for countries of family origin, such as Chinese,
18 Filipino, or Asian Indian, but they have to aggregate into
19 the Asian category. And then the two minimum categories
20 for ethnicity are Hispanic or Latino and not Hispanic or
21 Latino.
22 In looking at administrative data, the race and

1 ethnicity information and data is drawn from applications
2 which use federal standards. The single streamlined
3 application that's used for the exchanges also uses this,
4 and so they use the same ones.
5 We took a look at 2018 T-MSIS data to actually
6 see what we could find once information from all those
7 applications and renewals are aggregated up to the federal
8 level, and we found very high levels of missing or unknown
9 data. There is lots of detail in Table 1 in your paper.
10 For example, 11 states were missing data for 10 to 30
11 percent of enrollees, and 5 states were missing for more
12 than 30 percent. Fourteen states had 10 to 30 percent of
13 people of unknown race, and seven states had more than 30
14 percent.
15 We also tried to see how the data that were
16 reported comported with benchmarks that we used from other
17 sources, and we looked at the American Community Survey,
18 and we found that results that do not accord with what's
19 reported in the American Community Survey For example, some
20 states reported 0 percent Hispanic, including Connecticut
21 and D.C., which we know from the ACS, that 15.7 percent of
22 those in Connecticut are Hispanic, and in D.C. it's about

1 11 percent. Several states reported 0 percent non-
2 Hispanic, Arkansas, Tennessee, Kansas, Iowa, for example.
3 So it makes you wonder for the data that are there, the
4 usefulness of that data.
5 In terms of survey data, for example, the earlier
6 presentation from Erin and Melinda drew on the National
7 Survey of Drug Use and Health, and that's one of the
8 surveys we typically use in our analyses along with the
9 National Health Interview Survey, the National Survey of
10 Children's Health. These all use the federal data standards
11 that I just mentioned.
12 But when it comes to doing analyses of
13 disparities in Medicaid and CHIP, the sample sizes are
14 often not sufficient for subgroup or state-level analyses.
15 For example, our MACStats tables in which we report on the
16 experience of care and access issues, we aggregate to these
17 categories we see here. We can't get down to look at some
18 of the other groups like Asian or Native Hawaiian and
19 Pacific Islander or Native Americans. In some cases, you
20 may have to also aggregate across several years.
21 Back in 2014, CMS actually conducted a Nationwide
22 Adult Medicaid Consumer Assessment of Healthcare Providers

1 and Systems, the NAM CAHPS or Medicaid CAHPS, and that can
2 be used to analyze racial and ethnic groups at the state
3 level. They drew an extremely large sample for that survey
4 aiming for 1.5 million interviews, 29,000 in each state,
5 and that survey was designed to be able to look at the
6 subgroup level and at the state level. But it was only
7 fielded once in 2014. There's no current plan to repeat
8 it.
9 We've been doing some work ourselves internally
10 to analyze that data. It's interesting, but it's already
11 highly outdated. It was in the field prior to the Medicaid
12 expansion, and so its usefulness in guiding current policy
13 may be somewhat limited.
14 So in the paper, there are a number of very high
15 level suggestions for data improvement, and I want to be
16 clear that these ideas are not fully developed, and what
17 would be helpful today would be get a sense of which ones
18 you would like to pursue a little bit more and what you
19 would like to know so we can support your discussion.
20 Obviously, the willingness of enrollees to
21 identify their race and ethnicity at application does
22 affect administrative data. Programs can't require

1 individuals to provide that information because it's not a
2 condition of eligibility, and there's always been a fair
3 amount of well-founded skepticism among racial and ethnic
4 minorities about how such information will be used.
5 Nonetheless, there are strategies and techniques for
6 helping folks understand how that data will be used, and
7 application assisters, for example, could be helpful in
8 this regard.
9 The other is to place more emphasis on the
10 validity and reliability in state submissions for T-MSIS.
11 Obviously, T-MSIS has been a long project underway, and CMS
12 has created priorities for various fields, focusing first
13 on spending and eligibility group fields that are really
14 important for making comparisons across states. I note in
15 your paper the 32 separate items that CMS has outlined for
16 states as priorities in improving variables. Beneficiary
17 demographics appears in the top ten, and the first one is
18 for date of birth, gender, and zip code, and then it also
19 appears in the 32nd category, which is around race and
20 ethnicity.
21 In terms of survey data, the solutions are fairly
22 simple, but with substantial costs. Obviously, increasing

1 sample size or doing more dedicated oversampling so one can
2 use the data for this purpose are both options, not without
3 significant cost, depending on the survey. And I also just
4 want to put out here the question of having a dedicated
5 periodic survey of Medicaid beneficiaries. This is done
6 for Medicare and has been done for almost 30 years, and
7 that also is a substantial undertaking and would probably -
8 - the costs I reported in the memo, it's about $24 million
9 annually for a Medicare survey. It would have to be more
10 in Medicaid in order to get state-level estimates.
11 So, with that, I will stop presenting and be
12 happy to take any questions to the best of my ability, and
13 I look forward to your thoughts.
14 CHAIR BELLA: Thank you, Anne. Such an important
15 way to wrap up the day, so thank you for that presentation.
16 Fred to start. Fred, I think you might be on
17 mute.
18 COMMISSIONER CERISE: Sorry about that. Thanks,
19 Anne. You know, as we all start looking at this more, I
20 think we're finding what you're showing here, and that is,
21 we just don't have the information at basic levels to
22 understand how we're doing. We all kind of have an idea of

1 how we're doing, but -- so I think it's an important issue
2 to put out there. I am not familiar enough with what you
3 can get from the survey data. I know the CAHPS data where
4 you get experience and that sort of stuff, and it will be
5 important to look at that by race and ethnicity.
6 I also wonder how much reporting you get on
7 outcomes. You know, you could expect to look at this
8 across health plans, looking at how we're doing across
9 races and ethnicity by all of the things that we measure in
10 the health plans. You know, in addition to just basic
11 issues of access like we just talked about in the last
12 session, you know, do people have access? Is there a
13 difference in access, private offices compared to, you
14 know, public health settings and that sort of thing? So I
15 think it's an important thing to start to put a lot more
16 focus on, so I appreciate the work.
17 CHAIR BELLA: Kit, then Kisha.
18 COMMISSIONER GORTON: Yes, thank you for the work
19 and the soft way in which you laid out the challenges. It
20 seems to me that the first thing you do when you have a
21 problem is you shine a light on it, and it might not be the
22 most useful recommendation that a commission made that we

1 should elevate the priority of collecting race and
2 ethnicity data above 32nd in the queue. But on the other
3 hand, Fred's point, we can't address some of these problems
4 if we can't measure it.
5 I think there's a real and understandable level
6 of caution in some of the communities about wanting to
7 provide data to the government, and I'm not in a position
8 to give voice to that. But I know that it exists, and so
9 it seems to me that there is a role for CMS and the states
10 to educate the communities on what the uses of the data
11 would be. That may involve as well commitments on what the
12 uses of the data will not be. And so that may be tricky,
13 and it probably varies by jurisdiction, but I think to the
14 extent that we can get a sense of what the problem is,
15 there might be an opportunity to do one of the roundtable
16 discussions that MACPAC has done in the past to let a
17 broader array of people, particularly now that we're using
18 technology, to let people come in and express on their own
19 part or as advocates for groups and communities what it is
20 that they see the problems with getting these things done
21 correctly.
22 I think that what we can do to raise the issue to

1 say, okay, the country has expressed a need to address
2 institutional bias, MACPAC agrees with that. You know, we
3 look at ourselves on the screen and we know that we're not
4 as diverse as we probably should be, and so we need to
5 recruit more people to be on MACPAC who represent these
6 other communities so it looks more like the people we
7 serve; but as well to be able to say, okay, we've got to be
8 able to collect some level of data and do it in a way which
9 doesn't feel threatening to the communities but allows us
10 to frame these questions which people may have heard us
11 pose.
12 And, lastly, I will just applaud Anne by saying
13 that I agree wholeheartedly with her assessment that just
14 because it's hard and the data aren't great doesn't mean
15 we're not going to do it anymore. I think folks have to
16 some extent hidden behind that in the past, and I'm proud
17 that MACPAC's not going to do that.
18 Thanks.
19 CHAIR BELLA: Thank you, Kit.
20 Kisha and then Darin.
21 COMMISSIONER DAVIS: Yeah. I also want to thank
22 Anne and the staff for bringing this forward. I'm really

1 glad to see that we are looking at this and looking at the
2 data and just recognizing that it's not just Medicaid where
3 we see this issue.
4 My company looked at our own health data and
5 disparities and didn't have great data, and Medicare didn't
6 have great data from the commercial players. Even digging
7 into the electronic health records of individual practices,
8 very few of them had collected race and ethnicity data.
9 And you can't solve an issue if you don't have the data to
10 start on this Commission. We are always looking for more
11 data. So I think this is a great first start.
12 I'll also say that addressing racial and ethnic
13 disparities goes beyond just looking at the data on a
14 specific issue, and I think we've done a good job at our
15 meeting today of really trying to apply that health equity
16 lens to everything that we're doing and not just in the
17 things that maybe flag it.
18 We've spent a lot of time in the past talking
19 about the disparity in maternal morbidity and mortality,
20 which is great, and it lends itself very nicely to having a
21 conversation about racial and ethnic disparities, but we
22 also need to be looking at in a estate recovery. And we

1 also need to be looking at it in Medicaid expansion. We
2 also need to be looking at it in substance abuse, and so
3 how we take that health equity lens and really thinking
4 about who are the winners and who are the losers and is
5 there bias, specifically racial bias, in some of those
6 outcomes and being more intentional about that in our work
7 as we go forward.
8 CHAIR BELLA: Thank you, Kisha.
9 Darin?
10 COMMISSIONER GORDON: Yeah. Thank you for
11 pulling this together, Anne and the team.
12 I think it might be helpful hearing from some
13 states about some of the things that they're seeing that
14 are hurdles to getting this data in a better shape because
15 there's a whole variety of data that we collect over the
16 years, and when there's been issues, there's been a focus
17 on strategies to actually help improve the completeness of
18 that data.
19 Anne, you stated some of the hurdles of that, but
20 it would be interesting to hear from some states, maybe
21 states that are a little bit further along in this on
22 things that they have -- how they approached it and how

1 they've improved some of the data.

2 I will say, to your point that it may not be

3 perfect, may not be complete, but we're going to keep

4 moving ahead, I think that's good.

5 I did hear from one state just recently where the

6 observation was that they didn't have 100 percent good data

7 as it related to race and ethnicity, but he pointed out,

8 "Well, the reality is I don't need it to be 100 percent,

9 that if I can even have 75 or 80 percent, that's a pretty

10 representative sample when I drill down in different

11 communities to see whether or not there's an issue." I

12 thought that was a good point because I think sometimes we

13 do shoot for the perfect 100 percent, which I think is a

14 great goal, but that doesn't need to be where we arrive at

15 in order to be able to identify different opportunities and

16 places for improvement.

17 CHAIR BELLA: Chuck?

18 Thanks, Darin.

19 VICE CHAIR MILLIGAN: Anne, forgive me if you

20 mentioned this and I missed it. Are we planning to publish

21 an issue brief or anything just on how data is currently

22 collected, like what are the fields and how complete it is

1 and what the challenges are? I mean, a lot of what you
2 presented but also what was in our meeting materials, I
3 think would be a nice contribution out there because I
4 think people with less expertise, I think, maybe overstate
5 or misunderstand how it's collected, where there are gaps,
6 what the issues are.
7 Did you mention whether this is something we plan
8 to kind of put out and just like a fact sheet or an issue
9 brief or something?
10 EXECUTIVE DIRECTOR SCHWARTZ: I didn't, and it's
11 something we could do. And it's also just a question for
12 you all of whether you think that what was in the memo is,
13 more or less, complete enough that we could go ahead and
14 put it out now and then continue to work on this in some of
15 the areas or whether you think it makes more complete
16 package if we hold it and pull it all together later. But
17 it's really up to you on what we do.
18 VICE CHAIR MILLIGAN: Just speaking for myself,
19 then, I do think there's utility in getting this
20 information out to the public, and I think I have less
21 strong of an opinion about whether to try to publish, you
22 know, convert the meeting materials into something that

1 could be published sooner rather than later. I'm less -- I
2 have less of an opinion about that, but I do think we
3 should have a publication pathway or strategy about this
4 because I do think there is a great misunderstanding about
5 the granularity of how data is collected and complete and
6 accurate it might be.

7 CHAIR BELLA: Other comments?

8 [No response.]

9 CHAIR BELLA: I have a couple questions as well.
10 Let's see if others want to weigh in on whether to put
11 something out now or wait on that front.

12 Anne, I also apologize if you said this and I
13 missed it. What was the origin of the Medicaid CAHPS? How
14 did it come to be when it came to be? is my first question.

15 And then the second question is doing something
16 like that would be expensive. Medicaid, we spend a
17 significant amount of money on the program. So like
18 relative to what we spend on the program, is it like a
19 rounding error, or is it like expensive-expensive? And I
20 know the only thing we might have to judge it against is
21 Medicare, which is a much smaller scope, but help me
22 understand size of magnitude expense and then also sort of

1 why it came to be and why it was only a one-year thing.

2 EXECUTIVE DIRECTOR SCHWARTZ: So I don't have all
3 the back story about how it came to be, and that would be
4 something that I think I would have to find some of the
5 folks who were involved with that. And that's a doable
6 thing.

7 I did try to have, both for the paper and then
8 just for the meeting, exactly how much was spent for the
9 2014, and I haven't been able to get an answer for it. You
10 know, since the Medicare Current Beneficiary Survey is an
11 ongoing activity, you can just go directly to the most
12 recent budget documents, and the number is right there. So
13 that's something I want to find out because, obviously, you
14 would want to know that, and then we could find out a
15 little bit more about the evolution and how it came to be
16 and what the considerations are. I think that's the sort
17 of thing that I think would be useful to know, before we
18 would publish something, to have maybe a richer analysis of
19 that, and then you could still decide what you want to do
20 about that.

21 So that's my long-winded answer of saying I
22 really don't know, but we can figure it out.

1 CHAIR BELLA: That would be helpful if there's
2 more information you could get on that front.
3 Does anybody have any additional thoughts?
4 Comments? Anything else for Anne to think about as we
5 think about next steps?
6 [No response.]
7 CHAIR BELLA: All right. Well, as with so many
8 things we talked about today, I think you can tell there is
9 a great interest in this and a real desire to move forward
10 and do something and to continue to work in this area, so
11 thank you, and we'll look forward to bringing it back when
12 it's the right time.
13 Anybody have anything they want to say, before we
14 turn to public comment, on any topic at this point.
15 [No response.]
16 CHAIR BELLA: It's a such a softball, and nobody
17 wants it. You were much more talkative before lunch,
18 everyone.
19 All right. We are going to open it up to public
20 comments. So if there is anyone in the public who would
21 like to comment, please use the little raise-your-hand
22 button, and you will be recognized and unmuted.

1 [No response.]

2 CHAIR BELLA: I don't see any hands. The public

3 was much more talkative before lunch too, it appears. But

4 we'll give it just a second.

5 While we're waiting to see if anybody's hand pops

6 up, let me just preview what we have going on tomorrow. So

7 we'll start at 10:30. We'll start with a panel on duals

8 and integrated care. We'll hear from Tim Engelhardt at the

9 duals office and then two states, Illinois and Ohio. We

10 will then move into waiting list for HCBS services. This

11 is a continuation of a brief that you've seen. We'll talk

12 about Medicaid coverage of vaccines, and then we will end

13 the day looking at oversight and accountability for

14 pediatric oral health services and Medicaid managed care.

15 I see a smile on Kathy's face. You can imagine

16 that we might be turning to you for some wisdom there.

17 So that's tomorrow, and it looks like we do have

18 a hand, which is great.

19 **### PUBLIC COMMENT**

20 * MS. HUGHES: Okay. Richard Holaday, you've been

21 unmuted.

22 MR. HOLADAY: Richard Holaday from Delaware. I

1 am actually the director of quality for DMMA.

2 Since we have an employee event going on

3 tomorrow, will the event that's going on tomorrow be

4 recorded?

5 CHAIR BELLA: Yes.

6 EXECUTIVE DIRECTOR SCHWARTZ: It won't be

7 recorded -- we're not going to be posting a video of it,

8 but the transcript of our meeting is always up, usually, a

9 week or so after the meeting. So there will be a public

10 record, and you can experience it in a third of the time, a

11 quarter of the time, rather than sitting through the whole

12 meeting.

13 MR. HOLADAY: Thank you so much. This is

14 actually my first meeting. I really appreciate it.

15 CHAIR BELLA: Well, we appreciate you joining,

16 and if there's something that's of particular interest or

17 you have feedback to share on a subject particularly and

18 given the role you have in Delaware, please feel free to

19 reach out.

20 All right. We'll give it one more minute or 30

21 seconds to see if anyone else has anything, and any last

22 comments or questions from the Commissioners or, Anne, any

1 last things from you?

2 [No response.]

3 CHAIR BELLA: Okay. I don't think we have any

4 additional public comment. It looks like we have no

5 additional Commissioner or Anne comments.

6 Thank you all for sitting remarkably, relatively

7 still during the past few hours. We'll see if we can't

8 work in maybe a little bit more of a break at some point,

9 depending on how this works, but welcome any feedback on

10 how to make this smoother. But I want to say thanks to

11 Anne and James and the team for making our virtual meetings

12 work very smoothly and enabling broader participation.

13 So thank you all, and we will look forward to

14 seeing you tomorrow morning at 10:30. Bye.

15 * [Whereupon, at 2:59 p.m., the meeting recessed,

16 to reconvene Friday, September 25, at 10:30 a.m.]

17

PUBLIC MEETING

Via Go-to-Webinar

Friday, September 25, 2020
10:33 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
CHARLES MILLIGAN, JD, MPH, Vice Chair
THOMAS BARKER, JD
TRICIA BROOKS, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
STACEY LAMPKIN, FSA, MAAA, MPA
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

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

2 [10:33 a.m.]

3 CHAIR BELLA: Okay. Welcome, everyone, to day two of
4 our September MACPAC meeting. We're very excited to have
5 you all here and super excited to be kicking the day off
6 with a panel on duals and integration, and so I'm going to
7 start by turning it over to Kirstin who will sort of lay
8 out what we're going to cover in this session.

9 But I also want to say to our guests thank you for
10 joining, and especially thank you for working with us in
11 our new video MACPAC meetings. Much appreciated.

12 Kirstin.

13 **### INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES**
14 **THROUGH MEDICARE-MEDICAID PLANS: PANEL DISCUSSION**

15 * MS. BLOM: Thank you, Melanie, and good morning,
16 everyone. So I'm happy to be kicking off our work on
17 integrated care today with a panel of experts who will be
18 speaking about their experiences with Medicare-Medicaid
19 plans, or MMPs.

20 As you all know, MMPs are the capitated plans under
21 the Financial Alignment Initiative that fully integrate
22 care for duals. They're the most integrated option out

1 there, but they're not very widely available, and
2 participation rates have been fairly low, around 30 percent
3 on average. So as part of our work on integrated care, the
4 Commission is interested in what's next for MMPs and
5 opportunities to expand their reach.
6 As you saw, Commissioners, in your memo, we have a
7 full slate of work planned for the coming months,
8 ultimately leading to a chapter or chapters in the March
9 and June reports. So in addition to today's discussion,
10 we're also looking into opportunities for states to
11 maximize contracting authority with D-SNPs. We're looking
12 at the role of Medicare agents and brokers and other topics
13 like a new program for the dually eligible population. So
14 we'll be bringing you updates on this work at our meetings
15 throughout the fall.
16 So to start today to kick off our work, we have three
17 panelists who are on the front lines of improving
18 integration of Medicare and Medicaid coverage for duals at
19 both the state and federal levels. We're very happy to
20 have our panelists today.
21 First, we'll be hearing from Tim Engelhardt. He is
22 the Director of the Medicare-Medicaid Coordination Office,

1 and we're all very familiar with Tim. He's spoken to us
2 many times and dealing with the agency that's working to
3 align and coordinate benefits for the dually eligible
4 population. Prior to joining MMCO, Mr. Engelhardt was a
5 consultant with the Lewin Group, and before that he was
6 Deputy Director for Long-Term Care Financing with the State
7 of Maryland.
8 After Mr. Engelhardt, we'll hear from Laura Phelan.
9 She is the Director of Policy for the Illinois Department
10 of Healthcare and Family Services. Prior to her current
11 role, Ms. Phelan was the program manager of the state's
12 Medicare-Medicaid Alignment Initiative and was leading that
13 effort when the state made the decision to take their
14 demonstration statewide.
15 And then, finally, we'll hear from Karla Warren.
16 Karla is the integrated care manager for Ohio's Medicaid
17 program. She's the state's expert on MMPs and has been
18 leading the state's successful efforts in this area,
19 including having achieved the highest participation rate of
20 any of the demonstrations. Prior to her current role, Ms.
21 Warren was the managed care compliance manager for Ohio's
22 Medicaid program.

1 So, with that, I'll turn it over to our panelists. As
2 I said, Mr. Engelhardt will start, followed by Ms. Phelan
3 and then Ms. Warren. So, Tim, over to you.
4 * MR. ENGELHARDT: Thank you, Kirstin. Thanks,
5 everybody. And nice to see many of you.
6 I know the MACPAC work here predated the pandemic, and
7 we're not going to focus on COVID-19 today. But I just
8 want to flag something that I think is important here. We
9 published some analysis on the Medicare program a few
10 months ago and have refreshed it several times since. And
11 of all the people in the Medicare program, dually eligible
12 beneficiaries are four times more likely to be hospitalized
13 from COVID-19. There are a lot of reasons for that, but
14 it's a particularly jarring reminder that we all need to
15 continue to focus on this population. So I say that by
16 preface of thanking you guys for the continuing focus on
17 dually eligible beneficiaries.
18 Thank you, too, to the Commission for really
19 thoughtful comments on the latest round of Medicare
20 Advantage rulemaking in which we proposed to eliminate a
21 certain type of plan that we called a "D-SNP lookalike."
22 The MACPAC comment letter was surely the most thoughtful

1 and analytically driven and thorough one that we got, so my
2 compliments to the staff. Thank you. On that note, we
3 ultimately finalized new rules to phase out D-SNP
4 lookalikes by 2023, anxious we'll have a chance to
5 transition membership into other types of products. The
6 phase-out time will minimize any immediate impacts on
7 beneficiaries, but ultimately, I think it will restore a
8 level of state control over dual-specific managed care
9 contracting and create more opportunities for integrated
10 care over time.

11 And then I guess lastly, thank you for the thought
12 chapters in the June report to Congress. One of them, as
13 you know, focused on Medicare savings programs. Under the
14 present circumstances, I think the themes there of
15 simplifying the process for accessing subsidies and the
16 importance of economic stability for older adults and
17 people with disabilities is probably as resonant as it ever
18 was.

19 The other chapter focused on a discussion on
20 integrated care and a lot on the topic that we'll hone in
21 on today, on demonstrations under what we call the
22 "Financial Alignment Initiative."

1 As you guys know, we partner with 11 states on a
2 variety of integrated care demonstrations. Last April,
3 through a Dear State Medicaid Director letter, we offered
4 the states an opportunity to extend the time frame for
5 those, coupled with other programmatic improvements. Every
6 participating state has taken us up on that offer now, and
7 that means that while we have a few contracting actions
8 still to finalize, we'll be going through 2022 or 2023 in
9 just about all of those states. And that extra time for
10 the testing process is important, I think, for multiple
11 reasons. The first is the continuing need for more T-MSIS-
12 driven analysis. A source of consternation to me, as I
13 know it has been to the Commission, that we don't yet have
14 more Medicaid-focused analysis to answer important
15 questions about the cost and quality experiences in these
16 models. But I'm more confident than I've been in the past
17 that we're reaching a point where we'll have meaningful
18 analysis to answer some of those questions.
19 Extending those demonstrations for additional time
20 also gives us more opportunity to see how far we can go
21 with the improvement efforts. In the demos we assess
22 quality in multiple ways. HEDIS is one of them. On some

1 HEDIS measures, like care for older adults and behavioral
2 health measures, performance was pretty strong right out of
3 the gate in these demonstration programs. On some others
4 the baseline performance was really pretty low, and I'll
5 use one example here, the diabetes control measures, and
6 Karla is with us, so I'll choose Ohio as an example.
7 In 2015, the first year of relative stability in our
8 demonstration in Ohio, 60 percent of enrollees with
9 diabetes had poor HbA1c control. That's bad. But by 2016,
10 it was down to 51 percent, and by 2017, it was down to 44
11 percent, and then 36.5 percent in 2018. We're not going to
12 have ultimately the 2019 data for COVID-related reasons,
13 but we see from 60 percent to 36, almost cut that rate of
14 poor HbA1c control in half. But that's not where we think
15 we can get it. We know we can go further because it's
16 better in some other settings and other programs, and so
17 last year, when we extended the terms in the Ohio
18 demonstration, we applied a new 1 percent of the premium
19 withhold on that specific quality measure, and I am very
20 confident from meeting and talking with a lot of the plans
21 that, when the dust settles, we'll have even more progress.
22 So this is like a really -- I mean, integrated care is

1 a means to an end, and like improvements on these critical
2 measures and quality-of-life measures, satisfaction
3 measures are really the end, and this is important
4 population health work that is underway, and I'm really
5 happy to have additional run space to see how far we can go
6 with it before the time when we can inform it with more
7 MSIS data as well.
8 Finally, next week enrollment in the capitated model
9 duals demonstrations will exceed 400,000. That makes up a
10 very significant portion of what we are now reporting for
11 the first time ever is over a million dually eligible
12 beneficiaries in integrated care programs. That's a good
13 number, but it's not ultimately where we want to be, and so
14 we appreciate the Commission's support and guidance in
15 helping us get further along that continuum.
16 And, with that, I'd welcome questions when the time is
17 right, but I'll turn it to my colleague Laura Phelan.
18 * MS. PHELAN: Hi. I'm Laura Phelan. I'm from the
19 Illinois Department of Healthcare and Family Services, and
20 I wanted to spend some time today, you know, kind of more
21 of an operational focus, but talking about the state's
22 ultimate decision to extend the MMAI demonstration

1 statewide.

2 At the time, we were considering looking at the
3 opportunity to extend the MMAI program. This was a
4 discussion that was happening under the previous
5 administration. When the new administration came in, they
6 asked us to pause and reevaluate it. They wanted us to
7 look at whether we wanted to continue with the MMAI
8 demonstration, reintroduce D-SNPs into Illinois instead of
9 MMAI. Under the previous administration, we ended our D-
10 SNP -- well, when our D-SNP contracts were up for renewal,
11 we just didn't renew them and ended the program that way.
12 And then -- or if we wanted to offer both. And,
13 ultimately, we decided to not bring back the D-SNP program,
14 to stick with MMAI, and to expand it statewide.

15 Two of the primary factors for that, one was the
16 integrated care. We felt like MMAI, which at that point we
17 had had multiple years' experience operating, that the
18 opportunity for plans to assist with care coordination was
19 just much greater than our other options. We also have a
20 Medicaid MLTSS program for duals that opt out of MMAI that
21 has been statewide since 2018. And from comparing the
22 experience of individuals in those plans, which that

1 contract requires that the plans help coordinate care for
2 both Medicaid and Medicare services -- and we know that the
3 plans often struggle for the Medicare services they can't
4 control -- and comparing that to what was happening on the
5 MMAI side as well as the state's ability to set
6 expectations on the MMAI side, and in part from the support
7 from federal CMS, which adds extra weight, we felt like,
8 you know, MMAI was a more integrated product compared to
9 MLTSS and more integrated compared to D-SNPs where we would
10 -- even under the most integrated model, we'd be kind of
11 chasing Medicare Advantage enrollments, trying to align
12 them on the Medicaid side, in some cases with our MLTSS
13 program.
14 So integrated care was a big piece of it, and then we
15 also -- another large decision was the financial piece. We
16 had Milliman, who were our actuaries, look at it and
17 determined that financially the state saved money with the
18 MMAI program, largely because of the demonstration's
19 savings percentage. Once it was factored in, it allowed
20 the Medicaid rates to be lower than what they otherwise
21 would have been because we were getting that money back,
22 and at the same time, because of the combined Medicare and

1 Medicaid payment, allowed the health plans still to have
2 actuarially sound rates.
3 And the last piece was operational. So I mentioned
4 that we had had an MMAI program for a number of years and
5 had previously ended our D-SNP contracts. It would not
6 have been an issue of just reinstating our old D-SNP
7 contracts. When the contract was stood up, by the end of
8 it we had to have it be fee-for-service on the Medicaid
9 side. We couldn't get our systems to work to account for
10 the D-SNP enrollment and not pay the provider if they
11 submitted a claim both places, which creates obviously
12 program integrity issues. So it ended up as a fee-for-
13 service Medicaid D-SNP contract, and we would have needed
14 to have a new contract that was more integrated than that,
15 and then also required new system changes that we hadn't
16 been able to fix in years past.
17 We thought from the enrollment side the extra work of
18 the staff, even though MMAI on the enrollment side can be a
19 lot of work, that chasing those Medicare Advantage
20 enrollments trying to align with our statewide MLTSS
21 program would have been even more work.
22 We would have needed to develop new notices. We

1 already had notices we were using for our MMAI program. On
2 the quality side, we would have needed to set some new
3 rules about Medicare contract numbers for D-SNPs to get the
4 Illinois-specific data. We would have needed to develop
5 new reporting. And then we also felt like from a
6 beneficiary education standpoint that the D-SNP enrollment
7 would be more likely to be driven by health plans and
8 agents and brokers instead of our client enrollment broker,
9 which was currently helping individuals choose, again,
10 comparing it to the MLTSS program that we already had. And
11 then the relationship with CMS, which was one of the
12 factors in our decision, and we felt like over the years of
13 the MMAI program, we had created a strong partnership with
14 CMS both in the oversight and management of the health
15 plans as well as continuing to push for new ideas on how we
16 could improve quality and outcomes.

17 So between all of those pieces, we decided that rather
18 -- even though there was some risk in that MMAI was a
19 demonstration, that we were just going to look at the
20 options that were currently on the table for us and pick
21 the option that we felt was most -- provided the most
22 integrated care opportunity for our beneficiaries, and then

1 also simplified operations for the state given our
2 experience with MMAI and also financially was a potentially
3 better option for the state.
4 And so the MMAI is going statewide. It originally was
5 going to be January 1, 2021. Because of COVID-19 and
6 wanting to free up provider time and not have it be focused
7 on contracting, that start date has been moved to July 1,
8 2021. But we are looking forward to giving all of the
9 dual-eligible beneficiaries in our state an opportunity to
10 choose between MMAI and MLTSS for those who are in long-
11 term services and supports.
12 So that was just the overview that I wanted to start
13 off providing you all with today, and I will turn it over
14 to Karla.
15 * MS. WARREN: Thanks, Laura. Thanks, Tim. And thank
16 you to the MACPAC for having me here today. I'm excited to
17 speak to you about our program in Ohio. It's known as
18 MyCare Ohio.
19 I will state that -- I know Kirstin introduced me as
20 the state SME, but I don't see myself that way. It's
21 definitely a large team of us in Ohio that work hard in
22 making this happen. And I thank the great colleagues I

1 have every day for helping me understand all the different
2 complexities and nuances of our program.
3 I'll start by giving just a very brief overview of our
4 program, some of the things we've learned and what we're
5 trying to determine in going forward.
6 So, in Ohio, we are in our seventh year.
7 It seems a little hard to believe that, but I was
8 counting the years off before we got together, and I was
9 reminded how quickly the time does go.
10 We are in our large urban areas here. So it's not all
11 of our state, but it's about 29 counties in seven regions,
12 and we have five health plans participating.
13 We have about 83,000 in our program, and about 55,000
14 of them are what we call our community well. They are non-
15 LTSS individuals. We have 18,000 in our waiver and about
16 10,000 in our SNF program.
17 We do have a strong component of community
18 participation with our area agencies on aging. Our plans
19 are required to utilize the AAAs for waiver service
20 coordination for individuals who are 60 and older, and that
21 was done in part to help, really, the plans and managing
22 LTSS.

1 Our AAAs are great partners in our state and have
2 already really a recognized presence with individuals
3 receiving LTSS, and so we do think that is one of our
4 strengths of one of our programs. In fact, two of our
5 plans have chosen to go above and beyond those minimal
6 requirements and are actually utilizing the area agencies
7 on aging for all of their individuals in our program for
8 this care management services and waiver service
9 coordination. So they are coordinating the entire spectrum
10 of care for those plan members.
11 We have some great data from our RTI evaluation. We
12 see that skilled nursing facility utilization was down 15
13 percent and patient utilization down 21 percent and then
14 long-term SNF placement down 8 percent. We see great
15 readings in our CAHPS, about 9 or 10 of our health plan
16 rating. We've done similar surveys trying to get a better
17 sense at the state level about how individuals feel about
18 their care management relationships, and we have about 80
19 percent approval or satisfaction rating with both their
20 care manager and their services for coordinating their
21 benefits. So we're real proud of some of that.
22 We have seen that plans can get people to the right

1 setting at the right time. We don't have a whole lot of
2 Medicaid analysis available to us yet, but we do know just
3 by looking at utilization that when we look at our MyCare
4 plans compared to fee-for-service, the MyCare plans are
5 rebalancing NF and HCBS of about $30 million more a year
6 than our fee-for-service population experiences. So we do
7 see that as one of the highlights in getting them to the
8 right care setting at the right time.
9 We also have seen real strong care coordination
10 improvements with our community well population. So those
11 are individuals who don't have waivers, but of course,
12 they're getting care managed, and the plans are required to
13 do an assessment for those individuals. And we hear from
14 both individuals and then the plans that the community well
15 population sometimes is being made aware of waiver services
16 that they didn't know before were available, because in the
17 fee-for-service setting, somebody has to know where to go
18 and really be aware of how to take those first couple
19 steps, and now in our program, the care manager, of course,
20 is making sure that that community well individual has any
21 LTSS services that he or she may need. So we do see that
22 as one of our big positives.

1 We do have a Medicaid component that's required. So
2 if somebody is eligible for Medicaid in a MyCare county and
3 meets other eligibility requirements, they have to
4 participate. We do see that as one of the strong
5 foundational pieces of our program that has led to strong
6 participation over time. So we passively enroll
7 individuals, and of course, they can opt out of Medicare if
8 they choose to do so.
9 We started in '14 as kind of a Medicaid requirement
10 and the Medicare was optional. So people had to opt in,
11 and then in January of '15, we switched that to passively
12 enrolling everybody into Medicare and making that Medicaid
13 piece still required.
14 That did lead to some confusion for individuals and
15 providers at the time. So that's definitely a lesson
16 learned that we have. We're not quite sure that doing that
17 Medicare piece as optional at first was really a strong
18 point because people were first passively enrolled for
19 Medicaid, and then they were -- about 6 to 8 months later,
20 they were passively enrolled for Medicare. And so that
21 certainly created some confusion in our system.
22 We are thinking now of -- you know, now that we're

1 seven years in, we're trying to understand what might be
2 next for our program, and we're really at this time trying
3 to take time to figure out more of what's happening on the
4 ground level at this stage. We have a lot of positives.
5 We're hearing great coordination stories and data that
6 we've gotten from the RTI evaluation, but we don't have yet
7 a good sense of what does it really mean at the ground
8 level for our different peer management approaches.
9 And we recently have partnered with a local university
10 in our state, Miami of Ohio, Miami University, the Scripps
11 Gerontology Center there, and we're taking a look at doing
12 an evaluation really to get a sense of what are some of the
13 elements that the state needs to know about before we can
14 decide what's next for our program.
15 We have about two years left, two years and three
16 months, I believe. We're looking forward to the first
17 piece of this evaluation in January of 2021 and then a
18 second piece in mid to late 2021, and it will be a process
19 evaluation in January that's going to be talking with
20 stakeholders and getting a sense of what their experiences
21 have been. And then a second piece will be looking at data
22 to get a handle or get really better understanding of some

1 of the Medicaid utilization information that we have
2 available that has been something that we haven't had, of
3 course, at this point. As Tim had mentioned, we're
4 anxiously awaiting the RTI evaluations, but at this point,
5 we're not quite sure what would be the next steps for our
6 program. And we look forward to the upcoming evaluations
7 to give us a sense of what might be the best direction to
8 head to.
9 And that takes my remarks to an end. I turn it back
10 to the Commission now. Thank you.
11 CHAIR BELLA: Thank you.
12 Kirstin, do you have anything you want to add before
13 we go to comments and questions from the Commissioners?
14 MS. BLOM: No, just other than thanking you guys so
15 much for joining us and for sharing your experiences with
16 us. I really appreciate that.
17 CHAIR BELLA: Yeah. I want to echo that. It is
18 thrilling to hear from you what's going on in Illinois and
19 Ohio. So thank you so much, not to mention congratulations
20 to Tim and the duals office for those enrollment
21 milestones. That's also super exciting.
22 All right. We're going to turn to Commissioner

1 comments, start with Brian and then go to Martha.

2 [No response.]

3 CHAIR BELLA: Brian, you're on mute, I believe.

4 COMMISSIONER BURWELL: Thank you, Laura and Karla.

5 That's great to hear updates on your MMP programs.

6 I have one question for Laura around going statewide.

7 MS. PHELAN: Mm-hmm.

8 COMMISSIONER BURWELL: What has been your process for

9 selecting plans as you go statewide? Is that a competitive

10 process? Are the existing plans in your existing areas

11 allowed to bid in those areas? What is the process for

12 plan selection as you move to a statewide program?

13 MS. PHELAN: Sure. So what we actually did was we

14 offered it to all of the health plans that were currently

15 participating in the MMAI demonstration, and so we

16 previously had most of the plans participating in the

17 Greater Chicago area and one plan participating in central

18 Illinois. The other plan in central Illinois had since

19 left the market, and now all of those plans will be

20 statewide.

21 Four of the five plans that will be statewide are also

22 currently statewide in our Medicaid managed care program.

1 So we felt relatively confident that they would be
2 interested in a statewide expansion.
3 The health plan that was not participating in our
4 Medicaid managed care program and was only an MMAI in the
5 Greater Chicago area, we were a little less sure what they
6 would decide to do, but they decided that they wanted --
7 and that was Humana, which actually has a pretty large
8 Medicare network, including in other parts of the state,
9 and they decided that they wanted to expand statewide as
10 well.
11 We have one health plan in our Medicaid managed care
12 program that was not participating in MMAI. So we did
13 reach out to that health plan to find out if they would be
14 interested in joining the MMAI program, and they initially
15 were interested and then post COVID decided that they
16 didn't want to move forward at this time.
17 The reason that we asked that one health plan is our
18 Medicaid managed care contract that's statewide includes
19 the MLTSS program, and we were interested in creating
20 alignment between MMAI and MLTSS, where if someone was in
21 an MLTSS plan and felt like the care coordination services
22 were beneficial to them, that they would be able to

1 transition to that health plan's MMAI plan if they wanted
2 to and potentially keep the same care coordinator.
3 COMMISSIONER BURWELL: So you have four plans that
4 will be operating statewide?
5 MS. PHELAN: We have five, the four Medicaid managed
6 care plans plus Humana.
7 COMMISSIONER BURWELL: And will they compete for
8 enrollment on a statewide basis?
9 MS. PHELAN: Yes, right.
10 COMMISSIONER BURWELL: Will people be able to choose
11 or to choose to opt out of MMIA altogether? Correct?
12 MS. PHELAN: That's correct.
13 So we will have the -- just the enrollment process
14 will remain the same as it is today. So there's a passive
15 enrollment process where a letter goes out. They're, based
16 on an algorithm, assigned a health plan but told that they
17 can switch health plans or they can opt out of the program.
18 They're also told that if they receive long-term
19 services and supports, so in a nursing facility or on a
20 home- and community-based waiver, that they -- if they
21 choose to opt out of MMAI, they will still be required to
22 pick an MLTSS health plan.

1 COMMISSIONER BURWELL: Got it.

2 Karla, Ohio is well known for having one of the lowest
3 opt-out rates of all the demonstration states. Could you
4 talk a little bit about what you think are the reasons for
5 that?

6 MS. WARREN: I can. Thank you, Brian, for that
7 question.

8 So really one of the foundational reasons for that is
9 our Medicaid mandatory requirement, and we passively enroll
10 individuals once they're eligible into the Medicaid plan
11 and then the Medicare plan as well.

12 Of course, individuals have the ability to opt out of
13 that Medicare option. We see a pretty low opt-out rate
14 with the Community Well population. It's a little higher
15 with the waiver population and even higher with the nursing
16 facility population.

17 We do think that there is some provider influence and
18 what individuals choose to do there because, of course,
19 that's who they are most close with often. They don't have
20 that relationship with the plan yet, and so something we've
21 learned over time is that people's memories are really
22 strong.

1 And so early on, we did have some challenges with
2 payments and such. We have been past that for years, but
3 there are still some provider memories about those
4 challenges. And so there is some influence there for
5 individuals opting out, especially at the nursing facility
6 level. We did have significant experiences or challenges
7 with payment delays in nursing facilities, both them
8 understanding how to bill correctly and then the plans
9 understanding the nuances of Medicaid payments. So that's
10 a challenge that we still try to overcome now.
11 But we also believe that there is an understanding of
12 the benefits of having that wrap-around coordinated
13 services. We have understanding that the members believe
14 that the supplemental benefits offered by the plans are
15 very popular.
16 We have a strong partnership with our ombudsman office
17 in the state, and they give us a lot of feedback there
18 about why somebody is opting in or opting out. That's one
19 of our lessons learned definitely from the program is that
20 communication with the members, which is hard to get. So
21 one of the ways we do that is through the ombudsman
22 program.

1 COMMISSIONER BURWELL: Would you talk a little bit
2 about disruption of existing relationships between members
3 and their primary care physicians? Is that something that
4 happened, or did the plans minimize that, add physicians to
5 their networks, or --
6 MS. WARREN: Yeah. I can talk about that, yeah.
7 So we have seen over time some reluctance for
8 providers at the primary care level to really engage with
9 care management. Plans have done a lot of advocacy to
10 those provider settings, trying to get them to understand
11 why a care manager can add some value, but I think that the
12 PCPs have a lot of work to do. They're overburdened, like
13 every other provider. And they often just don't want that
14 additional layer in their practice, and so that's been a
15 factor there in trying to get that involvement from the PCP
16 and really understanding the value of this coordinated
17 plan.
18 What we have seen over time, though, is that the plans
19 really haven't narrowed the networks very much. If
20 providers want to participate in the network, we
21 traditionally have seen that happen. We don't really get
22 many complaints about not having access to the provider of

1 choice.

2 Our program has had long transition of care
3 protections in place, about a year for most providers, and
4 so we found that after that year period, plans aren't --
5 are traditionally selecting to narrow it.

6 So I think the reluctance of the provider preservation
7 is more of a lack of understanding of the benefits that the
8 plan can provide.

9 COMMISSIONER BURWELL: Thank you.

10 MS. WARREN: You're welcome.

11 CHAIR BELLA: Martha and then Sheldon.

12 COMMISSIONER CARTER: Hi. Thanks for that
13 presentation.

14 I'm curious about how you are working with the FQHCs,
15 community health centers. You know, the CHCs are really
16 experts in integrating clinical care and perform very well
17 in quality measures, especially care for patients with
18 diabetes. This isn't a real large population for the
19 health centers, but it's growing. I looked last night.
20 It's about a little less than 4 percent of the health
21 center population, which translates to about over a million
22 people across the country, which I think, if I'm looking at

1 the numbers right, it's slightly less than 10 percent of
2 all duals in the U.S.
3 But as the health center population, the Medicaid
4 population, which is quite large, almost 50 percent, ages,
5 then they're going to be more people eligible, dually
6 eligible in the health center population.
7 So I'm just curious how are the health centers
8 included and involved in the range of programs to integrate
9 care for people who are dually eligible.
10 CHAIR BELLA: Do either of you want to respond to that
11 one, Laura or Karla?
12 MS. WARREN: I can speak to some of what we have heard
13 from FQHCs. We have heard over time some challenges of
14 understanding their billing procedures from the plans.
15 Most of our communication has been more about the
16 operational side of it, and so we have made it clear to
17 plans to really make sure that they understand the
18 different billing procedures.
19 I think that there's been some challenges, but we have
20 made improvements in that space and making sure that
21 there's real collaboration between the FQHCs and plans.
22 I think my limited experience has been more about

1 operational challenges early on there.

2 MS. PHELAN: This is Laura.

3 I would say in regards to FQHCs that our work in

4 partnership with them has been -- well, we focused on

5 managed care in general and not specific questions about

6 the MMAI program.

7 To Karla's point on billing, we have biweekly HFS,

8 MCO, and provider billing meetings with our providers by

9 provider type, where top executives from the MCOs, the

10 provider association and their members, and then senior

11 leadership from HFS all sit in a room. And they have a

12 schedule where they submit their billing issues in advance,

13 but they couldn't get resolved on their complaint portal.

14 And they discuss them and try to find systemic issues that

15 includes MMAI claim issues but also includes our Medicaid

16 MCO issues. So it's integrated.

17 And even just this week, had a conversation with the

18 FQHCs, I think to your point, about health care access and

19 the work that FQHCs are doing to reach out to Medicaid

20 beneficiaries, including duals, and keep them engaged and

21 how that is or is not funded by the system and the savings

22 that it creates to the system as well as the better

1 outcomes that it creates for the members. But, again, that
2 conversation was higher level and not necessarily specific
3 to the MMAI program. It was about managed care in general
4 and actually even, in some ways, to the individuals
5 shopping on the marketplace.
6 COMMISSIONER CARTER: Tim, do you have anything to add
7 to that, from a national level?
8 MR. ENGELHARDT: No, although a primary federal
9 touchpoint had been on operational payments used as well,
10 especially the supplement between what they're contracted
11 rate is and the PPS rate.
12 COMMISSIONER CARTER: I couldn't hear all of that.
13 Sorry, Tim.
14 MR. ENGELHARDT: I'm sorry, Martha. Only echoing that
15 our primary touchpoints have also been operational and
16 payment focused, no clinical in their orientation.
17 COMMISSIONER CARTER: There may be an opportunity
18 there then.
19 CHAIR BELLA: Sheldon? You're mute, Sheldon. We
20 still can't hear you. Nope.
21 Jim, can you see what the problem is? Sheldon, try
22 taking your headset off maybe, and talk into your computer.

1 MR. BOISSONNAULT: Hi. This is Jim. Sheldon, it
2 looks like you are dialed in correct and using the
3 computer. So in terms of the dial-in, we don't control the
4 mute until a PIN is entered. So maybe--
5 CHAIR BELLA: All right, Sheldon. No pressure. While
6 you figure that out, I'm going to go to Chuck, and we'll
7 come back to you.
8 VICE CHAIR MILLIGAN: Yeah, I'm talking. Can you hear
9 me okay, Melanie?
10 CHAIR BELLA: Yes, we can hear you.
11 VICE CHAIR MILLIGAN: Great. Thank you all very much
12 for sharing insight with us today. I had, I think, three
13 questions. The first one, Karla, I wanted to ask you.
14 It's my understanding that you also have the D-SNP model in
15 Ohio, and I was wondering whether you have any observations
16 to share on the respective outcomes or the respective
17 approaches in kind of a compare-and-contrast sort of way.
18 So that was my first question.
19 MS. WARREN: Great. Thanks. So I will answer that
20 first question. In Ohio we do have the D-SNPs available.
21 I can say, though, it's been a pretty much hands-off state-
22 level relationship. We are MIPPA. Over time it's really

1 just been pretty minimal, in terms of requirements and
2 reporting back to the state. We're looking forward to
3 what's in place for 2021. And so we took this opportunity
4 with the new integration requirements to require the D-SNP
5 plans to report to the opt-out population for the MyCare
6 program, hospitalizations and SNF events to the MyCare
7 Medicaid plan.

8 So we're hoping to get some insight there as to how
9 that relationship will go, but we just haven't had a whole
10 lot of experience in our state with D-SNPs and really have
11 focused on MMP over time.

12 VICE CHAIR MILLIGAN: Thank you. The next question,
13 Laura, was for you, and Karla, feel free to jump in if you
14 have things to add. Laura, you had mentioned your kind of
15 analysis from Milliman and what is kind of in the state's
16 financial best interest, and the state savings percent and
17 so on.

18 So let me set the question this way. In the Medicaid
19 MCO world, so separate from dual eligibles, there's been,
20 as a result of COVID, a lot of underutilization of
21 services. States have retroactively changed rates to kind
22 of try to prevent health plans from getting a windfall from

1 getting capitation and yet having a steep reduction in
2 services. And it's affecting, you know, rate-setting going
3 forward as well, trying to forecast what's going to happen.
4 Is there a lot of pent-up demand that's going to come back,
5 or is there a new normal based on telehealth and so on.
6 And I'm wondering how, in your program, you are
7 accounting for the COVID-related implications to
8 utilization rates, forecasting, those pieces, given your
9 kind of commenting on your work with Milliman to look at
10 options.
11 MS. PHELAN: Yeah, sure. So on the -- and Tim may
12 know more about this than me, or I could follow up more
13 about this, I could follow up with you -- on our Medicaid
14 managed care side we ended up putting a risk corridor on
15 our plans for this year, largely because of what you were
16 talking about and really the uncertainty over when
17 utilization could potentially uptick or not. And thought
18 that was -- we paired that with a revised pay-for-
19 performance program where we returned the withhold to the
20 plans but had them submit spending plans for how to spend
21 it.
22 On the MMAI side, I know our current state lead was

1 talking to Tim's staff about what we had done on the
2 Medicaid side when they were trying to figure out what to
3 do on the MMAI side, but I actually don't know where they
4 ended up or if they ended up making a decision.
5 So I don't know if you know, Tim, but if not, I can
6 follow up and find out. And I can also get an update on
7 those conversations with Milliman about rate-setting for
8 the upcoming year.
9 VICE CHAIR MILLIGAN: And I know that on the straight
10 Medicaid side with the health plans there has been some
11 guidance coming out of CMCS around rates. Is there
12 guidance or thoughts that you're able to share with us on
13 that piece?
14 MR. ENGELHARDT: Well, first I want to start by saying
15 that the public reporting of financial experience, to my
16 knowledge, is never exclusive to like this population. And
17 so I guess to some extent I don't -- we still don't -- we
18 know utilization plummeted in the springtime. I don't know
19 how that varied from dual-eligible and non-dual-eligible
20 beneficiaries. I also don't have a complete sense yet of
21 the incremental costs of a lot of additional work and
22 support that we know many of the plans provide, be that

1 meal delivery and added PPE costs for individuals and for
2 in-home caregivers and some of that.
3 A word of caution that I don't think we like fully
4 know, especially in kind of the long-term care side of
5 things, what that experience has been. Nonetheless, surely
6 a weird experience in the spring. We, I guess somewhat
7 coincidentally -- it wasn't COVID specific -- we, in some
8 of the extensions on these demos we implemented -- we kind
9 of like ratcheted up the MLR level a little bit [inaudible]
10 got anybody’s below. Because really, we're going to end up
11 with some improvements. We had multiple states -- I don't
12 know the specifics in the multiple states with risk
13 corridors, and so I think we'll end up -- likelier than not
14 we'll end up with some recoveries for this period of time,
15 but a lot still we don't know.
16 VICE CHAIR MILLIGAN: Thank you. That's helpful. I
17 just had one final question, Laura and Karla, for both of
18 you, and it gets to Tim's opening comments around
19 lookalikes. I want to broaden it a little bit and just ask
20 your observations or experience in your two states with
21 competitive Medicare products that are also seeking to
22 enroll dual eligibles. So whether it's MA-PD plans that

1 are lookalikes or in that direction or I-SNPs or C-SNPs or
2 PACE models, I'm just curious around whether you're seeing
3 any trends about kind of increased competition from those
4 other products or not, and kind of what the implications
5 all of that has to your plans. That's my last question.
6 MS. WARREN: Hi, Laura. I can begin if you'd like.
7 So one of the things that we're trying to do in Ohio, at
8 our state Medicaid agency, is to better understand the
9 experiences of duals, and we are doing that by really
10 working closely with our SHIP program at the State
11 Department of Insurance and the ombudsman office, with
12 those two entities, to partner together for education and
13 awareness to individuals and trying to understand all of
14 the different marketing and communications that are
15 targeted to duals.
16 I don't think, traditionally, at the state Medicaid
17 level, do I have a good sense of the different products
18 that are being marketed. You know, certainly I read the
19 publications and I understand the confusion out there, but
20 I don't really know what it's like to be a dual, of course,
21 and to have those different products offered to me. And so
22 that's one of the reasons we have developed this closer

1 relationship with the SHIP program, and with individuals
2 listening, you know, it's coming up on fall open enrollment
3 season and so we are participating in the SHIP webinars to
4 the field and trying to understand better the questions and
5 answers that they're getting.

6 So really, we're just trying to get a better sense of
7 what it's like to be a dual, and so through that we're
8 going to hopefully understand better maybe recommendations
9 for improvement in the future and how our plans can work
10 with them.

11 MS. PHELAN: This is Laura. In Illinois we recognize
12 and hear from our MMPs, actually, about the lack of ability
13 of agents and brokers to enroll into our MMAI product in
14 the state. When it became an option for MMP programs we
15 did discuss it internally and the possibility that
16 individuals who maybe would be potentially better off in
17 MMAI were being directed elsewhere, because of agents and
18 brokers, but ultimately and largely based on Illinois'
19 initial Medicaid managed care experience, where there were
20 a lot of complaints about agents, and about beneficiaries
21 really feeling overwhelmed by the agents and brokers
22 pushing them in certain directions, decided to continue to

1 not allow them to enroll in MMAI and instead just to wait
2 and see what other states' experiences were.
3 I think another thing to note in Illinois is that
4 managed care is relatively new in the state, and even on
5 the Medicare Advantage side we don't have the largest take-
6 up. When we rolled out our MLTSS program, for example, we
7 had put into our algorithm that if someone had a Medicare
8 Advantage plan, we wanted to align their MLTSS plan, and we
9 were very surprised at how many did not have a Medicare
10 Advantage plan. For the most part, all of the duals that
11 we were enrolling into the MLTSS when statewide were in
12 fee-for-service.
13 So we think that there's still a really strong pull
14 towards original Medicare in Illinois, and that also has
15 made us more hesitant to introduce agents and brokers into
16 the MMAI program, and gives us less of a clear sense that
17 individuals are being steered into Medicare Advantage
18 products. We often find -- and we don't have a lot of
19 great qualitative data on it, but quantitatively --
20 qualitatively talking to our consumer advocates, so, you
21 know, the ombudsman or SHIP office, to our client
22 enrollment broker, front line staff. We find that a lot of

1 individuals are choosing to opt out of MMAI for original
2 Medicare. They're afraid to not be in fee-for-service more
3 than anything else.
4 MS. WARREN: That's similar in Ohio. We don't have
5 much uptick in MA plans either.
6 COMMISSIONER RETCHIN: Hey, Melanie?
7 VICE CHAIR MILLIGAN: I think Melanie is muted,
8 Sheldon. I think you're probably up.
9 COMMISSIONER RETCHIN: Okay.
10 CHAIR BELLA: Sorry. Yes, you're up, Sheldon.
11 COMMISSIONER RETCHIN: All right. Thanks. Great
12 presentation. This is always a rich discussion. I am just
13 sort of pointing out something and then maybe ask a
14 question from it. We often talk about integrating payment
15 for dually eligibles. As Martha was suggesting, we don't
16 talk a lot about the innovations that may be going on in
17 integrated care. And as we know, the duals are a
18 heterogeneous population, and like other subpopulations
19 about 20 percent of the duals account for 60 percent of the
20 cost.
21 So there must be some innovations going on, but I
22 wonder if there's a model staring us right in the face, and

1 that's the PACE program, that we really don't also address
2 that a lot. It's a thin program, only about 260 centers,
3 only about 50,000 enrollees. But the fact that the PACE
4 programs are now attracting for-profits, I wonder if
5 there's an opportunity to duplicate that or even sub out
6 from some of the health plans to PACE programs for the real
7 frail, $80,000 to $100,000 a year individual who's got five
8 or more adolescents to address.
9 Maybe, Tim, you might want to take that.
10 MR. ENGELHARDT: Thanks. The numbers you cited are
11 accurate. PACE, in fact, has grown significantly over
12 time. It's more than doubled in the past seven years. And
13 so there remains interest, but from a very small
14 [inaudible]. The for-profit presence, although new, is
15 still pretty limited but certainly growing, mostly through
16 acquisitions of already existing not-for-profit sites.
17 And we, at CMS, we do view it as part of the
18 integrated care toolkit and feel like cultivation and
19 growth is an important part of giving people good
20 integrated care, choices. This last six months has
21 finally, I think, challenged it in ways that are different
22 from any other type of service delivery model, as a

1 patient-based service, and they had to close down many of
2 their sites. And frankly, from as far as we can tell, they
3 have done a remarkable job at delivering services in the
4 home setting. And so I actually think that PACE will be
5 stronger in the long run because of the experiences over
6 the last several months.
7 We have not seen, to date, subcontracting arrangements
8 between health plans and PACE, at least to my knowledge,
9 and I actually think it makes a ton of sense except I think
10 there are some structural impediments as well as some
11 business relationship impediments too. But I'm glad you
12 raised it because it's something that we will look into
13 further, and I'll stop there.
14 COMMISSIONER RETCHIN: Thanks.
15 COMMISSIONER BURWELL: You are muted, Melanie.
16 Melanie?
17 CHAIR BELLA: Thank you, Brian. Any other
18 Commissioners who I have missed, and then I have a few
19 questions. No. All right. Great.
20 COMMISSIONER BURWELL: -- sometime, if we have time.
21 CHAIR BELLA: Okay. I have a question for each of
22 you, and Karla, I'm going to start with you. I know Ohio,

1 I know you have a strong nursing home lobby. I know you
2 have some legislation. I think it's probably active about
3 long-term care expansion. I'm sure I'm oversimplifying
4 greatly. But as you think about the climate there and you
5 make choices about what the future of your program looks
6 like, what would you need in order to make the decisions to
7 continue to invest in the demonstration?

8 So if you're a [inaudible] commission and we're
9 looking for ways to think about policy recommendations,
10 what would you need to want to continue to invest and grow
11 this program that you don't have today? Obviously,
12 anything you want to tee up for Tim to hear. You can
13 imagine, Laura, I'll ask you a similar question. Like what
14 do you guys need that you're not getting today, as we think
15 about how to make recommendations that support the states
16 to be able to grow and expand integrated models?

17 MS. WARREN: Thanks, Melanie. It really goes back to
18 some of what I said in my remarks in the beginning, is
19 having a real good sense of what's happening with the
20 Medicaid program in the state as a result of the program.
21 We don't really have that information in our first RTI
22 analysis, and the slowness of those, for many legitimate

1 reasons, has just not given us a full picture of what's
2 happening at the ground level.
3 You know, every state has its own unique Medicaid
4 program, and while we've gotten some good insight with
5 information we have available, we just don't have the data
6 that's really giving us the full picture. And so that's
7 why we made the choice to partner with a local university
8 to really drive the evaluation. We have great partners in
9 CMS and really value that relationship, but the RTI
10 evaluation is really -- it was driven by them and what they
11 want to know. And while we've gotten a lot of good insight
12 from it, it doesn't reflect everything that our state
13 Medicaid agency wants and needs to know in being able to
14 make decisions about the future.
15 CHAIR BELLA: So is that financially and clinically
16 and satisfaction --
17 MS. WARREN: Yeah. Yeah, I think we have a better
18 sense of what the care coordination model really means for
19 individuals. In our state we're trying to get a sense of -
20 - you know, we've given some flexibility to the plans, and
21 so what does that flexibility mean for individuals, you
22 know, trying to get a sense of, like, what value do the

1 different models bring, and which one might be better than
2 the other, and having a sense as to, you know, is there any
3 savings? Are there better health outcomes for this
4 Medicaid population? We're getting some data but not a
5 full picture yet and also a better sense of any value that
6 the plans are bringing with providers, too.
7 CHAIR BELLA: All right. That's helpful. Thank you.
8 Or similar but a little different because you guys have
9 chosen MMAI, and so as you think about sort of the
10 construct of the demonstration model itself, are there
11 other levers that you feel like you would need in order to
12 be able to grow that program and encourage beneficiaries or
13 providers to participate in the integrated program versus
14 maybe choosing to stay in MLTSS and original Medicare?
15 MS. PHELAN: Yeah, that's a good question. I think
16 the opt-out rate has continued to be a struggle for us. We
17 thought that it might have just been the order that our
18 programs rolled out and the timing. But when we started
19 the MMAI program, there wasn't -- the MLTSS program did not
20 stand up at the same time. As I mentioned, we had a lot of
21 individuals opt out because they were just concerned about
22 not being in a fee-for-service Medicare environment,

1 concerned about someone touching their Medicare as they
2 were used to it. And then also we had a lot of individuals
3 -- well, in some cases had nursing facilities opting
4 everyone out. Our enrollment lead always talks about how
5 initially someone had an opt-out stamp that they were just
6 stamping on things and sending back to us. And so then
7 they changed their process where you had to opt each person
8 out individually by calling, which didn't necessarily go
9 over well, but trying to make it clear that it was an
10 individual decision.
11 When we stood up the MLTSS program, we were hoping to
12 also use that as an opportunity to reeducate individuals
13 and see individuals come back to MMAI. What we have found
14 anecdotally from the client enrollment broker is that in
15 some cases when individuals find out they have to pick a
16 health plan anyway, that they do end up just sticking with
17 the MMAI program. But what we have not seen are
18 individuals that were already in MLTSS choosing to switch
19 to MMAI instead. I know that there was flexibility that
20 would allow us to, you know, keep individuals within their
21 same MMAI plan per quarter, and like looking at the data
22 compared to the operational implementation of that, it just

1 didn't seem like the tradeoff was worth the operational
2 lift for us because most individuals weren't choosing more
3 per quarter anyway. But I think that's where like
4 additional education could be helpful. At one point with
5 our health plans, they were going to run an unbranded
6 campaign for MMAI collectively. We're talking about a
7 marketing vendor, and it ended up just falling through, but
8 the state doesn't really have, you know, yet -- or
9 currently the resources to run outreach and education at
10 the level that we would like to.
11 I think to Karla's point, better access to data would
12 be helpful. We struggled with a similar decision -- or
13 like that lack of information, we could see the Medicare
14 savings, we couldn't see, you know, the Medicaid-specific
15 savings. And then we're just looking instead at, you know,
16 from a premium and rate perspective because that was
17 available to us. We're trying to increase our data
18 analytic capability at the state level as well. But I
19 think it's probably a mix of like education and outreach,
20 and, you know, having more data to better make a case that
21 you can have better health outcomes if you choose MMAI than
22 maybe if you choose fee-for-service, although at the end of

1 the day I don't know if that -- someone who's nervous about
2 losing their health plan -- or their Medicare the way they
3 know it, I don't know that that compels them. But we're
4 interested in further partnership with CMS and any
5 additional data that we can use to further evaluate our
6 program.
7 CHAIR BELLA: That's really helpful. I don't know how
8 much you follow the MACPAC work, but the Commission is very
9 sympathetic to the issue of state capacity and resources
10 and very supportive of trying to call attention to the need
11 to get resources to states to do things like analytics and
12 outreach and engagement. So if we ever need somebody to
13 vouch for us that that's an issue, we'll come back to you
14 guys, I think.
15 MS. PHELAN: Sounds good.
16 CHAIR BELLA: Tim, my question for you will come as no
17 surprise. What other tools would you need to be able to
18 support the states that you're working with and to bring
19 new states into the fold? And I'm thinking like either,
20 you know, kind of a new pathway at the agency level or
21 something within the existing CMMI tools that you have.
22 MR. ENGELHARDT: Well, I mentioned that earlier, more

1 run space on the existing work is something we need because
2 it allows us to build the evidence base in a way that I
3 greatly sympathize with what Laura and Karla both said on
4 the lack of all of the data. So I think that's a big one
5 with important immediate impacts for the Illinoises and
6 Ohios, but for other states as well who don't know where
7 they're going to be.
8 Secondly, while we have opened the door to new states
9 to come into comparable models, many struggle with lack of
10 their own capacity, with other burning priorities, and
11 certainly while that was true a year ago, it's ten times
12 more true now. And so from a resource perspective, that
13 remains a big one.
14 And there are structural issues, too, and while the
15 last set of Commission reports focused on a lot of Medicare
16 issues -- and it was very, very helpful -- I just feel like
17 I need to remind everybody that one of the biggest
18 constraints to full and meaningful integration is the
19 persistence of service carveouts within the Medicaid
20 program. Looking at Toby because he's in California. But
21 like we have -- you know, we have a behavioral health
22 carveout. We have a relatively significant long-term-care

1 carveout, too. And so in our most populous state, it's
2 really hard to bring all the pieces together even we get
3 the federal side right. And so I just -- that remains a
4 big kind of structural factor because it limits the number
5 of states that we can really work with on this type of
6 model for which, you know, our standard is closer to full
7 integration.

8 CHAIR BELLA: And so if the Commission were to try to
9 support -- so I hear you on the run room and the capacity.
10 But what about with the existing authority you have? Does
11 the office need any different or new authority? You're not
12 going to be able to mandate this California carve-in, IHSS,
13 for example, but like -- so other kinds of things that come
14 to mind?

15 MR. ENGELHARDT: The Innovation Center authority that
16 we use, as I think most of you know, allows us to waive
17 certain provisions of federal law. Those provisions are
18 very limited on the Medicaid side, but we do usually
19 accomplish them through 1115 authorities or others.

20 Should we find savings and quality improvements
21 through that Innovation Center authority, we have the
22 ability to extend and expand a particular model. We don't

1 technically have the authority to make something permanent,
2 and so should we pass that test, it will allow us to
3 operate, say, MMAI in Illinois without an end date looming
4 over us. It would still necessitate some level of
5 monitoring and oversight and evaluation longer term. That
6 is -- it's great that we have that ability, but I know that
7 it's a source of frustration for some of our State partners
8 that, you know, we need to be in a testing phase, and as
9 you can see now, sometimes that's exceeding seven years for
10 us to continue to be testing before we can pass that. And
11 that's a struggle for us.

12 So from an authority perspective, we have a lot. I
13 don't want to complain about that. But it keeps us in a
14 testing mode for a potentially very long time. I guess
15 bigger picture here, there are so many like choices and
16 potential failure points between the normal status quo and
17 integrated care. It necessitates the right combination of
18 policy choices at the state level. It's choices made by
19 health plans usually in our capitated model. And then it's
20 choices by beneficiaries. And so like the matrix of all
21 the circumstances people can be in and all the policy
22 options that we have to go through is really broad. And,

1 you know, I think one of the challenges we think about here
2 in this demo context is how it relates to existing program
3 authorities and whether or not we remain better served by
4 just expanding those further or trying to narrow them down.
5 Whether that's at the CMS decision level or state decision
6 level or the plan decision level, there's a lot of
7 variables and a lot of difficult decisions about choice and
8 innovation versus simplicity and clarity.
9 CHAIR BELLA: Thank you.
10 Does anyone else want to ask a first question?
11 Otherwise, Brian, we have time for one long-ish --
12 COMMISSIONER BURWELL: I'm willing to concede my time
13 if guests just want to make final comments or final -- you
14 know, leave us with the most important thought. No? Okay.
15 I'll ask Laura and Karla -- this kind of follows up on
16 Melanie's questions as to the importance of senior
17 administration support. I'm talking the governor's office,
18 et cetera. We are trying to address why aren't more states
19 moving forward with the development of new models and how
20 important that support from on high is to the ongoing
21 success of your program.
22 MS. PHELAN: This is Laura. I think that it's always

1 important to have leadership buy-in. We are actually on
2 our third administration under the demonstration, and it
3 was started under a Democrat, continued under a Republican,
4 and now we're back to a Democrat again. So, also, I think
5 the ability to continue to invest in the MMAI program and
6 to expand it is a reflection that I think for this
7 demonstration -- and in Illinois, this has not been
8 considered -- this has been considered a bipartisan issue
9 and initiative, wanting to use managed care over fee-for-
10 service to bring better coordination to our beneficiaries,
11 to set quality standards, and to really try to move the
12 needle. And I think this demonstration has allowed us on
13 the dual-eligible side to really align with those same
14 goals for the states on the Medicaid managed care side.
15 And we've continued over the years to try to more closely
16 align those two programs along the way to help with state
17 staff administration, our EQRO oversight. We have many of
18 the same plans health plans in operating in both spaces.
19 It helps our consumer advocates and people assisting with
20 enrollments.

21 And so I just want to say that leadership buy-in has
22 been really important, and also the flexibility and

1 partnership with CMS allowing us to take this program and
2 try to align the goals across our Medicaid managed care
3 program and our Medicare-Medicaid products has been really
4 helpful in Illinois.
5 COMMISSIONER BURWELL: Thank you.
6 MS. WARREN: Hi, Brian. So I would say similarly we
7 have, you know, gotten buy-in over time from many of our
8 stakeholders. We are a fairly large population in managed
9 care in our state, but this was our first time that LTSS
10 and BH were enrolled in managed care, and so I think that
11 there has been some challenges there. As I spoke about in
12 the beginning, you know, there were payment delays. We're
13 past that significantly, but those memories still are
14 lasting, unfortunately. So we have some hurdles there to
15 cross.
16 We are in a new administration, same party, but only
17 less than two years in, and a second year, you know, of
18 course, in a pandemic. So there are just a lot of
19 priorities, and our current administration is really still
20 evaluating the program.
21 I think another resource constraint in our program is
22 that our state is undergoing re-procurement for our

1 traditional managed care program as well as some pharmacy
2 reform and an FI model. And so there are a lot of
3 different initiatives going on in the state Medicaid
4 agency, and it really goes back to what we mentioned before
5 about, you know, this constraint of resources are something
6 that we really experience every day at the state Medicaid
7 agency, and that is, you know, one of the challenges in
8 trying to figure out the successes and failures of the
9 program, is just the ability of staff resources to devote
10 to it.
11 COMMISSIONER BURWELL: Thank you, Karla.
12 CHAIR BELLA: Well, we are at our time for the panel,
13 so we're going to be responsible about the timing. Thank
14 you to the three of you for joining us. You've given us a
15 lot to talk about, and you have kicked off our integrated
16 work for this report cycle, so thank you very much. And we
17 really appreciate you spending time with us today.
18 MR. ENGELHARDT: Thanks, Melanie.
19 MS. PHELAN: Thanks for having me.
20 CHAIR BELLA: Have a great day.
21 MS. PHELAN: Thank you.
22 MS. WARREN: Thank you.

1 ### FURTHER DISCUSSION BY COMMISSION
2 * CHAIR BELLA: Kirstin, do you want to kick anything
3 off or go into any more detail about the work plan? Or do
4 you want to just have round-robin conversation at this
5 point?
6 MS. BLOM: I'm open to just having a conversation,
7 Melanie. I don't know if you guys have any thoughts on
8 sort of next steps on the MMP side in particular. That
9 would be helpful. But that's all I've got, unless you have
10 any questions about the work plan. I'm happy to answer.
11 CHAIR BELLA: Well, let's start with comments about
12 what we just heard and kind of thoughts on this portion of
13 the work. Chuck, would you like to start?
14 VICE CHAIR MILLIGAN: Sure. I thought it was a good
15 panel. I thought the comments, Melanie, prompted by your
16 questions around more timely evaluation information, more
17 timely information in general, I think that that was
18 important for these administrators to kind of steer their
19 programs. And I think in all likelihood it means they're
20 going to need to final local evaluation approaches.
21 I do think that the response to COVID is going to be
22 important to understand better in terms of the implications

1 for service delivery, for rate setting, for integration.
2 And I am struck, again, by the comments that -- and,
3 Kirstin, maybe this is feedback for you and Anne as we kind
4 of think through the work plan, the comments that Sheldon
5 and Martha made around -- you know, integrated financing is
6 one piece, but integrated care delivery is another piece.
7 And so, you know, what do we see underneath in terms of
8 value-based contracts? What do we see underneath in terms
9 of kind of integrated UM process, integrated discharge
10 planning, integrated transitions of care?
11 I think having a better understanding of how these
12 programs really then drive kind of the vision of
13 integration and really thinking of it as a comprehensive
14 benefit package and comprehensive management of provider
15 risk, provider relationships, and health outcomes I think
16 will be helpful for us.
17 I guess I'll just conclude, you know, Tim mentioned an
18 important milestone with a million individuals in some form
19 of integrated model, whether it's enrollment in the
20 identical D-SNP and MLTSS plan or MMP or PACE kind of
21 collectively being about a million members. You know,
22 relatively, compared to all dual eligibles, that number is

1 increasing, which is a good thing, but it's still
2 relatively low as a percentage. And so I do think that
3 whatever the Commission can do to help promote policy
4 development and recommendations that advance integration I
5 think will be in the best interest of dual eligibles.
6 So I'm not sure if that was very insightful, but that
7 was kind of a summary of what I heard and where my thoughts
8 took me.
9 CHAIR BELLA: Thank you, Chuck. Brian and then
10 Sheldon.
11 COMMISSIONER BURWELL: So I thought it was an
12 excellent panel. One of my takeaways from what I heard
13 them talk about was more work needs to be done around
14 consumer education. It's a very complex landscape out
15 there. There's more and more choices that people have.
16 Where they are getting their information around what
17 choices to take is not clear. I know that there are a lot
18 of different sources of information, whether it's
19 providers, enrollment brokers, the plans, the state, et
20 cetera, and that they would like more -- they would
21 certainly like, if there was an investment of resources,
22 more resources into helping states target their dual

1 eligible population with more information about what their
2 choices are and what the various implications are.
3 The relationship between the dual eligible and his or
4 her PCP is obviously a very important part of the choice
5 process, and it was interesting to me to hear Karla saying
6 that that was really not a big issue in Ohio and therefore
7 contributed to the low opt-out rates that their plans were
8 very open to expanding their networks to include the
9 member's PCP. And there was like a lag of some kind,
10 where, you know, they were given the time for that to
11 happen, or, you know, don't worry about it, you'll be able
12 to keep your same doctor.
13 I haven't seen more research into that factor. The
14 relationship between members, their primary care
15 physicians, and integrated care models would be of interest
16 to me.
17 CHAIR BELLA: Thank you, Brian. Sheldon?
18 COMMISSIONER BARKER: Sheldon, you're on mute.
19 CHAIR BELLA: Sheldon, sorry. We still can't hear
20 you.
21 MS. BLOM: Actually, Melanie, while Sheldon's figuring
22 that out I have one question. One thing that Tim brought

1 up was the issue of carve-outs on the Medicaid side. He's
2 mentioned that to me before. So I don't know if anyone has
3 any reaction to that, I would be interested to hear.
4 CHAIR BELLA: Toby.
5 COMMISSIONER DOUGLAS: Yeah, I was thinking how to
6 respond to that one, because clearly definitely have a
7 reaction and I think Tim is right on. It's a huge
8 impediment, whether it's in California or in other states.
9 And, you know, clearly there are options that can
10 occur on the Medicare side [inaudible] on D-SNP plans. But
11 on moving to the financial alignment I'm just wondering if
12 there are assessments we can do looking at just what states
13 have done to incent plans to work on integrating or moving
14 to ways to create financial incentives with carved-out
15 services, whether it's through types of value-based
16 arrangements with carved-out personal care or carved-out
17 behavioral health. But, you know, some states, like
18 California, it's going to be nearly impossible to ever
19 integrate, fully integrate back some of these services.
20 The question is what are other steps that can be taken to
21 move to virtual integration through different types of
22 incentive arrangements.

1 And this goes beyond just duals. It's thinking this
2 through in general, as we're moving to that range. I don't
3 know what the answer is. I mean, the only other approach
4 is just trying to go back to some of the approaches of the
5 FIDE SNPs and other ways to get around it. But if we're
6 going to go through just straight Medicaid and Medicare
7 financial alignment it's very difficult to see some of
8 these states being able to carve back in some of these
9 products, given all the different political forces that
10 prevent it from occurring, that we need to look at other
11 ways and what are the tools and ways we can assess the
12 implications of plans or states to incentivize better
13 integration through coordination.
14 CHAIR BELLA: Chuck, on this point? Do you have a
15 response on this point?
16 VICE CHAIR MILLIGAN: I do. I have a second comment
17 that I'll defer in case others haven't had a first bite at
18 the apple.
19 I'm not recommending this but there is separate
20 alternative, which is at a federal level presumably you
21 could alter the state savings percent or use financial
22 levers inside of MMP that would vary based on how fully

1 carved-in the model is. And so if a state wants to
2 continue a BH carve-out, it would be within its right, but
3 if it carved it in, presumably there should be some
4 consideration on the Medicare savings that might be
5 generated by avoided hospitalizations, avoided ED visits,
6 because you're managing mental illness or addiction,
7 substance use disorder because the health plan is dealing
8 with it through peer support specialists or building out a
9 continuum of care ion the BH side.
10 So there are some potential levers inside of the
11 innovation center authority to incentivize carve-ins that
12 don't simply kind of defer to whatever a state may or may
13 not choose to do, but to change some of those levers.
14 CHAIR BELLA: Thank you, Chuck. Sheldon.
15 COMMISSIONER RETCHIN: Yeah. Am I on?
16 CHAIR BELLA: You are.
17 COMMISSIONER RETCHIN: Yeah. I'm going to circle back
18 to the point I made during the panel over integrating the
19 care and the clinical models. Years ago I participated
20 with Mathematica on site visits of Medicare Advantage
21 plans, looking for innovations, and these were all site
22 visits, focus groups with providers. And we found that by

1 far the most innovation was going on in the staff model
2 HMOs versus the IPAs in the Medicare Advantage plans.
3 And I raise that because I think that for particularly
4 the very frail elderly portion of the duals it's going to
5 be difficult for primary care physicians out of the gate,
6 or primary care providers out of the gate, to take care of
7 somebody who has annual expenses of $100,000 or more. They
8 have falls. They have frailty. And I just wonder if a
9 role we could play is to explore this with calls to some of
10 the plans that are participating, or at least encourage
11 Tim's office to just explore what kinds of clinical
12 innovations are going on, whether it's standardized
13 interdisciplinary teams. Because I do think understanding
14 the advances in clinical care are going to be really
15 important.
16 CHAIR BELLA: Thank you, Sheldon. Kit?
17 COMMISSIONER GORTON: So I would align myself with
18 what Toby was saying. In Pennsylvania, when we set it up,
19 the behavioral health carve-out was the cost of success.
20 It just wasn't going to happen without the behavioral
21 health carve-out. It's now been the situation on the
22 ground for 25 years. And unwinding that, particularly in a

1 state where, you know, as Darin pointed out yesterday, most
2 states the Medicaid director does not have the authority
3 over the behavioral health system.
4 And so, you know, I just think that's going to be
5 hard. I do think that it might be useful, at this point,
6 to Kirstin's point, to catalog. If I ever knew which
7 states had which carve-outs and whatever, I don't remember
8 now. And it might just be useful for people to understand
9 how carved-out things continue to be, either fully carved-
10 out or partially carved-out. Some states have put people
11 in. Some states have put some people in. You know, you
12 have the Rosie D kind of phenomena in states like
13 Massachusetts. And so you get sort of a wraparound layered
14 on top of a carve-in sort of.
15 So I think that there might be something useful in a
16 modest, descriptive work just to say, you know, this has
17 been identified as one of the issues and here's where that
18 situation exists on the ground and what it may take to undo
19 it.
20 And then if I could, just going back to what Brian
21 said, and Brian is not alone in this, we tend to sort of
22 argue that this is a problem of consumer education. And

1 one, there is a plethora of choices. All of us at a
2 certain age get mailboxes full of choices about our health
3 care coverage every week. But I'm not convinced -- and
4 this is theoretical but I'll say it anyway -- I'm not
5 convinced that we have made the value proposition
6 compelling enough for individual consumers and for many
7 individual providers. I think we heard loud and clear in
8 Illinois is people want to be in fee-for-service Medicare,
9 and we haven't convinced them why not. And providers want
10 them to be in fee-for-service Medicare, and we understand
11 why they feel that way.

12 So until we tip the balance so that it makes sense for
13 providers to want their people in instead of breaking out
14 the opt-out stamp, and where people, you know, find a
15 reason to want to do this, right? We all, as an article of
16 faith, say, oh well, integrated care is better. You know,
17 I don't know that we have sold the country on that. And I
18 think, quite frankly, that may not be the sole problem but
19 I do think that we need to look to ourselves and the
20 academicians and to the plans, right? Everybody today
21 talked about lack of data.

22 The lack of data says that seven years into this

1 program we still can't say definitely it made a big
2 difference in people's lives, at a level which would
3 convince an individual consumer or family member that
4 that's where they should land. They should surrender their
5 fee-for-service Medicare program that they understand, with
6 the doctors they've chosen and that they like, and go into
7 this new thing -- I don't think we've convinced people that
8 it's that much better.
9 And so I think that will remain a problem. Choice is
10 a fundamental American value. It isn't going to go away.
11 And so, you know, I do think we need to look somewhat at
12 what evidence base we've provided people that this is
13 better.
14 CHAIR BELLA: Thank you, Kit. Chuck and then Brian.
15 I'm sorry. I'm going to go to Bill because he's hasn't
16 spoken. Chuck, Brian, and then I'm going to wrap this up.
17 COMMISSIONER SCANLON: I just wanted to go to where
18 Kit just was, because two or three meetings ago there was
19 data that we viewed that said that about 20 percent of
20 duals reported they were in good or excellent health. And
21 I think that telling them sort of why integrated care is
22 better for them, when they're largely going to rely on

1 Medicare, and what Medicaid has been doing in a large
2 number of states is not doing their co-pays.
3 And so I think the question is what case do you make
4 to them that integrated care is going to better? Is it
5 because the co-pay is going to be covered now and,
6 therefore, access is going to be improved? Because I don't
7 think the coordination is necessary there if you're in good
8 or excellent health. You can be low-income and over 65 and
9 be a dual, but you can still be in excellent health.
10 CHAIR BELLA: Chuck. Thank you, Bill.
11 VICE CHAIR MILLIGAN: Yeah, I'm sort of leaning into
12 the same part of the conversation, Kirstin. You know, one
13 of the things, as I'm listening to this, that I think would
14 be helpful is a little bit of a side-by-side about some of
15 these things. Let me just tick off three really quickly.
16 The agent and broker role -- and Laura from Illinois
17 mentioned this -- you know, I think agents and brokers, you
18 know, they get commissions for placing people into some
19 Medicare products, but I don't tend to vilify agents and
20 brokers. I think they are often local, locally known.
21 They're trusted. And so there is that piece of it and kind
22 of how does that affect take-up.

1 I think there's a supplemental benefit side Medicare
2 Advantage that I think isn't really well understood in
3 terms of how that drives decisions about, you know, what
4 products to be in on the Medicare side or not. Because
5 access in a lot of Medicare Advantage products to, you
6 know, dentures and dental benefits and vision and
7 eyeglasses and over-the-counter drugs and all this other
8 stuff, I think that's influential and I think it's not
9 available in some of these integrated models, where it's
10 kind of outside Medicare and Medicaid both in certain ways.
11 The other part of it is that I think this gets to the
12 original Medicare piece. I think a lot of providers are
13 going to get paid the same, paid the same rate, 100 percent
14 of Medicare generally, whether it's original Medicare or
15 not, but the UM requirements are significantly different in
16 original Medicare, where it tends to be a light touch in
17 terms of kind of looking over providers' shoulders around
18 approving an authorization request.
19 So I think having a side-by-side of some of those
20 drivers of decision-making, I think that would help inform
21 the policy challenge or issues or where we might want to
22 kind of take our work.

1 CHAIR BELLA: Thanks, Chuck. Brian?
2 COMMISSIONER BURWELL: Just in the context of not
3 knowing a lot about outcomes of integrated models, and, you
4 know, having to make the case kind of building on what Kit
5 said, I just want to point out that the Arnold Foundation
6 is also supporting work around duals. I've had some
7 conversations and one of the products that they sponsored
8 was a bibliography of all the research that's been done
9 around duals. And I just, because of this meeting, went to
10 that link and it's incredible. All the RTI, state-specific
11 RTI evaluations have now been released and are available.
12 Another development is that it seems like the academic
13 community has come across duals as a good area of research
14 focus, and there's a lot of academic papers coming out in
15 the last few years. So, I mean, we should try to stay
16 informed as much as we can of the new research that is out
17 there. You know, I'm sure Kirstin's read all these things,
18 but the rest of us haven't.
19 I'm just thinking, you know, how can we draw upon the
20 information that is coming out about integrated models in
21 our conversations about, you know, what should happen next
22 and how successful are they. You know, there's a lot about

1 the what in terms of, as Sheldon was saying, utilization
2 changes, but there's very little about the how. You know,
3 what are the models that are being used?
4 I'm just saying that there's a lot more out there than
5 we may have previously thought.
6 CHAIR BELLA: Yeah. I guess I would make one comment.
7 We actually, MACPAC has done an inventory of the
8 evaluations and duals programs. And so there is a lot of
9 information out there. I would say that I think like the
10 team here has tried to stay ahead of that and on top of
11 that, and putting that together. I actually have a comment
12 on that, but Anne, did you have a comment to make?
13 EXECUTIVE DIRECTOR SCHWARTZ: Well, I was just going
14 to say over the summer, we updated the inventory that we
15 had done maybe a year and a half ago. I don't think it
16 really changed our top lines, in terms of what we took away
17 from it, but we're trying to stay on top of that.
18 And then I also just wanted to say, remind folks that
19 what Kirstin mentioned earlier is that we're doing work now
20 on the role of Medicare agents and brokers, so you'll be
21 hearing more about that in a less anecdotal way going
22 forward.

1 CHAIR BELLA: Thank you, everyone, for comments, and
2 Kirstin, for putting the panel together. I came away with
3 three things just to share, to think about as you continue
4 to work in this area.
5 One is just that continuing to try to understand --
6 and as one of our goals, our stated goals of the Commission
7 is increasing enrollment in integrated products, right, so
8 continuing to learn from what is competing against growing
9 that enrollment. And the competition could come from lack
10 of education about choices. It could come from lack of
11 understanding, like to Kit's point about why this is
12 better, either because we don't have enough to make that
13 case or we're not doing a good job to make that case. It
14 could come from fear, and that's the whole I'm scared of
15 leaving fee-for-service. It could come from having too
16 many choices. Tim kind of alluded to that, and we know
17 there have been markets where there's been influences for
18 where people end up that aren't necessarily because it's in
19 the person's best interest, whether that's lookalikes or
20 that ties to our agents and brokers.
21 And so I think that body of work, agents and brokers
22 is just one piece of the things that could potentially be

1 keeping out of integrated products, so thinking about that.

2 The second is to talk about the lack of data for a
3 second. I mean, it is disturbing to hear that seven years
4 in the state sits on its own Medicaid data, doesn't feel
5 like it has good information upon which to make decisions.
6 And so it has been a struggle to integrate the data, so
7 line it up, and especially to have it be in the same time
8 periods as Medicare data is available more timely.

9 But kind of looking at what we have done with the
10 inventory of evaluations, and as you talk to states getting
11 very concrete about what it is that they're missing
12 information on. Kit, actually, I think there's been more
13 work around more of the qualitative beneficiary experience.
14 Are you getting your needs met? Do you know who your care
15 coordinator is? And some of it is stronger in some states
16 than others, and I think even Karla alluded to that, that
17 they feel like they haven't good insight into the care
18 coordination piece. It feels to me like they don't have
19 good insight into the savings piece or into maybe some of
20 the like typical outcomes, although some of that is in RTI
21 work.

22 So I think, Kirstin, it's good to know what's out

1 there but I really want to understand from the states like
2 what is holding them back. What do they not have, and how
3 do we help them get that?
4 And then the third piece is just, you know, I think we
5 batted around the question at the end of last year, like
6 should the MMPs be made permanent? And, you know, we did
7 see, like these programs, we saw PACE started us a demo for
8 a really long time that was made permanent. We saw D-SNPs
9 spend a lot in several years. They were made permanent.
10 As we think about MMPs and continuing to try to give states
11 some stability and reason to invest in these programs, how
12 would we think about what we would ever want to see, or
13 what Congress might be wanting to see to think about
14 advancing permanency of these programs, and is that
15 something that would have to be done with sort of a
16 different sort of authority than what is allowable for the
17 Secretary to do within CMMI?
18 So I just think that if demos continue to be extended
19 and we're now going on seven years in Ohio, we'll hit nine
20 or ten years with this most recent extension, like it is
21 time to be thinking about what would it take for these
22 things to be permanent. And, therefore, then if we said to

1 be permanent we need to have better data on XYZ, it seems
2 like it would inform the work in really tangible ways about
3 where to go with some of things at the state and federal
4 level.

5 So that's just my two cents on that, but thank you for
6 pulling together. Let me just see if any other
7 Commissioners have any last thoughts, and if not, we will
8 turn to public comment.

9 CHAIR BELLA: Okay. We will turn to the public. If
10 you'd like to make a comment please use your waving hand
11 button and you will be unmuted, introduced, and we would
12 ask you to also include the organization you're
13 representing.

14 MS. HUGHES: Okay. We have Camille Dobson. Camille,
15 you're self-muted. If you could unmute yourself and make
16 your comment.

17 **### PUBLIC COMMENT**

18 * MS. DOBSON: Hi. Good afternoon. Sorry I missed
19 yesterday. I couldn't figure out the raise hand button.

20 Anyway, just one comment today, Melanie, on your main
21 point about Medicare enrollment. The plans that we work
22 with -- oh, sorry. Camille Dobson from ADvancing States.

1 We represent the aging and disability directors who
2 administer Medicaid LTSS programs, including those for dual
3 eligibles.
4 Part of my work with the six or seven national plans
5 that are in the Medicare Advantage and MMP space has been
6 the lack of enthusiasm shown by the SHIP counselors in
7 counseling individuals about the benefits of integrated
8 products. And so we are partnered with SHIP TA center
9 that's run by a AAA out in Iowa, that's funded by ACL.
10 And our work product for them this year is going to be
11 focused on educating the SHIP counselors about integrated
12 care, so trying to do our part to explain to them, one,
13 what that looks like. A lot of them don't understand
14 managed care, in general. They're suspicious personally
15 about managed care in Medicare. They themselves typically
16 are not enrolled in a Medicare managed plan or any other
17 kind of integrated product.
18 So we'll be doing some virtual education with them.
19 We'll be putting together a fact sheet and some training
20 materials that they can access from the SHIP TA center
21 throughout the year, hopefully to make a little bit of a
22 dent in having them not discourage individuals who express

1 interest, for example, in an MMP or in a D-SNP or any other
2 kind of program, to try and address a very small part. I
3 agree with Melanie that it's a bigger issue than this, but
4 we wanted to do our part, and I thought I would just let
5 you know that we are trying to attack it from our network's
6 side. Thank you.
7 CHAIR BELLA: That's great, Camille. Thank you, and
8 thanks for the comments yesterday as well.
9 I don't see any other hands, but we'll give it just a
10 minute. While we're waiting for that I'll just remind
11 folks that we are about to break for lunch and we will
12 reconvene at 12:45 Eastern time. We will start with a
13 session on waiting lists for HCBS services, that Chuck is
14 going to lead.
15 All right. If the person from GoToWebinar could
16 confirm, I don't see any other public comment. Is that
17 correct?
18 MS. HUGHES: That is correct. No other public
19 comments at the moment.
20 CHAIR BELLA: Okay. Thank you so much. Thank you,
21 everyone. Thanks to the Commissioners. Thanks to the
22 public who stuck with us this morning. We will see you

1 back at 12:45.

2 * [Whereupon, at 12:17 p.m., the meeting was recessed,

3 to reconvene at 12:45 p.m. this same day.]

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1 AFTERNOON SESSION

2 [12:46 p.m.]

3 CHAIR BELLA: Okay. I know we are missing a couple,
4 but I'd actually like to keep on track. So, Chuck, I'd say
5 go ahead and get started.

6 VICE CHAIR MILLIGAN: Okay. Well, welcome back,
7 everybody and all of the members of the public who are
8 attending this meeting.

9 The next topic we're going to be taking up is the
10 state management of home- and community-based waiver
11 services waiting lists.

12 MACPAC published some really good materials in late
13 August, and with us to kind of present the key findings
14 from that and describe some of the potential next steps in
15 our work are Kristal and Tamara.

16 Welcome back, Kristal and Tamara, from yesterday. I
17 will turn it over now to you all to walk us through the
18 presentation and prime us up for the discussion. And,
19 Kristal and Tamara, I'm not sure which one of you is on
20 point, but it's all yours.

21 **### STATE MANAGEMENT OF WAITING LISTS FOR HOME- AND**
22 **COMMUNITY-BASED SERVICES**

1 DR. VARDAMAN: Tamara will be starting off.

2 CHAIR BELLA: Okay.

3 DR. VARDAMAN: I think she's having some audio --

4 * MS. HUSON: Oh, okay. Thank you. I was having a

5 muting issue there. Okay.

6 Okay. So good afternoon, Commissioners. Kristal and

7 I are happy to be back with you. We'll be presenting today

8 on the topic of state management of home- and community-

9 based services waiver waiting lists, and just to remind

10 you, the findings from this work were published last month

11 on our website as an issue brief and an accompanying

12 compendium, which we will be discussing today.

13 So this slide is simply an overview of what we'll be

14 discussing. We'll start with some general information on

15 Medicaid coverage of HCBS, HCBS waivers, and waiting list

16 management practices. Then we will highlight some of the

17 key takeaways gleaned from stakeholder interviews, the

18 experiences of individuals on waiting lists, strategies

19 used to reduce or eliminate waiting lists, and the growing

20 need for HCBS. And we conducted 16 interviews with federal

21 and state officials, state associations, beneficiary

22 advocates, and other experts as part of this work. And

1 then, finally, we'll end with some policy considerations.

2 Next slide, please.

3 So Medicaid home- and community-based services, or

4 HCBS, allow people with significant physical and cognitive

5 limitations to remain in their homes or home-like settings

6 rather than in an institution. And while HCBS is not a

7 mandatory benefit, all Medicaid programs currently provide

8 some HCBS benefits. And states can cover HCBS in their

9 state plans, which require such benefits to be made

10 available to all enrollees, or through various waiver

11 authorities that could be targeted to certain populations.

12 So waivers under Section 1915(c) and Section 1115 of

13 the Social Security Act are often used by states to cover

14 HCBS and permit states to limit the number of individuals

15 served and establish waiting lists. State plan services,

16 however, are not allowed to have waiting lists.

17 Next slide, please.

18 So as part of our work, we analyzed Section 1915(c)

19 and Section 1115 waiver documents for all 50 states and the

20 District of Columbia. We searched Medicaid.gov for

21 approved waivers and compiled selected information from

22 these waivers into a compendium.

1 We found a total of 254 approved Section 1915(c)
2 waivers operating in 47 states and D.C. and 14 Section 1115
3 waivers. Three states, Arizona, Rhode Island, and Vermont,
4 used Section 1115 as their sole HCBS authority. Section
5 1115 demonstration waivers are not specific to HCBS, and we
6 only analyzed those waivers that included an HCBS
7 component.
8 Next slide, please.
9 So states typically offer multiple Section 1915(c)
10 waivers in order to target a specific population or
11 multiple populations. The number of waivers by population
12 targeted, as seen on this slide, are from our compendium.
13 As you can see, the largest number of waivers target
14 individuals with intellectual and developmental
15 disabilities followed by individuals with physical
16 disabilities and individuals age 65 or older. The fewest
17 waivers target individuals with HIV/AIDS or those with
18 mental illness or serious emotional disturbance.
19 The categories of populations, as seen on this slide,
20 are taken from the defined list of target groups found in
21 Section 1915(c) waiver applications. Section 1115 waivers
22 do not have the same distinct group categorizations, and

1 therefore summarizing populations for those waivers is more
2 challenging.
3 We found that many Section 1115 waivers provide
4 services for individuals who are aged, blind, or disabled,
5 but a few states also target individuals with autism,
6 traumatic brain injury, HIV/AIDS, or behavioral health
7 needs.
8 Next slide, please.
9 The states are allowed to set caps on the number of
10 people served under a Section 1915(c) waiver and may
11 establish a waiting list when demand exceeds the waiver's
12 approved capacity. Some Section 1115 waivers also allow
13 for waiting lists.
14 A lot of what we know about waiting lists comes from
15 the annual Kaiser Family Foundation survey. According to
16 their most recent survey for fiscal year 2018, 41 of 51
17 states reported having an HCBS waiver waiting list for at
18 least one population, with total waiting list enrollment of
19 nearly 820,000, and an average wait time of 39 months.
20 In states that we interviewed, estimates of wait times
21 ranged from less than one year to 14 years.
22 It's also important to note that eligibility screening

1 for waiver services happens at different times in different
2 states, making it difficult to measure unmet needs and
3 compare waiting lists across states. According to the
4 Kaiser survey, 33 of 41 states with waiting lists screen
5 individuals for waiver eligibility before placement on a
6 waiting list. Some states use specific screening tools to
7 determine waiver eligibility, taking into consideration
8 factors such as financial eligibility or functional status.
9 Next slide, please.
10 So as part of our analysis of Section 1915(c) waivers
11 and Section 1115 waivers, we characterized waiting list
12 management practices into seven categories based on the
13 criteria for waiver entry found in the waiver. Of the 254
14 approved Section 1915(c) waivers that we reviewed, we found
15 199 of them document how waiting lists are managed, and 11
16 of the 14 Section 1115 waivers also documented this.
17 Fifty-five Section 1915(c) waivers and three Section 1115
18 waivers made no mention of a waiting list. So we could not
19 determine management practices for those waivers.
20 We found that first come, first served is the most
21 popular method with 62 Section 1915(c) waivers using this.
22 This is when an individual placement on a waiting list is

1 determined by how long they have been waiting, with the
2 longest tenured individual at the top of the list receiving
3 the next available waiver slot.
4 Priority was used in 46 waivers. For these waivers,
5 assessment and screening tools are often used to determine
6 an individual's need for services, taking into account
7 factors such as level of care requirements, natural
8 supports available to them, or risk of
9 institutionalization.
10 Another 21 waivers used a combination of priority and
11 wait time, such as by assigning people to priority
12 categories but ordering them by wait time within those
13 categories.
14 Fifty-nine Section 1915(c) waivers and two Section
15 1115 waivers specified that there would be no waiting list
16 for that waiver.
17 And with that, I'm going to turn it over to Kristal
18 who will discuss some of the key themes from our
19 stakeholder interviews.
20 * DR. VARDAMAN: Thank you, Tamara.
21 So as Tamara noted, the one theme that emerged from
22 our work is that it's really difficult to compare waiting

1 lists and to judge the extent to which waiting lists
2 reflect unmet need for HCBS because of the waiver structure
3 and the waiting list management differences, as Tamara
4 noted, as well as when eligibility screening occurs.
5 Furthermore, unmet need for HCBS is hard to measure
6 because states do not track how individuals meet their care
7 needs while waiting for waiver services. So in our
8 interviews, we asked stakeholders to discuss what happens
9 to individuals while they wait for waiver services, and
10 they mentioned several options.
11 First, some states use tiered waivers, where one HCBS
12 waiver may have a more limited benefits package than
13 another. So an individual may be waiting for the more
14 intensive service package but receiving services through
15 another waiver.
16 Individuals could also be receiving state plan
17 services, and children can receive services through the
18 early and periodic screening, diagnostic, and treatment
19 benefit, or EPSDT.
20 In addition, stakeholders frequently cited support
21 provided by family caregivers as a source of care as well
22 as schools. Given the key role of the family caregivers

1 for many people in need of HCBS, the loss of a caregiver
2 can change the need for waiver services to urgent, and we
3 found that some states reserve waiver capacity for
4 individuals when critical needs such as this arise.
5 Many individuals also said it's possible that
6 individuals enter institutions to receive LTSS while
7 waiting for a slot in the HCBS waiver. We couldn't
8 quantify this, and research shows most people on waiting
9 lists do actually live in the community.
10 In terms of strategies to reduce or eliminate waiting
11 lists, state funding was cited as the most important
12 factor. In some states, explicit support from the governor
13 or state legislator has led to funding increases that
14 helped reduce waiting lists.
15 Multiple stakeholders also noted that litigation, such
16 as cases related to Olmstead enforcement, plays a role.
17 For example, one state told us that they prioritized moving
18 nursing home residents onto the waiver due to an Olmstead
19 settlement agreement.
20 Finally, some stakeholders spoke about the potential
21 of making HCBS a mandatory benefit. One state official
22 noted that since HCBS are optional, they are always more

1 vulnerable to budget cuts to nursing facility services. An
2 advocate proposed that even if some waiver services
3 remained optional, it would still be beneficial to make a
4 subset of HCBS an entitlement.

5 A number of states told us that they're experiencing
6 or anticipating a growing need for waiver services due to
7 the aging population. Both states and advocacy
8 organizations expressed concern over the impact of this
9 aging population on state capacity, and also some states
10 did say that they were experiencing increasing demand for
11 HCBS waiver services for children as well.

12 In addition, increasing life span and service
13 intensity also affect a state's ability to meet the needs
14 of individuals with intellectual or developmental
15 disabilities.

16 A number of interviewees mentioned provider capacity
17 as a limiting factor in meeting this growing need. Several
18 stakeholders noted that in some places, there's already
19 trouble meeting existing demand due to workforce shortages.

20 Our discussions with states and other stakeholders
21 often turn to the topic of rebalancing more generally and
22 Medicaid's institutional bias. Therefore, we wanted to

1 raise these policy questions for your consideration today
2 as you discuss the results of this work.
3 First, this work raises the question of how can state
4 efforts to rebalance be further encouraged and supported.
5 Since fiscal year 2013, national Medicaid spending on HCBS
6 has exceeded that for institutional services, although
7 national data obscure variation and rebalancing across
8 populations in states. This can be seen as the results of
9 federal and state efforts, including the Balancing
10 Incentive Program and the Money Follows the Person
11 Demonstration Program, or MFP.
12 The MFP program, for example, has helped states
13 transition beneficiaries from institutional settings back
14 into the community. Just this week, CMS released
15 information on an opportunity for supplemental funding for
16 states that are continuing to participate in MFP. Although
17 MFP was set to expire, Congress has provided new funding
18 several times over the past few years through some Medicaid
19 extender bills.
20 In terms of ongoing work in this area, we wanted to
21 highlight that MACPAC has contracted with RTI and the
22 Center for Health Care Strategies to conduct interviews

1 with stakeholders in five states with relatively low levels
2 of rebalancing. We hope that this work will identify
3 barriers that Medicaid programs encounter in serving more
4 individuals in the community, particularly in rural areas
5 and for subpopulations. We anticipate presenting the
6 findings from this work in April 2021.
7 The next question we would like to raise is whether
8 there should be fundamental changes in Medicaid LTSS
9 policies; in particular, whether HCBS should be made
10 mandatory or if there should be different policies for LTSS
11 subpopulations. Changing what is often referred to as
12 Medicaid's institutional bias would require a change in
13 statue and would likely come at a significant cost. This
14 cost would depend on a variety of factors such as the
15 eligibility criteria, the service package, and whether or
16 not nursing facility services remain mandatory.
17 Another key design issue is whether policies should
18 differ for different populations receiving LTSS. Waiting
19 lists for waivers for people with intellectual and
20 developmental disabilities are the largest share of total
21 waiting list enrollment, and many interviewees commented
22 about the specific LTSS needs of this population.

1 MACPAC currently has a contract under way with Health
2 Management Associates exploring how Medicaid serves this
3 population, including variation in eligibility and service
4 offerings across states. We expect to bring you the result
5 of HMA's work sometime this winter.
6 We're also exploring the development of external
7 research contracts to consider the design issues and costs
8 of making HCBS benefits more readily available. We'd
9 appreciate any thoughts Commissioners have on these issues
10 as we consider moving forward with that.
11 And now we'll turn it back to the Commission, and we
12 look forward to your discussion. Thank you.
13 VICE CHAIR MILLIGAN: Thank you very much, Tamara and
14 Kristal.
15 If Commissioners want to comment, if you could just
16 signal to me.
17 While I wait for that, Kristal, you mentioned in terms
18 of the stakeholder interviews. Could you just kind of let
19 us know when those occurred? Because the context with
20 COVID is that the mortality issues in nursing facilities
21 really, I think, motivated a lot of discussion about home-
22 and community-based settings being perhaps safer and also a

1 lot of activity around state flexibility. So could you
2 just locate when those stakeholder interviews occurred kind
3 of relative to what else is happening this year?
4 DR. VARDAMAN: Yes. They were actually at the
5 beginning of the year, so just before the COVID pandemic,
6 and so they don't reflect comments regarding states'
7 responses to COVID.
8 VICE CHAIR MILLIGAN: Okay. Thank you.
9 I will give the group a second here. My mic might be
10 frozen because I'm not seeing a lot of movement.
11 COMMISSIONER BARKER: It looks like Bill has his hand
12 up.
13 VICE CHAIR MILLIGAN: Okay. Bill, let's go with you
14 first, and I'm guessing, Brian, even if I can't see your
15 hand up, I'm maybe going to go to you next as somebody
16 who's worked in this space for a long time.
17 Bill?
18 [No response.]
19 COMMISSIONER BARKER: Bill, I think you're muted.
20 VICE CHAIR MILLIGAN: Bill, we can't hear you if
21 you're speaking.
22 [No response.]

1 VICE CHAIR MILLIGAN: So, Brian, do you mind if I jump
2 to you and I'll come back to Bill?
3 COMMISSIONER BURWELL: Sure.
4 VICE CHAIR MILLIGAN: And I see Kit's hand up after
5 that.
6 COMMISSIONER BURWELL: Okay.
7 VICE CHAIR MILLIGAN: And then Leanna.
8 COMMISSIONER BURWELL: What I am hearing in the field
9 is that most waiting lists, that waiting lists are heavily
10 weighted towards persons with intellectual and
11 developmental disabilities as a population that has always
12 been underserved.
13 And I do agree that with the findings that I think a
14 lot of people, particularly parents or aging parents, put
15 themselves -- or their children on waiting lists as a
16 planning strategy for what will happen to their child when
17 they're too old to care for him or her or if they die. So
18 they do it as an insurance policy.
19 They may be receiving services through other sources,
20 but the waiver program is a richer package of services and
21 has more options for how people receive services. So
22 knowing that it may take years for their child to get to

1 the top of the list, they put their child on very early.
2 I think Kristal noted that, in some cases, waiting
3 lists are up to 14 years long, which is a long time.
4 In regard to reducing waiting lists, a number of
5 states do -- have used MLTSS or have had as a policy
6 objective in converting their systems from fee-for-service
7 to managed care has been to expand access and reducing
8 waiting lists, and I think there's some states that claim
9 success in eliminating waiting lists in their conversion to
10 MLTSS. I don't know how that -- whether it was the change
11 in the delivery model or whether there was additional
12 financing put into the system during the conversion that
13 may have led to that result.
14 I do think just kind of why -- I do think lack of
15 funding is the number one reason why states have not been
16 able to address their waiting list issues. So often a
17 reduction in the waiting list is associated with a new --
18 an additional funding from the legislature, so that more
19 waiver slots can be approved. But I have been hearing a
20 lot more lately that workforce shortages are another major
21 factor in the expansion of home- and community-based
22 service capacity in many states, particularly in the ID/DD

1 population.

2 Obviously, COVID has accentuated that problem as many
3 HCBS personal care providers have been hesitant to go into
4 people's homes or have been in lockdown. So I do think
5 it's worthwhile for the Commission to explore workforce
6 shortages in the HCBS market as a major factor in states
7 not expanding capacity in this area.

8 That's all I would say.

9 VICE CHAIR MILLIGAN: Okay. Thank you, Brian. And,
10 Melanie, I'll add you to the list. Bill, you're up.

11 COMMISSIONER SCANLON: Okay, thanks. That was the
12 organizer that had shut me out.

13 What I wanted to start with is say I think we should
14 focus on the HCBS waivers and not worry about this idea of
15 an institutional bias sort of in Medicaid, because I think
16 that concept is really kind of vacuous. The reality is
17 that residential LTSS is an absolute necessity, and I don't
18 think any state Medicaid program would operate without
19 covering some nursing facility services.

20 To give you a contrast, drugs are an optional service
21 in Medicaid, and no state operates a program without
22 coverage of drugs. One tried it about 30-some years ago,

1 and it turned out to be very much of a negative experience,
2 and they quickly stopped. I think the same thing would
3 happen with respect to nursing facility care in part -- if
4 we go back again, it used to be we had two classes of
5 nursing facilities, skilled and intermediate, and
6 intermediate was optional, and every state with the
7 possible exception of California covered intermediate-care
8 facilities. So I think it's not worth our effort to be
9 thinking about that.
10 When we look at HCBS and we have this idea of should
11 it be a mandatory service, I think we have to be very sort
12 of careful and thoughtful there, because we had no HCBS
13 services before 1981 where states were given the waiver
14 authority and which they felt they could manage these
15 services. And the fact that we have, as reported today,
16 learned that there are over 800,000 people onwaiting lists
17 suggests that these management tools may still be very
18 important to the states.
19 Now, the attitude or maybe you could think of it as
20 the political perspective towards HCBS undoubtedly changed
21 since 1981, but there is still the issue of it's an
22 expensive service, and the population that needs it is

1 probably being significantly underserved. When we heard
2 from stakeholders that families are filling in the gaps,
3 that's not always -- I don't believe that's always the
4 case. There was a systematic survey -- and, unfortunately,
5 it was done more than 20 years ago -- of actual people
6 needing care. And when you asked them, 20 percent of them
7 said they were not getting basic services, like getting to
8 the toilet, sort of getting fed, getting dressed, et
9 cetera.
10 So the issue of LTSS underservice is really something
11 that we have to come to grips with. So if we think about
12 sort of taking away some of the states' flexibility, which
13 may be sort of positive in a theoretical sense, then we
14 need to be thinking about sort of what will happen in terms
15 of the budgetary implications and how states will try to --
16 will cope with sort of those budgetary implications,
17 because as pointed out, the Baby Boomers are moving into
18 the age where LTSS becomes a much more frequent need.
19 VICE CHAIR MILLIGAN: Thank you, Bill. And, Toby,
20 I've added you to the list. Kit, you're up.
21 COMMISSIONER GORTON: So just two quick points.
22 First, important that we remember that one of the things

1 that gets built into waivers is often different eligibility
2 criteria. On the one hand, there may be diagnostic and
3 assessment criteria that are required to expand the waiver.
4 But, on the other hand, often the financial eligibility
5 requirements are changed, and historically that was
6 important when many states did not have adult coverage in
7 Medicaid but could serve special needs populations through
8 these different waiver eligibility categories.
9 That works because, as Bill said, these services are
10 much more expensive, and if you had to live with
11 comparability and statewide-ness for these services for
12 everybody who wanted them or who could make a case that
13 they needed them, it would very quickly become
14 unaffordable.
15 So I think that I would just sort of align myself with
16 Bill. There are a lot of moving parts here, and one needs
17 to be very careful because mandatory services come with
18 mandatory requirements. We saw that little example of what
19 happened with MOUD; you know, a tiny tweak in language
20 caused a huge mess. And this would be even more of a mess,
21 I believe.
22 The second quick thing I wanted to say, we were

1 talking in the last session about, you know, sort of
2 fragmentation and carveouts and what populations are not
3 accessible to managed care solutions, either in Medicaid or
4 for the duals. One of the things is that in many states
5 the waiver populations or some of the waiver populations
6 are carved out, and the services that might be available
7 through a duals demonstration might be better than in the
8 Medicaid fee-for-service and Medicare fee-for-service
9 programs, but they may not be better than the waiver. And
10 in many cases, being in a waiver sort of gets you out of
11 bounds for participating in a managed care program. And so
12 that's yet another barrier. States have built these
13 programs to meet the specific needs of target populations,
14 and so just because you might want to be in an integrated
15 care model in Medicaid and Medicare doesn't mean that you
16 might not get a better array of services if you are in a
17 state's elderly dementia waiver.
18 So it's just another factor that people take into
19 account of when they make the decisions which programs they
20 want to be in.
21 VICE CHAIR MILLIGAN: Thank you, Kit. Leanna?
22 COMMISSIONER GEORGE: Unmute myself, okay. Yes, just

1 to kind of piggyback on what Brian said. There's a
2 standard joke amongst parents. Do you go ahead and get
3 your baby on the waiting list as soon as they're born? So
4 when they're hitting high school, you'll have the help you
5 need. That is a common comment amongst parents.
6 I think part of the problem, as a parent, I'll just
7 let you know that EPSDT had HCBS services in it. I didn't
8 know. So I'm wondering if we can look at pediatrician and
9 parent education programs to make sure that people that are
10 working with these families know that you have these
11 services available to you if you have Medicaid. So you
12 don't have the situation you don't know what you don't
13 have.
14 One concern I have about putting more HCBS in Medicaid
15 as a mandatory thing is how will it affect those that are
16 not Medicaid, they're on waiting lists? Would that cause
17 states to reduce the number of waiver slots available and,
18 therefore, make it harder for a person who does not
19 currently qualify for Medicaid because of finances or
20 children to be able to get the services they need? So
21 that's my question there, how that would be impacted.
22 And, also, take a look at what is the residential

1 options available, especially for children. In North
2 Carolina it's crazy to find a short-term treatment option
3 that's residential for people. A friend of mine last year,
4 her son was in the ER for four days. They sent him home.
5 They couldn't find a spot for him after four days in the
6 ER. She now looks like a bad wife because of how
7 aggressive her son is. So if there's a waiting list just
8 for institutional options and there's a waiting list for
9 these IDD waiver services, then we really have a problem
10 because there's nowhere for these parents to go to get the
11 help that they need. So that's what I have to say about
12 that.
13 Also, once again -- I'm sorry. One more thing is once
14 you know the waiting list for -- Brian, a lot of these
15 services, keep in mind IDEA ends at 21 for these children.
16 So once they age out of school systems, school services,
17 they have nothing available for age 22 beyond. That's
18 parents having -- it's hard. A lot of parents try to get
19 these waivers in place so that when they transfer to
20 adulthood with their child that they have an option for
21 where they can go and things like that, because, yeah, I'm
22 living it.

1 VICE CHAIR MILLIGAN: Okay. Thank you, Leanna.
2 Melanie and then Toby.
3 CHAIR BELLA: Yeah, thank you, Chuck. I had one
4 question and then one comment. My question is just around
5 waiting lists, sort of the waiting list administration.
6 This is many, many years ago, but I was in a state -- a
7 Medicaid director in a state that did first-come, first-
8 served, and we tried to transition to one of the priority-
9 based or need-based, and it was near impossible. As a
10 matter of fact, we weren't able to do it, for reasons that
11 it was very scary and felt unfair to people that had been
12 on there forever, even if they didn't have that level of
13 need.
14 So as we think about trying to get a -- trying to
15 constantly refine our understanding of what the true
16 waiting list number is, meaning people today who qualify,
17 who need services today, did you hear from anybody who
18 wanted to transition the way they do their waiting list?
19 And is there any best practice sharing for states that it
20 might work a little bit better or give families some sort
21 of assurance that, like Leanna said, they don't have to
22 sign up at first, and that they know that they'll get

1 services? Did that come up at all, anybody who was asking
2 for better ways to do it? Or was it more just a
3 cataloguing of how they do it?
4 DR. VARDAMAN: I think for the most part it was mostly
5 just a cataloguing of how they do it. I don't think we
6 heard from anyone, Tamara, that was interested in switching
7 from, you know, priority-based to first-come, first-served
8 or vice versa. But I do think that there was, you know,
9 some interest in resources and states sharing information
10 that came through those interviews.
11 CHAIR BELLA: Okay. And then my comment, Chuck, is
12 just, you know, I find myself guilty, and Bill, you know,
13 thinking about institutional bias a lot. And I guess what
14 would be helpful for me is thinking about how we can set up
15 a framework to start to think about policy issues
16 surrounding an institutional bias in the program. So not
17 saying that we're just going to take away nursing home and
18 make HCBS permanent, but start to think about all the
19 implications about how the program is structured today and
20 the intended and unintended consequences of that and begin
21 to think if we wanted to make some changes, how would we
22 think about doing that? And it doesn't have to be, you

1 know, one goes away and one comes on, and we've heard from
2 states, we heard from Patti Killingsworth, I think, in
3 Tennessee. There were incremental things that the states
4 are asking for where we could sort of dip a toe in and try
5 to have at least equal treatment of how we look at some of
6 the things we paid for in the community versus what's paid
7 for in institutional settings.

8 So I would like to see us kind of looking -- setting
9 up a framework to have a discussion about where there is
10 institutional bias and how we might be able to address
11 that. And I guess I would, channeling Kisha, remind us
12 when we think about institutional bias and what we're
13 talking about today, we should be applying the health
14 equity lens to this one big time, as well, as we look at
15 sort of who's getting care where and who has barriers and
16 access problems, particularly look at institutional versus
17 community.

18 VICE CHAIR MILLIGAN: Thank you. Toby, and I did,
19 Brian, see that you want a second bite, so I'll come to you
20 next. Toby?

21 COMMISSIONER DOUGLAS: Yeah, I'll be brief. I
22 definitely want to channel a lot of Bill's points around,

1 you know, just being careful here, especially with the
2 implications on cost. But I do strongly urge that we look
3 at just overall cost implications from a structure that
4 builds on what Melanie said around the institutional bias
5 when we're looking at both sides of it and really bringing
6 it back to the discussions around duals, because I don't
7 know that the question is should we make HCBS a mandatory
8 Medicaid benefit is the right one because states -- I mean
9 the costs are just astronomical. But how does this fit
10 into broader policies around integrated care across
11 Medicare and Medicaid, and whether, you know, we need to be
12 fundamentally thinking about structures?
13 But the costs -- we need to better understand the
14 costs, which a state, if we were to just say this is
15 mandatory, would have implications on other components of
16 their Medicaid budget or providers or, you know, just
17 fundamentally would cause other choices that they would
18 have to make. So just looking through one silo isn't the
19 way we're going to do it, but we do need to highlight that
20 these are needed services that have consequences when not
21 provided or institutional care and for sub-populations, and
22 then how do we address this holistically?

1 VICE CHAIR MILLIGAN: Thanks, Toby.
2 So let me just kind of organize. We've got ten
3 minutes left. Brian, I see you wanted to come in again.
4 Bill, I see you wanted to come in again. I want to have my
5 first bite at the apple. I'll wait until both of you kind
6 of make your remarks, if you could just save me a little
7 bit of time. And then, Kristal and Tamara, I'll come back
8 to you to kind of help us wrap. Brian?
9 COMMISSIONER BURWELL: So I'll try to be quick. Two
10 comments. One is I want to link this conversation with the
11 one yesterday we had on Medicaid estate recovery. So I
12 think it's clear, while states are very supportive of
13 meeting the demand for HCBS, that the demand exceeds the
14 supply or the ability of states to finance those services
15 as a mandatory benefit, and states would not be supportive
16 of making HCBS a mandatory service given the way -- we do
17 spend $50 billion a year already on 1915(c) waivers, up
18 from zero. So the states like to have tools in order to
19 help them manage, and another tool is on the financial
20 eligibility side. If people of all financial means in
21 regard to assets can get access to these services through
22 Medicaid estate planning on the front end or all these

1 provisions on the back end, that is another leakage that
2 works against state management of the costs of these
3 services.
4 Second, in regard to the institutional bias, I think
5 we do have incremental approaches already. One is MLTSS.
6 If you pay plans a blended payment for both populations,
7 you create incentives for plans to divert as many people as
8 possible and delay nursing home admissions because it will
9 increase their bottom line. So I think MLTSS is a good
10 incremental model for reversing the institutional bias, and
11 two states, at least, as far as I know, do have global
12 budgets for long-term care. They are Vermont and Rhode
13 Island. And Vermont has actually eliminated the nursing
14 home benefit as a mandatory benefit in their LTSS program
15 under their global budget. So there are models out there
16 that have directly addressed the institutional bias.
17 VICE CHAIR MILLIGAN: Thank you. Bill?
18 COMMISSIONER SCANLON: I just was going to say I think
19 the states have demonstrated with their actions that they
20 don't have an institutional bias. Right now there are
21 about 1.6 million nursing facility beds. If we had the
22 number of beds that are proportional to the population, I

1 think the current served population that's potentially in
2 need, it would be more like 2.7, 2.8 million. Through
3 moratorium and certificate of need, the states have reduced
4 the number of nursing home beds regardless of whether or
5 not people want to use them.
6 Secondly, they've got control over the rates they pay,
7 which also tends to reduce sort of the use of nursing
8 facilities. So the states have been very sort of open and
9 aggressive in some respects about saying we are not in
10 favor of institutions or nursing facilities, and the
11 consequence is then that we have this much smaller supply,
12 and we have to worry about whether or not we are paying
13 them appropriately, because as we've seen with COVID, we
14 have this huge disproportionate share of the deaths have
15 occurred within nursing facilities.
16 VICE CHAIR MILLIGAN: Thank you. So I have a couple
17 of comments myself, and then I want to try to pull together
18 some of what I've heard.
19 One of my comments is that I want to come at the
20 institutional bias issue from a different direction. I
21 think there is an institutional bias, but I think there are
22 incremental ways for us to think about it short of having

1 HCBS be a mandatory benefit. One form of institutional
2 bias, I think, is the fact that if somebody's in a nursing
3 facility, room and board is included in the payment rate,
4 so it's considered medical; whereas, if somebody's in the
5 community, room and board is prohibited for Medicaid. And
6 what that means is somebody has to rely on whatever income
7 they've got, which might be not very extensive with SSI or
8 something else.

9 So I think if we can learn something more about -- and
10 I think there's a way to shape an HCBS waiver where room
11 and board stipends could be included, and it could still be
12 cost-neutral within the cost neutrality requirements of a
13 1915(c) waiver. So I'd like to understand that piece of
14 it.

15 I want to go back to a second aspect of institutional
16 bias, which is kind of a comment that Kit made about
17 eligibility. And, again, in states that have Medicaid
18 eligibility spend-down requirements, if you have to spend a
19 lot of money on nursing facility care, you can go into a
20 nursing facility. It reduces your countable income because
21 of the cost of the nursing facility. The state uses your
22 Social Security or pension benefits to defray the Medicaid

1 cost, but you can still get the Medicaid card; whereas, the
2 cost of room and board in the community isn't considered a
3 countable medical expense, which means you could be over
4 income for eligibility.
5 So I'd like to understand that part better, those
6 forms of institutional bias, because you could still have
7 HCBS as optional, but potentially we could make a
8 recommendation around how room and board is treated in
9 community-based settings for both eligibility purposes and
10 being inside of cost neutrality for states.
11 The second comment I wanted to make -- and this is
12 more for the public -- there is a relationship between how
13 nursing facilities are paid and HCBS waiting lists. The
14 nursing facilities can keep people -- like lighter-need,
15 higher-functioning people in nursing facilities if they
16 perceive that they need that to manage their mix of payment
17 and staffing. And so I do want to flag for the public that
18 we're going to be tackling nursing facility payment issues
19 as kind of the other side of this topic during the course
20 of our work in upcoming meetings.
21 I think, and we heard a little bit about this, we
22 don't have a great sense of true need. We know, and you

1 guys shared with us, the number of people on waiting lists.
2 But, in fact, we don't know many of those would be eligible
3 for a waiver slot even if one was offered, because people
4 can get on a waitlist early for IDD. They can get on
5 without their financial eligibility being evaluated. They
6 can get on without their functional eligibility being
7 evaluated. So I think that's an important issue to come
8 back to.

9 So let me try to wrap up, Kristal and Tamara. I heard
10 a few follow-up areas that I want to just call out. One is
11 provider capacity in HCBS. Leanna touched on this with
12 residential options. Brian and Bill, I believe, touched on
13 this with workforce for attendant care and homemaker type
14 services.

15 So I think it would be good for us to have a better
16 understanding of provider capacity as a constraint on HCBS.
17 I think it would be good for us to understand those other
18 levers of institutional bias that I referenced, and also
19 whether MLTSS, as Brian noted, is also kind of a pressure
20 release valve on kind of getting at institutional bias, and
21 to Bill's point about just kind of licensed nursing
22 facility beds. So kind of having a fuller picture on that

1 I think would be helpful.

2 If there's some way for us to get a sense, to get a
3 little bit more knowledge of the characteristics of people
4 on waiting lists, you know, based on waiver type, based on
5 how much screening has happened, how often the screening
6 has happened by the states to kind of pre-certify people,
7 potentially, to get a truer sense of how many of those
8 individuals might actually qualify.

9 And I want to go back, I think finally, to Melanie's
10 comment about the first come, first served nature of this
11 in many states with many waivers. I think of that as being
12 a significant problem, because if states are looking at
13 HCBS as a cost-neutral option or how they look at it from a
14 budget perspective, if somebody is offered a waiver slot or
15 may or may not go into a nursing facility any time soon,
16 that's a net new utilizer, a net new expense for a state.
17 Whereas if somebody is prioritized and assessed as being
18 imminently admitted to a nursing facility, then it's a much
19 clearer cost savings and clearer tradeoff. But as Melanie
20 noted, the first come, first served nature has a lot of
21 equity issues and perceived fairness, and that's a
22 difficult thing to change once you've got it.

1 So I do think understanding a little bit more about
2 the implications of the states' administrative criteria to
3 manage a waitlist and the effect of that on nursing
4 facility cost avoidance or the other kind of more inpatient
5 settings would be helpful for us to understand.
6 That was a lot. And also just one other comment for
7 the public. The way we're going to be managing public
8 comments is at the end of all of the sessions this
9 afternoon we'll have public comments about all of these
10 sessions. So if you have comments about this particular
11 session, we'll be taking those at the end of the agenda for
12 the afternoon.
13 Kristal, Tamara, do you have any questions for any of
14 us, based on what you've heard? Any further direction you
15 need from us? Do you have what you need? If you could
16 just maybe have the last word on whether you feel kind of
17 ready to help keep driving the work or if you have
18 questions you want to resolve before we move on.
19 DR. VARDAMAN: Thank you all. I mean, today's
20 conversation was great and you've given us a lot of things
21 to think about. We'll take it back to the office and
22 discuss and get back to you about, you know, our plans for

1 going forward.

2 VICE CHAIR MILLIGAN: Okay. Thank you. Thank you
3 very much. And Commissioners, thank you for a great
4 discussion on the topic.

5 Melanie, back to you.

6 CHAIR BELLA: Thank you, Chuck. We are now going to
7 switch gears to a very timely topic, which is Medicaid
8 coverage of vaccines. So Chris and Amy are going to lead
9 us through this session.

10 **### MEDICAID COVERAGE OF VACCINES**

11 * MR. PARK: Great. Thank you. I'll be doing the slide
12 presentation by myself, but I do want to acknowledge all
13 the work that Amy's done on this subject.

14 To begin with, the COVID-19 pandemic has really
15 focused attention on the important role of the government
16 in the development and distribution of vaccines. While
17 there are many concerns and operational questions about how
18 any potential COVID vaccine will be distributed to
19 providers and individuals, we're not going to focus on
20 those specific concerns but rather Medicaid coverage of
21 vaccinations more broadly.

22 We'll start by reviewing coverage of Medicaid coverage

1 of vaccines and how coverage is different depending on age
2 and eligibility pathways. Next, we'll discuss how Medicaid
3 pays for vaccines and results from a recent study from the
4 Center for Disease Control and Prevention. Then we'll walk
5 through how the difference in Medicaid coverage and payment
6 rates may contribute to lower vaccination rates. And
7 finally we'll discuss some strategies and potential policy
8 options that could help improve vaccination coverage in
9 Medicaid.
10 The goal of this session is to determine how the
11 Commissioners want to proceed on this topic and what work
12 staff can pursue that would be helpful in informing the
13 Commission's understanding of the issues, development of
14 possible policy options, and any future recommendations.
15 In 1993, Congress created the Vaccines for Children
16 program, or VFC, to provide coverage of all vaccines
17 recommended by the Advisory Committee on Immunization
18 Practices, or ACIP. Children under 19 years old who are
19 Medicaid eligible, uninsured, underinsured, or an American
20 Indian or Alaska Native are eligible to receive
21 vaccinations through the VFC program without cost-sharing.
22 The Department of Health and Human Services estimates

1 that over half of young children and one-third of
2 adolescents in the U.S. are eligible for vaccinations
3 through this program. Vaccines provided through the VFC
4 program are purchased directly by the CDC at a discounted
5 price and then distributed to the state, which in turn
6 distributes them at no charge to providers.
7 While the CDC has the lead responsibility for policy
8 development and implementation of the VFC program, it is
9 established under the Medicaid statute. It is fully funded
10 by the federal government, so there is no charge to
11 beneficiary or state for any vaccine provided through the
12 VFC program. However, states and beneficiaries could be
13 responsible for charges related to any related office visit
14 or the administration of the vaccine.
15 For adults, coverage is a little different. Coverage
16 for a Medicaid-enrolled adult differs depending on
17 eligibility pathway and state. As part of the coverage
18 expansion to the new adult group, the Affordable Care Act
19 required that these beneficiaries receive benchmark
20 coverage, also known as an alternative benefits package.
21 The alternative benefits packages are required to provide
22 coverage of essential health benefits, or EHB. One of the

1 essential health benefits required that preventive services
2 must be provided without cost-sharing, and these include
3 all ACIP-recommended vaccines.
4 For other adults who are not subject to EHB
5 requirements, vaccination is not a mandatory benefit. This
6 means that states can choose which vaccines that they want
7 to cover. They do not have to cover all ACIP-recommended
8 vaccines. In addition, states may require cost-sharing
9 within federal guidelines for these vaccines.
10 These differences in vaccine coverage requirements
11 mean that a large portion of Medicaid enrollees may not
12 have access to all ACIP-recommended vaccines without cost-
13 sharing. As of 2020, about 20 percent of Medicaid
14 enrollees are in the new adult group and therefore have
15 mandatory coverage. Since children are covered under the
16 VFC program, and they are about 40 percent of the
17 population, this means about 60 percent of the total
18 Medicaid population has coverage of all ACIP-recommended
19 vaccines. For the remaining 40 percent of Medicaid
20 enrollees, coverage will be dependent on state.
21 Another factor contributing to this potential gap in
22 vaccine coverage is that vaccines are explicitly excluded

1 from the definition of a covered outpatient drug used for
2 inclusion in the Medicaid Drug Rebate Program, or MDRP.
3 This means that states do not have to cover all vaccines
4 and manufacturers do not have to provide statutory rebates
5 for these products.
6 Researchers at the CDC recently published a study
7 examining variations of vaccine coverage, beneficiary cost-
8 sharing, and payment across state Medicaid programs in 2018
9 and 2019. They found that while all states offered some
10 vaccine coverage for Medicaid-enrolled adults, only 24 out
11 of the 29 states in the study covered all ACIP-recommended
12 vaccines.
13 Section 4106 of the Affordable Care Act provided an
14 incentive to improve coverage of preventive care, including
15 vaccines. States may receive a 1 percentage point increase
16 in the federal matching rate on vaccine-related spending if
17 they cover all recommended vaccines without cost-sharing.
18 In the CDC study, only 12 out of the 44 states responding
19 had implemented this particular option.
20 States vary in how they pay providers for adult
21 vaccinations. States pay providers for the cost of
22 acquiring a vaccine under the appropriate billing code, and

1 states may also make a payment to cover the cost of the
2 vaccine administration or any associated visit. The CDC
3 study reviews state fee-for-service fee schedules in 2018
4 and 2019 to identify the payment amount for relevant
5 vaccine billing codes and found that payment levels varied
6 greatly by state.
7 For example, the 9-valent human papillomavirus, or
8 HPV, vaccine had the highest median payment, around
9 $204.00, and the widest range of payment amounts, varying
10 from around $5 to over $490. Another example of the
11 Haemophilus influenzae type b vaccine had the lowest median
12 payment rate, around $18, and it had a range of payment
13 rates from $5 to $30.
14 States may also make a separate payment to cover the
15 provider's cost of administering the vaccine. The CDC
16 study found that 41 out of the 49 states studied made a
17 fee-for-service payment under one of the four vaccine
18 administration codes, and 37 states made payment under all
19 four codes. Like payment for the vaccine, the amount
20 Medicaid pays for vaccine administration varies by state.
21 For example, the median payment for the first dose of an
22 injected vaccine was a little over $13, and payment ranged

1 from about $3.70 to $28.

2 Several studies have found that adults with public
3 insurance generally have lower rates of vaccinations than
4 privately insured adults. A study found that publicly
5 insured adults had lower vaccination rates for tetanus,
6 diphtheria, and pertussis, or Tdap, hepatitis A, and
7 hepatitis B, than privately insured adults.

8 The lack of mandatory coverage in Medicaid for all
9 ACIP-recommended vaccines can be a barrier to access and
10 may contribute to these lower vaccination rates. A study
11 on Tdap and influenza vaccination during pregnancy showed
12 that Medicaid-covered adults showed lower rates of
13 vaccination among pregnant women compared to those with
14 commercial insurance.

15 Another factor is the relatively low payment rates in
16 Medicaid can also create a barrier to access to physician
17 care, which, in turn, can affect vaccination rates. Recent
18 studies suggest that some states' payment levels may not
19 cover a provider's cost of acquiring or administering adult
20 vaccinations. In the CDC study, researchers found the
21 median Medicaid payment to health care professionals for
22 administration of a single adult vaccination by injection

1 was about $13. This median payment was below the $15 to
2 $23 average cost to providers for administering vaccines to
3 adults estimated by another study.
4 In an earlier 2014 survey of primary care physicians,
5 55 percent of respondents reported that they lost money
6 administering vaccines to adult Medicaid beneficiaries,
7 compared to 25 percent reporting having lost money
8 administering vaccines to adults covered by other payers.
9 The COVID-19 pandemic highlights the importance of
10 vaccinations as part of the nation's public health
11 response. Policymakers have recently proposed and passed
12 legislation to make any potential COVID-19 vaccine more
13 accessible. However, these actions are specific to the
14 COVID-19 vaccine and may not increase access to other
15 vaccinations. Furthermore, while the federal government
16 has already negotiated for the purchase and distribution of
17 millions of doses of the COVID-19 vaccine under Operation
18 Warp Speed, payers will likely have some responsibility for
19 covering the purchase of the COVID-19 vaccine once its
20 initial supply is depleted.
21 Given these uncertainties with the long-term coverage
22 and financing of the COVID-19 vaccine, and the fact that

1 Medicaid-covered adults have exhibited lower rates of
2 vaccinations in general, the Commission may want to
3 consider strategies to improve vaccine coverage and uptake
4 in Medicaid more broadly. These options would primarily
5 affect adults, since Medicaid children are covered through
6 the VFC program.
7 First, Medicaid policy regarding adult vaccination
8 varies across states and even among adults within a given
9 state. Policymakers could make all or certain vaccines a
10 mandatory benefit for all Medicaid enrollees. Furthermore,
11 coverage could be mandated without cost-sharing to help
12 remove this potential barrier, and would equalize vaccine
13 coverage and cost-sharing requirements across all Medicaid-
14 covered adults, regardless of eligibility pathway.
15 For example, the Health and Economic Recovery Omnibus
16 Emergency Solutions, or HEROES Act, passed by the House of
17 Representatives, would make coverage for COVID-19 vaccines
18 mandatory without cost-sharing, in Medicaid, the state
19 Children's Health Insurance Program and the VFC program.
20 Another option could be policymakers could create
21 incentives for states to provide vaccine coverage, such as
22 the federal match increase provided under Section 4106 of

1 the Affordable Care Act. Policymakers could consider
2 increasing the FMAP bonus or providing additional federal
3 vaccine funding through other means to provide greater
4 incentive for states to cover all vaccines without cost-
5 sharing.
6 Another option would be to make vaccines a covered
7 outpatient drug and subject to the requirements of the
8 MDRP. Under the MDRP, states would be required to cover
9 vaccines as part of participating manufacturers' products.
10 In exchange, states would receive the statutory rebates on
11 these vaccines. The CDC researchers noted that some states
12 have mentioned cost was one of the reasons why they did not
13 provide coverage for all vaccines, so accessing the
14 statutory rebates through the MDRP could help address
15 states' financial concerns.
16 Recently, Senator Wyden introduced legislation in the
17 Senate Finance Committee that would include federally
18 funded COVID-19 vaccine in the MDRP and would provide just
19 the inflationary rebate to these products. This proposed
20 legislation has not been subject to debate in the
21 committee.
22 Finally, there is precedent for the federal government

1 to directly purchase and administer the vaccines through
2 programs such as the VFC program or the Section 317
3 Immunization Program. The Section 317 Immunization Program
4 can be used to purchase vaccines for uninsured or
5 underinsured adults to fulfill public health needs such as
6 responding to outbreaks of vaccine-preventable diseases.
7 In a similar manner to the VFC, a program could be
8 established for Medicaid-enrolled adults under which the
9 Secretary of HHS negotiates the purchase and distribution
10 of vaccines to states. And as mentioned previously, the
11 initial purchase and distribution of the COVID vaccine has
12 already been negotiated by the federal government under
13 Operation Warp Speed. While specific guidance has not yet
14 been released on how public and private payers will receive
15 access to these pre-purchased vaccines, it does provide
16 another example of how the federal government can directly
17 purchase and distribute vaccinations.
18 With that I'll turn it back over to the Commission.
19 The staff would appreciate any guidance you have on how to
20 proceed on this topic. Should the Commission want to
21 explore any of these strategies as possible policy options
22 we can do additional analysis to further develop these as

1 potential recommendations. And with that I'll turn it back
2 over to you for questions.
3 CHAIR BELLA: Thank you, Chris.
4 We are very fortunate to have a member of ACIP, the
5 Advisory Committee on Immunization Practices. So I want to
6 ask Peter to kick us off, and I'm going to give you the
7 option for the last word, Peter. So please go ahead, and
8 then I see Fred. And we'll keep an eye out for other hands
9 too. Stacey, thank you.
10 COMMISSIONER SZILAGYI: All right. Thanks, and, Chris
11 and Amy, great job on I think a very important topic, and I
12 have to say that the people in the immunization field have
13 been waiting for the government or some advisory group to
14 start thinking about policy options like this.
15 It's not a conflict of interest, but I did want to
16 mention that I do research in raising immunization rates in
17 children and adults, not so much policies, but at the
18 practice or health system level, and ACIP makes the
19 recommendations for vaccines for people living in America.
20 And I'm one of the voting members of ACIP, and we're
21 working hard now on the COVID vaccine.
22 Just a couple of kind of background thoughts I have

1 and then some comments about some policy options.

2 So vaccine-preventable diseases are expensive, $9
3 billion a year, and it could go up to potentially $15
4 billion a year. And most of that, 80 percent of that, is
5 from unvaccinated individuals, so for existing vaccines.
6 So if we could improve the percentage of individuals who
7 are vaccinated, that would be an enormous benefit.

8 If you look at, let's just say, flu vaccination rates
9 in adults over 65 versus 50 to 65, there's a 20 percent
10 difference in influenza vaccination rates. What's the
11 difference? The adults over 65 are covered by Medicare.
12 Not all of it is due to financing, but a large proportion
13 of that is due to financing. So we have the opportunity to
14 really raise rates.

15 The vaccines that are recommended go through a
16 rigorous evaluation, and the current adult vaccines, such
17 as influenza pneumococcal and Tdap, are cost savings to the
18 medical, not just at the societal level but to the medical
19 system. So not that many things are actually documented to
20 be cost savings, but this one is.

21 And kind of the final background comment -- and then
22 I'll turn to some of the options -- I was actually very

1 involved with creation of the VFC program, and I remember
2 the days very well where childhood vaccine -- the childhood
3 vaccine situation was just like the adult vaccine situation
4 now, and studies started to show that there were cost
5 barriers. The VFC program was complicated. It took a lot
6 of work to implement, but it wasn't the only reason
7 childhood vaccination rates skyrocketed. But it was
8 clearly a major reason, and there is an opportunity to do
9 policy interventions in the adult world.
10 And maybe one other point, there's something different
11 about vaccines than other health care services because if
12 somebody gets a vaccine-preventable disease -- if somebody
13 has diabetes, they won't spread that to other people. If
14 somebody has a vaccine-preventable disease, they can spread
15 it. The COVID epidemic has made that really apparent, and
16 vaccine -- and that doesn't -- those diseases do not follow
17 state lines.
18 So what might we do? I agree with your assessment,
19 Chris, in terms of the barriers. Copays affect uptake.
20 Even if the vaccine is covered on Medicaid, many American
21 adults need to pay a copay, and that is a barrier.
22 Secondly, administration fees also affect vaccination

1 rates a lot because it costs somewhere between $10 and $20
2 for practices to vaccinate an individuals. They don't get
3 administration fees. A practice is going to prioritize it
4 less than other services. If they have to purchase
5 vaccines up front and some offices have to pay $100,000 a
6 year just to purchase vaccines up front, that can be a
7 barrier.

8 So I think all of these are clearly barriers, and let
9 me just give you -- so what are the range of options? If
10 you can go back to Slide 8, Chris, I think that would be
11 really helpful. I like the idea of MACPAC getting into the
12 field of looking at options, looking at what are the
13 options that might have a big effect or a small effect,
14 what are options that are complicated or simple to
15 implement, and sort of other characteristics of the various
16 options. And I do think these are the four potential
17 options we could look at.

18 So mandatory coverage, just as an example, would be a
19 relatively simple option to implement. It wouldn't mean
20 that it doesn't have up-front costs, because it certainly
21 would, but it would be simple to implement. But it would
22 also need to cover appropriately the cost of the vaccines

1 and administration fees with no copayments if we really
2 want optimal immunization rates.
3 Additional funding from the FMAP is much more
4 complicated to implement and I believe would not have
5 anywhere near the effect, and it's evidenced by the fact
6 that many states haven't taken up the opportunity right
7 now. So including the vaccines in MDRP, also definitely an
8 option that is worth looking at. I think it wouldn't have
9 anywhere near the large effect.
10 Doing a VFC-like program could be a moonshot for adult
11 vaccines. It would have an up-front cost. I think if it
12 was--the way it is for children, if it was combined with
13 adequate payments, we could really raise adult vaccination
14 rates to levels that have never been seen before in any
15 country, and I think that could be a moonshot and is
16 definitely worth an option to look at. So I would really
17 advocate MACPAC look into this issue and not necessarily
18 come up with a recommendation for which option but to show
19 different options and then sort of the various
20 characteristics of the option. I think that could be very
21 helpful.
22 And one final point, when we were working on the VFC

1 program, we spent a lot of time getting input from
2 providers and from patients, the public, a lot of time
3 learning how the vaccine program worked before it was
4 implemented, and if a VFC-like program is one of the
5 options to be considered by Congress, then I think it would
6 behoove us to go through that same very careful procedure
7 that it went through for childhood vaccines that has
8 resulted in extraordinarily high childhood vaccine rates.
9 So thanks.
10 CHAIR BELLA: Thank you, Peter.
11 Fred and then Stacey.
12 COMMISSIONER CERISE: Yes. Great comments, Peter. I
13 agree with your point of view on this.
14 Chris, I have a technical question. When you talked
15 about the MDRP in the proposal by Congress to apply the --
16 when they would start that, they would just apply
17 inflationary rates? They wouldn't try to achieve an
18 initial discount? Is that right?
19 MR. PARK: Sure. The way they're setting it up is
20 that the -- normally, there's two components. There's the
21 basic rebate and the inflationary rebate. So states would
22 not get the 23.1 percent rebate that is normally given to

1 brand drugs. It would only give the inflationary rebate,
2 and they would consider the baseline price to be the price
3 that the federal government has negotiated under Operation
4 Warp Speed.
5 Say, for example, they negotiated a rate for around
6 $19 per dose from Pfizer. So that would be the baseline,
7 and if that price over time increased faster than
8 inflation, then Medicaid -- and they're also applying this
9 to Medicare -- would get a rebate to offset that
10 inflationary difference.
11 COMMISSIONER CERISE: I see. So that was for COVID.
12 Presumably for these others, they would negotiate some
13 initial baseline rebate as a starting point?
14 MR. PARK: Certainly -- yeah, depending on how
15 policymakers went in to set this up, you could establish a
16 baseline payment rate based on the start date, when the law
17 goes into effect, or some other start date, or -- and you
18 could also broaden it to include the basic rebate if
19 policymakers so choose.
20 COMMISSIONER CERISE: Gotcha. Okay. Well, I think
21 just to align with Peter on this, we're 60 percent of the
22 way there in the Medicaid program. Why wouldn't we go all

1 the way?

2 We talked about bias before. We have an incredible
3 bias towards doing things late in the delivery system and
4 not the public health investments that we need to make. So
5 just to make a point, there are very few -- there's not a
6 lot of things that we do from a prevention standpoint that
7 actually save money, and we do a lot of things that cost a
8 lot of money. You compare these vaccines, for instance, to
9 use in statins for primary prevention, which we will pay
10 for under the drug program. They just don't compare. I
11 would certainly favor pursuing something here to take the
12 rates up and to take out the disincentives for people not
13 to get immunized.

14 CHAIR BELLA: Thank you, Fred.

15 Stacey and then Tricia.

16 COMMISSIONER LAMPKIN: Thank you.

17 A quick technical question or clarification from Chris
18 and then a couple of comments.

19 So, Chris, you talked about the VFC program and
20 Medicaid children. For children in stand-alone CHIP
21 programs, is it accurate that they can't participate in
22 VFC, but it is a state plan benefit for all of them, and so

1 there's no question that the CHIP -- stand-alone CHIP
2 children are eligible for vaccines?
3 MR. PARK: I'm pretty sure it is a covered benefit,
4 but I would have to look into that. I think for purposes
5 of the VFC, CHIP is considered to be insurance, so they are
6 not originally covered unless they are considered
7 underinsured. So if the CHIP program doesn't cover that
8 particular vaccine, then I think they could access the
9 vaccines through VFC, but I would have to look specifically
10 on CHIP coverage of vaccines and get back to you.
11 COMMISSIONER LAMPKIN: Okay. Thank you.
12 Then I was also going to ask the question about cost
13 effectiveness, which Peter addressed and then Fred too. I
14 think that's a really important foundation to lay for the
15 options and whether it's that all are cost effective or
16 there is some subset of the adult-recommended vaccines that
17 are cost effective, but just sort of what it sounded like
18 from Peter's comments, that would be helpful to understand.
19 But I would agree that there seems to be something to
20 do here, and mandatory coverage with some federal
21 incentives makes a lot of sense to me.
22 CHAIR BELLA: Thank you, Stacey.

1 Tricia and then Kit.

2 COMMISSIONER BROOKS: Yeah. I would definitely ditto

3 what Stacey just said that this is ripe for some kind of

4 action on Medicaid for adults.

5 I actually didn't realize it when I was reviewing some

6 of the materials to see that all of the states have taken

7 up the Vaccine for Children program. It was voluntary, and

8 it took a while for us to get to all 50 states.

9 But there are some issues with measuring immunization

10 rates as a result of that, particularly in Medicaid. So I

11 think it would be helpful as we look at the potential of a

12 federal purchasing program for adults that we also look at

13 the experience and history of the Vaccine for Children

14 program and extract from that best practices and lessons

15 learned, that if we were to go that far with the Medicaid

16 program, how could we improve upon the experience that

17 we've had with it for children?

18 CHAIR BELLA: Thank you, Tricia.

19 Kit?

20 COMMISSIONER GORTON: I agree with what everyone has

21 said.

22 I do think one other thing we need to look at before

1 we go down the path of making a recommendation is supply.
2 Peter probably knows more about this than I do, but one of
3 the things that's happened over the last decade to two
4 decades is the number of manufacturers actually producing
5 vaccine has gotten smaller and smaller. And we have had
6 periods of time where one or another vaccine was not
7 available. I personally have just concluded an eight-month
8 odyssey to try and get a second Shingrix vaccine because it
9 was just so short, in such short supply that the providers
10 were getting a little, hoard, and then they'd save it for
11 the people that they really thought needed it.

12 And that's all appropriate from a provider and patient
13 care perspective, but one of the, hopefully, good things
14 that would come from this would be a substantial increase
15 in our need to produce vaccine. And I think we've gotten
16 some pace to that over the last few months in terms of
17 finding out how many duck eggs you need to produce enough
18 COVID-19 vaccines just for the trials, and I think that we
19 shouldn't be lulled by the fact that all the big drug
20 manufacturers have lined up for COVID. There's a whole lot
21 of reasons why they're doing that.

22 At the end of the day, without a pandemic and a huge

1 public health emergency, our ability to supply this level
2 of vaccine, I think, is quite limited, and I do think that
3 we should try and get some sense of that in terms of
4 perhaps even talking to the people who make the stuff to
5 say to them, you know, "If we were to do this and bring in
6 the other 40 percent of the Medicaid population -- could
7 you supply the vaccine? What would it take? What kind of
8 pricing would you need? I think we need to get some sense
9 of whether or not the manufacturers can actually deliver,
10 and then as Peter said, the whole setting up a program to
11 get it out to people is enormously complex. So I just
12 think that's another factor we need to take into account,
13 the operations of it.
14 CHAIR BELLA: Darin. And then, Sheldon, I couldn't
15 tell if you were just waiting or you actually want to make
16 a comment.
17 COMMISSIONER GORDON: I agree with many of the things
18 that were said.
19 Something that Kit just brought up raised a question
20 for me, and maybe, Peter, you can shed some light on this -
21 - or Chris.
22 I like leveraging some of the things, the systems that

1 we already have out there, so VFC makes sense. But one
2 thing that I heard every time around the VFC program was
3 when a provider receives their supply of vaccine, that they
4 can't use that supply for their commercially insured
5 children. And it created issues because it obviously --
6 you know, there may be a need right there for the
7 commercially insured. You have excess supply, but you
8 can't use it. And it creates some really odd dynamics.
9 And I'm just curious if that is something that's more
10 common out there, and the only reason I bring that up is if
11 we want to leverage the VFC program or VFC-like program.
12 It just made me think of Kit's points. We've got to figure
13 out how to solve for that problem before we go down that
14 path.
15 CHAIR BELLA: Thank you, Darin.
16 Sheldon, I have to admit I still couldn't tell if you
17 want to make a comment, but now is your chance to do it.
18 COMMISSIONER RETCHIN: I will.
19 This is a question for Peter and Chris, perhaps, but I
20 guess the question on terms of vaccination rates in both
21 adults and the children, but particularly adults, does it
22 appear at all that vaccination rates may be more associated

1 with where you live in the sense that we have lower
2 provider participation rates in Medicaid, and yet vaccines
3 are still being allocated that way? We don't have the
4 public health infrastructure to take up the gaps. Is that
5 of any concern? Maybe for COVID but all vaccines. Peter?
6 Chris?
7 COMMISSIONER SZILAGYI: Yeah. Do you want me to
8 answer some of these or try to address some of these
9 questions?
10 COMMISSIONER RETCHIN: Yeah.
11 COMMISSIONER SZILAGYI: The last one, there are state
12 variations in vaccines. The rural areas have lower
13 vaccination rates than urban areas. It's hard to tease
14 out. It's always hard to tease out in this field what is
15 due to costs, and is it cost to the providers or cost to
16 the patients? And what is due to other access barriers?
17 So there is some geographic variability, but I think
18 study after study has shown that costs in general are a
19 barrier for all populations.
20 Interestingly, thinking about disparities, there used
21 to be very large racial and ethnic disparities in childhood
22 vaccinations, and they're gone, so eliminating cost

1 barriers. Actually, there's a little bit of disparities in
2 that some vaccines, the rates are higher for Hispanic
3 populations than white populations. So where have you
4 heard that for other metrics in health?

5 There are very large racial and ethnic disparities in
6 the adult vaccinations, especially for adults under 65. I
7 think also a little bit over 65. So that's the disparity
8 question.

9 The VFC question that Darin -- you know, the issues
10 that Darin and Tricia and Kit brought up are really, really
11 good, and this is why I thought it would be helpful. I'm
12 not even sure we want to have a recommendation as opposed
13 to a clear evaluation of a number of different policy
14 options.

15 So when I talked about simplicity or complexity, a
16 mandatory coverage is simple. It may not be the best
17 option. I don't know, but it's simple. VFC is more
18 complex, and one of the ways it's more complex is, Darin,
19 exactly what we were talking about. Every pediatric
20 practice that serves Medicaid has two refrigerators, one
21 for VFC and one for commercial. It's complex. It works
22 now. It's hard sometimes to convert practices that don't

1 serve that many Medicaid beneficiaries. So there's some
2 complexities, but obviously, the system has overcome it
3 over time because the vaccination rates are high. And most
4 are still giving vaccines. But that's why I think
5 simplicity and complexity should be one of those dimensions
6 if we evaluate this, as would state flexibility versus the
7 federal guideline.
8 The supply question is also a really great question,
9 Kit. I think -- in fact, I know vaccine manufacturers,
10 they supply and they're manufacturing by the expected
11 demand over the next years, and it's really hard for them
12 for flu vaccine, for example. They are all international
13 corporations right now, and so just what happens in America
14 isn't the only thing that influences them. So there's an
15 HPV vaccine shortage across the world but not in America
16 right now, but across the world.
17 So the other issue to think about is there's going to
18 be newer vaccines coming down the pike, and they will be
19 more expensive than influenza vaccine, which is very, very
20 cheap. So supply is a consideration. I'm not so sure how
21 that will weigh our thinking in terms of which policy
22 lever.

1 And then -- oh, there was another point that I think
2 Tricia brought up that I was going point out. Oh. No,
3 this was Stacey, the cost effectiveness.
4 So ACIP has this very, very strict evidence-to-policy
5 framework that we need to cover. That includes: Is it
6 effective? Is it safe? What are the practical issues?
7 What does the target audience want? Is it cost effective
8 or cost savings? And there are a couple of other
9 components. For every single vaccine that's recommended,
10 we have to go through that process, and if it gets hung up
11 in one of those processes, then a vaccine frequently is not
12 recommended.
13 That doesn't mean that all vaccines are cost savings,
14 Stacey. So most are cost effective but not cost saving.
15 So Shingrix, for example, is not going to -- may not be a
16 cost-saving vaccine. It's a cost-effective vaccine. So
17 you get the difference.
18 And some vaccines are not recommended universally.
19 They're recommended for only specific patient populations,
20 and there's going to be more of those coming down the road.
21 But I really like the idea of weighing into this
22 because of the incredible expertise of the MACPAC staff and

1 the Commissioners.

2 CHAIR BELLA: Thanks, Peter.

3 Anne, did you want to clarify anything?

4 EXECUTIVE DIRECTOR SCHWARTZ: Yeah, and speaking on
5 behalf of our CHIP expert, Joanne, a clarification on
6 vaccine coverage. The kids covered by separate CHIP are
7 not eligible for Vaccines for Children, but vaccines are
8 covered under the well child care component of separate
9 CHIP.

10 CHAIR BELLA: Thank you. Martha?

11 COMMISSIONER CARTER: Hi, a quick question, and just
12 for future research. I'd like to understand why vaccines
13 are not included in the MDRP. I don't think most vaccines
14 are included in 340B either. But what was the underlying
15 decision point there? And what would be the challenges to
16 changing that policy if we -- as you're looking into that,
17 I'd like to know that background.

18 MR. PARK: Sure. I don't know that off the top of my
19 head, but we can research to see if we can find in the
20 legislative history exactly when that was made or why they
21 made that decision not to include it in the program.

22 CHAIR BELLA: Tom?

1 COMMISSIONER BARKER: I just want to respond to that
2 last question. Martha, I think -- I'm not sure if there's
3 a policy reason, but I think the legal reason is just the
4 way covered outpatient drug is defined in Section 1927.
5 It's a drug approved under a certain section of the Food,
6 Drug, and Cosmetics Act, but vaccines are approved under
7 the Public Health Service Act. And I'm pretty certain that
8 that is the -- that's the legal reason. I'm not sure if
9 there was a policy reason for not including vaccines or if
10 Congress just didn't think of it when the MDRP was drafted
11 back in the early '90s.
12 COMMISSIONER CARTER: It would be helpful for vaccines
13 to be included in 340B, too, so it would be --
14 COMMISSIONER BARKER: Yeah, and I think it's the same
15 reasoning because 340B just gloms off of the MDRP
16 definition of covered outpatient drug.
17 COMMISSIONER CARTER: Yeah.
18 COMMISSIONER BARKER: But it's a good point.
19 CHAIR BELLA: All right. Any other Commissioners?
20 [No response.]
21 CHAIR BELLA: I want to say a couple things and then,
22 Peter, give you the last comment.

1 Chris, I think one of the things you asked is to gauge
2 our interest. I think this shows you that the interest is
3 very high to continue doing work in this area. And I want
4 to align with Peter's suggestion of -- I'll call it a
5 "framework." I know it's not. It may be a matrix -- where
6 we're looking at these different options and if there are
7 any others on, you know, elements such as cost and cost-
8 effectiveness and ease of administration and ease of
9 flexibility and impact and all of those things. I don't
10 think any of us know what the recommendation would be quite
11 yet, but we could certainly tee this up to have something
12 perhaps for June if we want to go down that path.
13 Otherwise, we could certainly contribute to the field even
14 by going through some of the different options and kind of
15 the dynamics of each of those options I think would lend
16 itself to the policy debate in a helpful way.
17 So, Peter, thanks for suggesting that, and we'll turn
18 to you to see if you have any closing comments based on
19 what your colleagues have said.
20 COMMISSIONER SZILAGYI: No. I think you've summarized
21 it really well, and I think your thoughts would take
22 advantage of the strengths of MACPAC and make an important

1 contribution to a public health field and public health in
2 general, so thanks. I really appreciate everybody's
3 comments.
4 CHAIR BELLA: Well, those actually are your thoughts,
5 so thank you. And, Chris, do you have any questions or any
6 clarifications from us?
7 MR. PARK: No. I think we've got a clear direction on
8 how to proceed.
9 CHAIR BELLA: Okay, wonderful. Thank you very much.
10 We are going to move into our last session, which is
11 Oversight and Accountability for Pediatric Oral Health
12 Services in Managed Care, and Joanne is rejoining us.
13 Where are the slides? And then just to reiterate what
14 Chuck said in the beginning of this afternoon's session,
15 we'll take public comment on all of these things that we've
16 discussed this afternoon following this session.
17 Welcome back, Joanne. It's all yours.
18 **### OVERSIGHT OF AND ACCOUNTABILITY FOR PEDIATRIC ORAL**
19 **HEALTH SERVICES IN MEDICAID MANAGED CARE**
20 * MS. JEE: Oops. I advanced my slide by accident.
21 Hang on.
22 Okay. All right. So today we are going to talk about

1 oversight and accountability for pediatric oral health
2 services in Medicaid managed care. This work came about
3 because of previous studies and reporting that showed that
4 children are not getting sometimes the care and services to
5 which they are entitled. Children in managed care are not
6 getting those services. And we thought that we would take
7 a look at oversight and monitoring, and we thought we would
8 start with pediatric dental care. And there are several
9 reasons for this.
10 First is that all children in Medicaid and CHIP have
11 coverage for dental services.
12 Second is that there's a high proportion of states
13 using managed care for dental services.
14 Third, dental caries is a very common chronic
15 condition for children, and it is preventable.
16 And then, lastly, the data show that there is a lot of
17 room for improvement in children's oral health status.
18 Okay. So the presentation today will cover some
19 contextual information and data. I'll briefly go over our
20 approach for this work. Then I'll share some findings with
21 you on the monitoring and oversight activities that
22 interviewees shared with us. We'll talk a little bit about

1 some potential other policy levers that states are using to
2 help drive improvements in children's oral health status.
3 We'll touch on some challenges in monitoring and oversight.
4 And then I'll end with some questions for you all,
5 Commissioners, about the implications of this work.
6 Okay. So Slide 3 provides you some data and some
7 context for the discussion this afternoon. Overall, you'll
8 see that the percentage of children having at least one
9 preventive service increased from 23 percent in 2000 to 48
10 percent in 2018. And while the increase is meaningful, it
11 also means that there's about half of children who are not
12 receiving preventive dental services.
13 According to the American Academy of Pediatric
14 Dentistry, children should have an oral examination once
15 every six months depending on their risk status, and every
16 one of those visits represents an opportunity to provide
17 preventive services.
18 The percentage of children with elevated risk for
19 dental caries who receive a dental sealant on a permanent
20 molar in 2015 was 23 percent and 24 percent in 2018, so not
21 a lot of movement on that measure. And dental sealants,
22 just as a reminder, are applied to molars and are very

1 effective at arresting or preventing dental caries, and
2 they are generally recommended.
3 So the last bullet on this slide is just about managed
4 care, and about 68 percent of children were enrolled in
5 comprehensive managed care, and more than half of states
6 that enroll children into managed care are carving in
7 pediatric dental services, and then the rest would be
8 carving them out, either to another plan or perhaps to fee-
9 for-service.
10 Okay. So to help states take proactive steps to
11 address oral health in their Medicaid programs, CMS
12 launched the Oral Health Initiative in 2010. As a part of
13 the OHI, CMS set national and state-level goals to increase
14 the percentage of children receiving preventive dental
15 services by 10 percentage points. And as I noted, while
16 there has been substantial improvement on this measure, the
17 national goal and in most states the goal hasn't actually
18 been met.
19 Through the OHI, CMS has worked with states to develop
20 oral health action plans. CMS has also provided technical
21 assistance and several state-to-state learning
22 opportunities covering a range of topics such as reducing

1 childhood caries and quality improvement and value-based
2 purchasing -- or payment.
3 In June, CMS announced that the OHI would continue
4 from 2020 through 2022, and that there would be a new
5 technical support opportunity for states who opted to
6 participate on advancing prevention and reducing childhood
7 caries.
8 And, finally, just this last bullet here is a reminder
9 that the federal Medicaid managed care rules, which provide
10 the minimum standards as well as some requirements related
11 to monitoring and oversight, do apply to MCOs that are
12 providing dental services as well as dental plans.
13 So to understand how states are holding MCOs and
14 dental contractors accountable, we worked with the National
15 Academy for State Health Policy, or NASHP, to review state
16 policy documents and conduct interviews with state
17 officials, representatives from MCOs and dental
18 contractors, and some consumer advocates and stakeholders
19 as well. This work focused on 11 states. That varied in
20 terms of whether they carved in oral health services to
21 MCOs or carved them out, and whether the MCOs use
22 subcontractors to deliver their dental services.

1 Overall, states, MCOs, and dental contractors appear
2 to be using for the most part a similar set of monitoring
3 and oversight tools, although there was variation in the
4 number of activities that states and plans engaged in as
5 well as their frequency. And the types of monitoring and
6 oversight activities and the frequencies generally are
7 spelled out in contracts. And based on the interviews that
8 NASHP conducted, I think it's fair to say that the states,
9 the MCOs, and the contractors are really engaged in
10 numerous activities for monitoring. MCOs and contractors
11 submit, you know, numerous reports across several different
12 topics, and states receive those reports and are reviewing
13 them.
14 Key activities for monitoring networks and providers
15 that interviewees identified to us include geo-access
16 analyses that the plans report and that states validate or
17 conduct on their own sometimes; provider network reports
18 with information such as the number of providers
19 participating by type; as well as providers disenrolling
20 and the reasons for their disenrollment.
21 States share lists of Medicaid-enrolled providers with
22 plans and contractors to identify which Medicaid providers

1 are not in their networks, and that presents potential
2 recruitment opportunities for the plans.
3 Plans and states also monitor providers to assess
4 whether providers are taking Medicaid patients as well as
5 appointment availability, how long it takes to get
6 appointments and that kind of thing.
7 All right. To monitor whether children are receiving
8 the services they need, including preventive and follow-up
9 care, states review reports that the plans submit. These
10 can be sometimes the HEDIS reports that plans are filing or
11 the CMS 416 form, and just as a reminder, the 416 form is
12 the EPSDT participation and utilization report that they
13 are required to submit to CMS.
14 Plans and contractors also report on their outreach
15 and beneficiary education efforts, such as the number and
16 types of events that are held in the community as well as
17 the number of participants who came to those events.
18 Contracts also sometimes indicate or specify specific
19 performance targets that MCOs or contractors must meet.
20 For example, the Massachusetts contract specifies a minimum
21 percentage increase in children having preventive services
22 that the contractor must achieve, and if those targets are

1 not met, contractors may be subject to financial penalties.
2 Plans are also monitoring providers to see whether
3 patients are receiving dental services. As a part of this,
4 some plans produce provider scorecards that compare their
5 performance against the performance of other network
6 providers. And I guess the idea there is a little
7 competition is a good thing.
8 Plans are assessing which beneficiaries or members are
9 having visits also by conducting claims analyses, and they
10 can look and see who has had a visit in the last six months
11 or 12 months, and this helps identify which individuals
12 require some follow-up.
13 They also identify children with open referrals for
14 follow-up care, but for whom there is no related claim, as
15 well as children who had scheduled appointments but did not
16 keep them, which are referred to as "broken appointments."
17 And, again, this just helps to identify which children and
18 families require some follow-up.
19 Monitoring grievances and appeals is another important
20 tool for identifying any trends that might need to be
21 addressed. However, interviewees told us that dental
22 grievances were infrequent, and it seems that the reported

1 data on this occur at a pretty high level. So it's not
2 clear just how many details are in those reports as to the
3 precise nature of those claims -- or those complaints,
4 excuse me.
5 Other monitoring tools that interviewees mentioned to
6 us were performance improvement projects, which I like to
7 refer to as PIPs, and these are required through the
8 Medicaid managed care rule, and they can relate to oral
9 health services, but they are not required to.
10 States and MCOs and dental contractors all stressed
11 the importance of their ongoing and frequent engagement
12 with each other, and they thought that that was, you know,
13 maybe the most important part of their ability to work
14 together towards their goals on children's dental care.
15 Stakeholder feedback was also viewed as important to
16 the monitoring process. For example, stakeholders are
17 involved in different kinds of advisory groups. They are
18 important in raising concerns to states and plans as well
19 as helping beneficiaries file grievances or appeals if
20 necessary.
21 And then, lastly, with respect to enforcement
22 activities, states and MCOs pursue informal actions before

1 they pursue anything more formal. And so by this I mean
2 that if an issue arises, states will call their
3 counterparts at the plans and engage in a conversation
4 about the issue, try to identify the cause or the source of
5 the problem, as well as potential solutions. If issues
6 cannot be resolved in this way, then they might bump it up
7 to a more formal level of action, and this would include,
8 for example, corrective action plans or potentially
9 financial sanctions.
10 So in addition to monitoring and oversight, states and
11 plans are using other levers to improve children's oral
12 health and increase the use of services. These include,
13 for example, incentives to encourage providers to
14 participate in Medicaid networks. One state told us that
15 it allows providers to bill for extra time spent treating
16 children with special health care needs to expand access to
17 providers for this population.
18 Another state told us that they were exploring options
19 for tuition reimbursement. That seemed like it was in
20 pretty early stages, and they didn't really have very many
21 details to offer on that.
22 Other states told us about administrative incentives

1 that they use, such as reducing prior authorization
2 requirements, which they said providers often say are
3 onerous.
4 Pay-for-performance models also came up. Two examples
5 are California, which uses incentive payments to increase
6 the use of preventive dental services, and Texas, which
7 uses a capitation withhold of 1.5 percent.
8 And, lastly, some states use beneficiary incentives to
9 encourage their use of preventive dental care. These
10 include providing them with gift cards or reward programs
11 for children who are coming to preventive services.
12 We asked states about challenges that they experience
13 in monitoring and oversight of MCOs and dental contractors,
14 and what we heard was that the challenge was not so much in
15 monitoring but really in the recruitment of providers and
16 encouraging families to use dental services and get into
17 the dentist for visits. They did identify a couple
18 challenges, though. These include constrained state
19 resources. They noted that it takes quite a lot of time to
20 review the reports that MCOs and dental contractors are
21 submitting, and that, you know, their staff are really
22 pulled in lots of different directions, and so reviewing

1 that can be a little challenging sometimes.

2 Other challenges they identified included lack of data
3 to identify gaps for children of different racial and
4 ethnic groups. One state specifically said that they
5 didn't have a good way of measuring cultural competence, so
6 that was something that they were working on. Other
7 challenges were lack of providers as well as lack of
8 beneficiary awareness of their dental benefit or how to
9 access those benefits.

10 Okay. So where does this leave us? It does appear
11 that states and plans are engaged in, you know, numerous
12 activities related to monitoring of plans and contractors
13 for dental care. However, given the performance on dental
14 measures this work raises questions about the effectiveness
15 of those activities.

16 The last slide here poses some questions for your
17 consideration, and we would appreciate some feedback from
18 you on these. They are whether existing oversight and
19 accountability activities are sufficient for ensuring
20 further improvements for children's oral health care. If
21 they are not, what changes would be needed to improve their
22 effectiveness. And what other structures or levers might

1 be more effective.

2 So I'll turn it back to you all.

3 CHAIR BELLA: Thank you, Joanne. I'm going to start
4 with our expert in dental services and preventive care and
5 all those things. I'm going to turn to Kathy and then
6 Darin and if the rest of you will raise your hand if you
7 would like to comment. Okay, thank you. Kathy.

8 COMMISSIONER WENO: Well, first of all I want to say
9 thanks to Joanne and everyone who did a great job of kind
10 of summarizing some of the issues that are involved with
11 oversight of MCOs by Medicaid programs, and I'm sure a lot
12 of people can relate to this, even issues that don't have
13 anything to do with oral health. This is an issue, I'm
14 sure, for many people.

15 I'm going to specifically talk about the oral health
16 component, obviously. I do think states have a
17 particularly difficult time with monitoring MCOs and their
18 subcontractors on oral health issues because of what Joanne
19 said. Primarily what I see in most states is a lack of
20 staff and other types of resources, the time that it would
21 take to actually analyze the reports and the data that the
22 MCOs are proving to state Medicaid programs.

1 When I worked in Kansas there was actually no one who
2 only worked on dental alone. It was spread among three
3 people and it was not even a full-time job. So that's a
4 difficult way for states to see much improvement in oral
5 health national indicators.
6 The other thing is they have to somewhat rely on the
7 MCO and their subcontractors, or their subcontractors, for
8 clinical expertise about oral health treatment, and there
9 isn't a lot of program management or ideas that are coming
10 from the states on how to improve their indicators. So
11 they are relying a lot on CMS for direction on what they
12 should be working on, which is great why they have decided
13 to reboot the Oral Health Initiative.
14 I was in Kansas during the time that the first go-
15 around on the Oral Health Initiative went through. They
16 did produce an awful lot of really good information and
17 they also provided some great expertise on the national
18 level about oral health issues. Unfortunately again, on
19 the state level, there wasn't a lot of incentive to
20 participate so many states didn't do a lot with that
21 information. So it was a good thing and I'm glad to see it
22 moving forward, and I have hope that things will improve,

1 although I don't think states have any more time or
2 resources now to devote to oral health, particularly during
3 this difficult time.
4 And lastly, I just want to also be sure to mention
5 that as far as health equity and disparities, oral health
6 remains one of the areas that is a real example of
7 disparities in both disease rates and access to care. In
8 order to really make any progress on these national
9 indicators that's something that has to be really
10 emphasized. Fortunately in oral health we do know what
11 does move the dial, what improves oral health. We have,
12 you know, lots of evidence to support things like fluoride
13 outreach and education, community health workers, school-
14 based program and community-based programs. All these
15 things do improve oral health in the areas in which they
16 are implemented. But again, we need for some of those
17 things to be taken up by states and also resources be
18 allocated to oral health.
19 So as far as MACPAC's work in the future I want to
20 make sure that oral health is included in discussion
21 whenever we talk about especially health equity, because
22 oral health has always been an issue here and it doesn't

1 appear to be improving a great deal.

2 So thanks again, Joanne.

3 CHAIR BELLA: Thank you, Kathy. All right, I have
4 Darin then Tricia, Martha, Keisha, and Peter.

5 COMMISSIONER GORTON: So first I agree with Kathy on
6 some of the points that she made, particularly about states
7 not necessarily having dedicated resources to it. I was
8 fortunate to see where we did.

9 I'd also say that I really appreciate all of the
10 analysis that was done and the gathering from the different
11 states, and I'm sure you would be the first one that would
12 tell me that, yeah, even within those different clusterings
13 that there was such variability from each of those states.

14 I find that a lot of the lessons that have been
15 learned on the acute care side, in management of MCOs, has
16 not necessarily carried over to the dental side. And you
17 see that in pockets. The reason I bring that up is some of
18 the things -- we've tried a variety of different things
19 over the years with dental, in the early years some things
20 very unsuccessfully, but in the later years I think we
21 learned from a lot of those mistakes.

22 And one of the things that I think we saw a lot of

1 progress, in improving on where we'd been, which I think is
2 really the measure that's important in trying to continue
3 to improve your state on past performance, was implementing
4 some value-based purchasing arrangements in the dental
5 space. And we heard one of the public commenters yesterday
6 ever mention that, you know, there's not a lot of that
7 being done, although there are some exceptions. They
8 referred to one of the DBMs in particular that's made some
9 progress there.

10 But we saw a lot of movement in a variety of dental
11 quality measure when we deployed a value-based purchasing
12 arrangement there, the DBM, the dental benefits manager,
13 working with providers in building out dental [inaudible]
14 which I think was important. And it just really shifted
15 the entire thinking about how the DBM and the state and
16 providers partner with one another.

17 And so, you know, I think as we see that grow, I think
18 we'll continue to see some improvement, but, you know,
19 Joanne, I don't know if you have a sense of the prevalence
20 of value-based purchasing in this space or not. But I do
21 think it's something that holds a lot of promise for us to
22 start making some improvements.

1 MS. JEE: Yeah, so I don't think I can say definitely,
2 you know, what the prevalence is. I can say that we did
3 hear from states. You know, some states have them, as I
4 said, have already implemented VBP. Other states said that
5 they were thinking about what kind of VBP model might work
6 in their states. And I do know that CMS had an IAP
7 program, looking at VBP for oral health. That has since
8 ended, and there were three states who participated in
9 that. So it's definitely on the radar.
10 COMMISSIONER GORTON: Yeah. Well, I appreciate that.
11 And I do think that when we look at states, the pricing
12 variability on how states pay for dental is pretty
13 dramatic. And, you know, I've been on both ends of those
14 spectrums and I think we saw very different participation
15 and engagement by our providers when we tried to make some
16 improvements there. So I think that's another factor when
17 we look at states' progress, maybe even more so than some
18 of the other areas of the Medicaid program.
19 CHAIR BELLA: Great. Thank you. Tricia, then Martha.
20 COMMISSIONER BROOKS: Thank you, Joanne. When I
21 listened to the presentation it's like, wow, oh my God.
22 All this stuff is going on. But the problem is there's

1 really no transparency around it, for stakeholders to
2 access these data and understand what states are doing.
3 You know, there's just not a lot out there.
4 If, indeed, the states are requiring the plans to
5 report their HEDIS and EPSDT measures, then one quick and
6 fairly simple way to increase transparency would be for
7 states to be posting that data. And by posting that data
8 where you're comparing plan to plan, which plans don't
9 always like, it is an incentive for them to compare
10 themselves to their competitors and potentially make
11 improvements there.
12 So I think a lot of work needs to be done in this
13 space. I also think that many of the issues that are
14 associated with oversight and accountability in oral health
15 also applies to managed care at large, for all pediatric
16 services. And I would hope at some point that the
17 Commission would also do this kind of inquiry into what's
18 going on for oversight and accountability for pediatric
19 medical services.
20 CHAIR BELLA: Thank you, Tricia. Martha, and then
21 Kisha, and then Peter.
22 COMMISSIONER CARTER: I think this is an interesting

1 perspective that I haven't thought about much. But what I
2 have thought about is I think that we're almost asking the
3 MCOs to do an impossible task in increasing dental usage
4 rates, because, well, a few things we know -- and let me
5 back up. I've got some personal experience. I've run
6 dental programs, stationary dental clinics and mobile
7 dental clinics that went out to schools and to addiction
8 services.

9 One of the big problems is that children are more
10 likely to get dental care if their parents get dental care.
11 And so we're looking at this in a world that is really
12 flawed, and I don't know how much we can ask the MCOs to
13 do. There are lots of things that people try, and one
14 thing that is effective, in addition to some of the things
15 that Kathy pointed out, would be, again, this is a drum
16 I've been beating today is fully integrating dental care
17 into medical care so you've got one whole person who
18 happens to have a mouth, and you put it all together and
19 provide services to that whole person. There seems to be a
20 little better uptake there.

21 But just in my own experience I know that even
22 pregnant women who were eligible for dental services didn't

1 access them.

2 I'm not proposing a solution. I'm just sort of
3 expanding the scope of the problem perhaps.

4 CHAIR BELLA: Thank you, Martha. Kisha and then
5 Peter.

6 COMMISSIONER DAVIS: Thanks, Joanne, and thanks,
7 Martha. You brought up a really good point. I know from
8 my health center days and my private practice days, one of
9 the things that, you know, working in a health center that
10 also had dental care, as a primary care doctor you look in
11 their mouth, you see a concern, and you send them around
12 the corner and they get dental services taken care of.
13 Then, in private practice, I look in a mouth and I see a
14 concern, and having that access in the community for a kid
15 or an adult to be able to get dental care when they have
16 Medicaid is really lacking.

17 And so for those patients that aren't connected with a
18 community health center, trying to access those services in
19 the community are really hard. And when you're in primary
20 care, trying to look at the whole person, including their
21 mouth, and making sure that there is some connection has
22 really been a challenge.

1 And I'm also curious about the levers that states and
2 counties have in terms of encouraging dental care. I just
3 enrolled my new kindergartener in school and it was a
4 requirement that they've had a dental exam and the dentist
5 has to sign off that they can go. I don't know how common
6 that is in other areas, but just what those different
7 levers are that states and communities have in terms of
8 encouraging it.
9 And then it's been mentioned before but also just,
10 again, bringing awareness to the issues around health
11 equity and dental care. And that's, you know, an area
12 where we really see great disparities. You can use tools
13 such as Health Landscape and other tools that do community
14 assessments and look at their areas in the country where 25
15 percent of the population doesn't have any teeth, and how
16 that goes into being able to eat healthy nutrition, you
17 know, the connections between dental care and heart disease
18 and all of those factors that just kind of snowball, and
19 how we start that out in children at a young age. So how
20 will we get there?
21 CHAIR BELLA: Thank you, Kisha. Peter?
22 COMMISSIONER SZILAGYI: I agree with pretty much all

1 of the comments that are made. Joanne, can you go back to
2 Slide 11, which is your questions for us?
3 MS. JEE: Sure.
4 COMMISSIONER SZILAGYI: I'm not an expert in oral care
5 but as a pediatrician -- just while we're waiting for it to
6 go back -- this is such a frustrating issue for me, because
7 dental caries is preventable, completely, and it's so
8 prevalent. And I'm just wondering whether we're almost
9 asking -- the bullets are asking the wrong questions. I
10 mean, are existing oversight and accountability sufficient
11 for ensuring further improvements? I would say no, but I'm
12 not sure whether the problems lies in oversight and
13 accountability at all, as opposed to developing newer ways
14 to improve oral health, and I'll go with one in a second.
15 What changes are needed to improve their
16 effectiveness? Again, I'm not so sure it has to do with
17 oversight and accountability, as opposed to other things.
18 I often think about Don Berwick's statement, when people
19 were asking him, "What do we do about the Triple Aim?" and
20 he said, not totally facetiously, "Do everything." So
21 instead of just do one strategy, do multiple strategies and
22 really hammer away until you actually get better outcomes.

1 So this is an example -- dental sealants. Dental
2 sealants have been shown to be incredibly effective. They
3 actually don't have to be given in a dentist's office, and
4 I'm a firm believer that every child should be getting oral
5 health care in a dental office. But what we do know is
6 that a lot of children go to pediatric practices for well
7 child visits at these ages and don't make it to the dental
8 office.
9 And there has been study after study, for maybe 15
10 years, that have shown that dental sealants can be given in
11 pediatric offices, it doesn't take an oral health
12 specialist to do it, and it can markedly reduce oral health
13 care. So somehow it seems to me that we have to figure out
14 policy levers where we both support and help the system so
15 that oral health experts, dentists or dental hygienists,
16 see kids, but we can also reduce caries markedly, to
17 address the main question which is implications for
18 improving children's oral health, by levers in other ways.
19 And let me give you a specific example about dental
20 sealants. So I am part of a primary care pediatric
21 practice, 70 percent Medicaid. For the major Medicaid
22 managed care organization -- this is in Los Angeles -- we

1 earn $10 per member per month per child. That's $120 per
2 year per child, no matter how many visits, no matter what
3 we do. That's what we earn. We would love to give oral
4 health. We would love to give dental sealants, but the
5 people who run my practice, you know, we can't afford them
6 because we are losing money as it is, for $120 a year from
7 the managed care plan. Fifty percent of our patient
8 population, or 60 percent.
9 So, you know, there are solutions. Some of it does
10 come to, I think, policies that reflect payment in both the
11 dentist world and in the pediatric health care world.
12 CHAIR BELLA: Chuck, and then Kathy.
13 VICE CHAIR MILLIGAN: Thank you, Joanne, and thank
14 you, Commissioners. I've learned a lot from listening.
15 When I've led a Medicaid health plan this has been a
16 big challenge, and I want to maybe pick up on where Peter
17 left off. I think improving children's oral health, you
18 know, what are the access barriers and what are the
19 challenges? And I think there are some different things we
20 should tease out. For example -- and Peter, to your last
21 comment, I think there's some evidence over the last 15
22 years that raising fee schedules doesn't produce a

1 commensurate increase in access. In other words -- and a
2 lot of states have tackled this, you know, raising dental
3 rates by 50 percent might have a 5 to 10 percent increase
4 in access. And so I think, Joanne, one of the things is to
5 try to understand better kind of the elasticity around
6 that.

7 The second thing I want to talk about in terms of
8 access is for families whose children are on Medicaid, and
9 going back to a comment that was made during yesterday's
10 meeting, to take time off from work often means losing
11 hourly wages, it means paying for transportation -- it
12 means a lot, you know, babysitters. It means a lot of
13 other kind of uncompensated costs. And I think in the
14 dental area, more so than in primary care, there aren't
15 after-hours opportunities. There aren't weekend
16 opportunities.

17 And so I think part of the access challenge is simply
18 how to get kids in where some of the dental practices may
19 not have expanded their availability to accommodate family
20 situations. And I'd love to understand that piece better.

21 And the other part that I've been involved in, on and
22 off in different places, is how we pay for education. How

1 we pay for medical education or training, there is a heavy
2 emphasis in sort of the GME programs and all of that in
3 increasing physician capacity in primary care. There isn't
4 kind of a commensurate approach to how we tackle building
5 out capacity with dentists, hygienists, assistants, and so
6 on. And so I think there is a supply component to this
7 that is under -- to me, it is a root cause of a lot of it.
8 There are a lot of dentists that don't take Medicaid.
9 I think this is an area where the FQHCs and community
10 health centers disproportionately deliver a lot of the care
11 inside of a PPS rate.
12 But I think how we think about Medicaid financing of
13 professional education, there's a dental component that I
14 think is worth just kind of capturing as an inventory issue
15 because I think it's pretty minimal.
16 Thank you.
17 CHAIR BELLA: Thank you, Chuck.
18 Kathy?
19 COMMISSIONER WENO: Yeah. I just wanted to follow up
20 on Peter's comments. I think he was talking about fluoride
21 varnish rather than sealants because sealants do --
22 COMMISSIONER SZILAGYI: Yeah. I meant varnish.

1 COMMISSIONER WENO: And I agree that as far as Chuck's
2 comments about trying to get -- you know, having to take
3 time off and that sort of thing, school-based clinics have
4 been shown to really increase access to care for kids as
5 well as school-based services. You can take a hygienist
6 out to a school and place sealants on kids there, and that
7 will -- especially targeting particular schools, there's
8 always a very effective way to increase the number of
9 sealants in a particular community. So those are just a
10 couple of corrections I wanted to throw out there.
11 CHAIR BELLA: Darin and then Bill.
12 COMMISSIONER GORDON: Hey, Kathy, I agree with you on
13 the school sealant thing. Just one caveat there, I think
14 when we did that, we had to offer those services to all
15 students. We couldn't just offer it just to Medicaid
16 students. So to your point, targeted, and we did look at
17 different factors that would increase the odds of
18 disproportionately impacting the Medicaid population, which
19 was our ultimate goal.
20 CHAIR BELLA: Thanks, Darin.
21 Bill?
22 COMMISSIONER SCANLON: To sort of follow up a bit on

1 what Chuck was talking about in terms of the workforce, I
2 mean, we do have a movement that has gotten some momentum
3 across the country in terms of dental therapists, to be
4 able to expand the supply of practitioners that can do a
5 lot of the services, not a full-range of services that a
6 dentist does, but sort of a very significant share.
7 For me, there was a dean of a dental school that
8 described it, and maybe it's an exaggeration. But he said,
9 "Dentists do 500 things. Therapists can easily do sort of
10 100 of them."
11 Right now, there's about 10 to -- well, actually,
12 there's closer to 13 states that have passed laws that
13 authorized dental therapy. These laws have often been
14 passed after very bitter fights. Getting the law in place
15 is one important step, but then you have to think about the
16 pipeline of training these individuals because we don't
17 have schools of dental therapy today across the country
18 that can provide sort of a ready supply of practitioners to
19 fill in sort of gaps.
20 And actually, I think another aspect of that would be
21 to create competition. When you talked about sort of
22 family-friendly practices -- I had my children so long ago.

1 There weren't urgent care centers when they were really
2 young. When urgent care centers opened up, our
3 pediatrician suddenly had evening and weekend hours. It
4 wasn't they weren't available by phone before then, but
5 they now have formal hours on evenings and weekends. So
6 competition, it can matter sort of in the delivery of care.
7 CHAIR BELLA: Okay. I'm going to ask, Kathy, if you
8 have any last comment.
9 [No response.]
10 CHAIR BELLA: You're on mute.
11 COMMISSIONER WENO: I also would like to agree with
12 Martha about integrated care. I think that integrating the
13 mouth to the rest of the body is where we're all headed in
14 the long term.
15 Dentists as a whole and dentistry and oral health care
16 has been slow to adopt a lot of things, and we hold firm on
17 our own coding system and all of these other barriers that
18 make it very difficult to fully integrate and to actually
19 use performance measures that are really meaningful, to be
20 able to use an electronic health record to monitor progress
21 and monitor disease rather than how many fillings we did,
22 you know, not looking at whether we really addressed

1 whether we reduced disease in a patient, but we did 14
2 MODs, so we must have.
3 Anyway, it's a challenge, but I think that dentistry
4 is slowly moving that way. It's just that most of the
5 topics that are commonplace, even managed care in many
6 states is a new thing in dentistry, so keeping that in mind
7 when we talk about trying to address oral health care.
8 CHAIR BELLA: Thank you.
9 So, Joanne, you have heard a lot of different things.
10 There's been talk of integration and accountability and
11 disparities and outcomes and access for kids. I'm going to
12 ask that you sort take that back and digest that and give
13 some thought to where we want to go with this,
14 understanding that we can't boil it all down. And we'll
15 sort of go back to the original intent of the project and
16 take this feedback in and again see where we go.
17 So do you have any last clarifications from the
18 Commissioners?
19 MS. JEE: No. I mean, there was a lot. So I'll need
20 to think about it, and the one thing that I do want to say
21 that I neglected to say at the beginning, which is that Amy
22 Zettle, our colleague on staff, was really helpful on this

1 project as well. So sorry, Amy, but thank you.
2 CHAIR BELLA: All right. Thank you, everyone, for
3 that discussion.
4 We are going to now turn to public comments. So just
5 to remind folks on the public, if you would like to speak,
6 click the little hand-raise button, and you will be called
7 on. And you will be unmuted, and we would ask that you
8 identify the organization you're representing today.
9 MS. HUGHES: At the moment, we have no hands raised.
10 CHAIR BELLA: No hands raised. I'm going to give it
11 just another minute and see, in the meantime, if any
12 Commissioners have any last comments or thoughts on
13 anything that we discussed today or yesterday.
14 [No response.]
15 CHAIR BELLA: Don't tell me that you're all tired of
16 being on Zoom and ready to be done on a Friday afternoon.
17 MS. HUGHES: We have two. We have two.
18 Colin, you have been unmuted. You can make your
19 comment.
20 **### PUBLIC COMMENT**
21 * MR. REUSCH: Great. Thank you.
22 My name is Colon Reusch. I'm with Community Catalyst.

1 I just want to say I appreciate the Commission taking a
2 close look at this issue. I think many of the barriers
3 that have been raised are longstanding, and I think the
4 discussion and framework that you've laid out so far is
5 moving in the right direction.
6 One thing that I would like to underscore is
7 Commissioner Weno's comment about how we track and measure
8 the care that's being delivered and the impact of that
9 care. I think the current measures are insufficient to
10 give us a good sense for whether or not the interventions
11 that are being delivered are actually having an impact on
12 the health of the population. So when we think about
13 oversight of programs and plans and contractual mechanisms
14 for improving access and quality of care, I think one of
15 the primary things we need to be considering is whether we
16 can move beyond those very surface-level measures of
17 utilization and look at mechanisms like risk assessment or
18 even some of the more complex measures that are coming out
19 of entities like the Dental Quality Alliance that would
20 look at the outcomes process that speak to more meaningful
21 care, for example, follow-up care when problems are
22 identified or the level of care that is being provided to

1 patients that are identified as being at high risk for
2 dental caries.
3 Certainly, I could go on, but I think that is, when
4 we're talking about oversight, one of the primary issues.
5 Thank you.
6 CHAIR BELLA: Thank you, Colin.
7 MS. HUGHES: All right. Hopefully, I'm pronouncing
8 your name correctly. Ademola, you have been unmuted. So
9 you may ask your question. You are self-muted, so if you
10 could just unmute your own way.
11 [No response.]
12 MS. HUGHES: You just need to click the microphone
13 icon under the orange arrow in the upper right corner of
14 your screen.
15 [No response.]
16 MS. HUGHES: Ademola Are?
17 [No response.]
18 MS. HUGHES: I can chat with this person.
19 CHAIR BELLA: Anne, while we're figuring that out, do
20 you have any final comments?
21 EXECUTIVE DIRECTOR SCHWARTZ: Well, I was actually
22 just going to say for this person or for anybody else who

1 might be having a technical problem, they can email us at
2 comments@macpac.gov, and we'll share them with all of the
3 Commissioners. It's not optimal, but it is an option.
4 Otherwise, no, I don't have any more comments.
5 Thanks, Melanie.
6 CHAIR BELLA: All right. I would just mention that,
7 first of all, I will say thanks to Anne and Jim for a
8 tremendous amount of work to make the virtual thing go off
9 with virtually not a hitch, so thank you for that.
10 Second, just thanks to the MACPAC staff. There's an
11 incredible amount of work on their plate, and things keep
12 popping up weekly or daily. So we'll do our best to sort
13 of juggle that but really appreciate the continued
14 thoroughness and just the amazing work that the staff does.
15 And last, I would say just to remind folks that our
16 next meeting is October 29th and 30th, and it will also be
17 virtual.
18 And we'll see if we have this last comment. It looks
19 like maybe not.
20 MS. HUGHES: There is no other hands raised.
21 CHAIR BELLA: Okay. Well, thank you all. Thank you,
22 Commissioners, for being engaged. Thank you to the folks

1 in the public who joined the meeting, and we'll see you all

2 in October. Have a great evening.

3 * [Whereupon, at 3:00 p.m., the meeting was adjourned.]

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