PUBLIC MEETING

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COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[10:31 a.m.]

CHAIR BELLA: Good morning. Welcome, everyone, to the December meeting.

We have an action-packed day ahead of us. We are going to start out with a session on directed payments.

I want to first just make sort of a housekeeping comment, although "housekeeping" might not be the best word, but I want to acknowledge and let the public know that one of the Commissioners, Kit Gordon, has decided to resign. Kit is finishing up. This is the last year of his term, and he has been serving as a substitute teacher, and he is going to continue to do so through the school year, which makes his participation on MACPAC not possible. So he's chosen to resign. If anyone has been wondering where the 17th person is, that is why.

With that, we will move into our session on directed payments.

Also, let me say for the record, we are very grateful to Kit for the service that he's had over the last five years, and we miss his voice. We know he wishes that he didn't have to make this choice.

Let me now move into directed payments. This is picking up on some work we've done a while ago.

Welcome, Michelle, I will turn it over to you to get us started, and hello, Rob. Good morning.

TRANSPARENCY AND OVERSIGHT OF DIRECTED PAYMENTS IN MEDICAID MANAGED CARE

* MS. MILLERICK: Great. Thanks so much.

So, to kick us off today, we're going to start with a presentation focused on the transparency and oversight of directed payments in managed care.

Just getting control of the mouse here. Just a little delayed.

Jim, do you think you could advance one and then I'm sure it will kick over to me in a second? There we go. Thanks.

So we'll start with some background on supplemental payments and managed care, and then we'll describe what directed payments are and how they relate to other types of supplemental payments.

We'll spend a few minutes on how states are currently using directed payments, focusing on their growth and what we know about spending, where there are some big

gaps, and then the meat of today's presentation will focus on what we learned from our key informant interviews in five states for which the key themes are listed here on the slide.

We think the issues raised in this presentation may warrant further Commission action and have outlined potential policy approaches for your discussion that can address these issues.

Before we dive in, I want to level-set with two comments. First, I want to mention that this is an area, as Melanie alluded to, where the Commission has done a substantive amount of work previously on supplemental payments, and so we view this work on directed payments as a continuation of that work and where these payments raise many of the same issues and where the Commission's previous comments on the need for greater transparency and oversight continue to be very relevant.

Second, there's a lot going on here, and there's a lot of technical detail, and I have a lot of slides. So I'm going to take a step back before we get into the themes from the interviews and spend a little extra time walking through the background of what these payments are, how they

came to be, and how they are similar to but yet different from other types of supplemental payments. So that's where I'll get started with the background.

It looks like I still don't have control to advance the slides for some reason. Jim, maybe you can help me, and I can say "next slide."

MR. BOISSONNAULT: Just confirming you do have control. That's you moving now. You're all set.

MS. MILLERICK: Okay, perfect. Now it's working. Thank you.

So, in fee-for-service, states can make supplemental payments up to the upper payment limit, or the UPL. For institutional providers like hospitals and nursing facilities, that's a reasonable estimate of what Medicare would have paid for a similar service, and that's in the aggregate for class of providers.

For physicians, the limit is based on the average commercial rate, or the ACR, which is usually a lot higher than Medicare.

Before the Managed Care Rule in 2016, states couldn't make supplement payments in managed care. The rationale was that because managed care rates are supposed

to be actuarially sound and sufficient to cover the reasonable, appropriate, and obtainable cost of providing services under the contract, that supplements to the managed care rate shouldn't be needed. But even so, some states made pass-through payment where the state would increase the capitation rates to the plans, and require the plans to pass through those additional payments to providers.

Those pass-throughs typically weren't linked to the use of services or quality goals. With the intent to tie payments more closely to quality and utilization, the Managed Care Rule phased out the use of pass-through payments over 10 years.

At the same time, it created this new option for directed payments, which really evolved as a new mechanism to, in effect, make supplemental payments in managed care.

The directed payment option allowed states to direct managed care plans to pay providers according to certain rates or methods. There are certain requirements that states have to meet in order to use directed payments. Most importantly, and different from other authorities, directed payments have to be tied to the utilization of

services, and they have to be tied to the state's managed care quality strategy. They also can't be conditioned on certain types of provider financing arrangements, such as provider participation in intergovernmental transfers, or IGTs.

Directed payment arrangements also have to be approved by CMS prior to implementation. So states submit a pre-print application form to CMS for review in advance, and then CMS asks the state for written responses to questions, which sometimes can go back and forth with multiple rounds of Q&A.

Directed payments are usually approved one year at a time, and they can't be automatically renewed. So you have to go through this pre-print process each year if you want to renew the arrangement.

So, next, I want to provide some context here on where directed payments fit in this broader universe of supplemental payments and then describe what the directed payment options are a little bit more clearly.

Starting with the types of payments that you can make in fee-for-service, the two main types are UPL supplemental payments, which we discussed a second ago, and

DSH supplemental payments which pay hospitals for Medicaid shortfall and unpaid cost of care for the uninsured.

On the managed care side, there are pass-throughs, which I also touched on, and these are the ones that are being phased out. Then we have this new option for directed payments that is our focus today.

In terms of the options for directed payments, we've classified them into two categories in our work; first, minimum or maximum fee schedules, which adjust the base payment rates that plans pay for specific services. So that could be using a state plan rate for fee-for-service, Medicare fee schedule, or some other alternative schedule that the stat develops.

Since many health plans typically pay providers state plan rates in managed care, anyway, these minimum fee schedules are generally less of a policy concern, and going forward, minimum fee schedules tied to state plan rates will no longer require CMS approval.

The second category of directed payments are these additional payments to providers, which is the green one there, and these raise more policy concerns because they're very similar to supplemental payments in fee-for-

service.

There are two categories of these additional payments to providers. The first is uniform rate increases, which require plans to pay a specified uniform dollar or percentage increase in payment that's above the negotiated capitation rate. Then the second is VBP arrangements, or value-based payments, which tie payment to a specific performance or outcome, like pay for performance, shared savingsarrangements, bundled payments, et cetera.

So these additional payments to providers that are highlighted in green are really the focus of our analysis and presentation today, and as you'll see in a minute, this is really where the bulk of dollars are flowing through the directed payment arrangements.

For our analysis, we contracted with Mathematica to review available directed payment approval documents and to conduct structured interviews in five states. We reviewed pre-prints and associated approval documents for all directed payment arrangements approved as of December 31, 2020, of which there are 230 distinct arrangements.

CMS provided these documents to us for the

purpose of this project, but generally speaking, the pre-prints and approval documents for directed payments are not publicly available without a Freedom of Information Act request.

For the structured interviews, we spoke to state officials and representatives from providers and plans in California, Florida, Massachusetts, Ohio, and Utah about their experiences with using directed payments. We also talked with national experts, actuaries, and staff from CMS.

So getting into how states are using directed payments, since the first directed payments were implemented in 2017, there's been a substantial growth in the use of directed payments. In 2018, Milliman conducted a review and found 65 distinct arrangements in 23 states had been approved at that time. Our most recent analysis reflects that through the end of calendar year 2020, this has grown to 230 distinct arrangements approved in 37 states. There's been growth across all types of arrangements, but the distribution of the types of arrangements, whether they're fee schedules, rate increases, or VBP, hasn't changed much over time, and that

sort of distribution is shown in the coloring of the bars.

In our review of approved directed payment arrangements, we were only able to find projected spending information for about half of the approved arrangements, so 96 of the 201 distinct arrangements. However, the spending projections from these arrangements is substantial. Overall, the 96 arrangements with available data are projected to cost $27.1 billion, which is more than spending on DSH and UPL in 2019. However, these numbers should be interpreted with caution since we are missing data on more than half of the arrangements and since the numbers that we did find are spending projections, not actual expenditures.

In addition, we found inconsistencies in the reporting such as the fact that it was unclear in some cases whether spending estimates were for the renewal year only or for the entire duration of the arrangement.

Moreover, it was difficult to allocate the estimated payment amounts for each payment and provider type because some of these arrangements use more than one type of payment method or target multiple providers.

This figure shows the distribution of projected

directed payment spending by arrangement type. Overall, we can see that the majority of the spending, approximately 26- of the $27 billion projected, is in this additional payments to providers category, which is the green and light blue sections of the pie chart. So, while about half of the arrangements are minimum or maximum fee schedules, it's really these additional payments to providers that make up the vast majority of the spending associated with directed payments.

In our review, we also documented other characteristics of approved directed payment arrangements. Of the additional payments to providers, the most commonly targeted providers are hospitals and physicians who are affiliated with hospital systems. Other arrangements targeted mental health and substance use providers, nursing facilities, HCBS, and dental providers, among others, but these make up a much smaller share.

Of the additional payments to providers, about two-thirds were financed by provider taxes or IGTs. Directed payments targeting hospitals were particularly likely to use these financing mechanisms, and there appears to be a strong relationship between the targeting and the

financing of payments were providers who financed the non-federal share of the payment are typically the ones who receive them.

Finally, with respect to quality goals, a majority of the additional payments to providers are intended to improve access, and that's how they tie to the quality strategy. But, in some cases, it's not clear how the payment is intended to improve access or if the selected measures are good indicators of improved access resulting from the payment.

This also raises questions about the fact that the underlying managed care rates are intended to be sufficient to ensure access. So it's not clear the extent to which meaningful improvements in access are being achieved above what is supposed to be achieved by the base rate.

Getting into the themes from our interviews, from our interviews, it's clear that states considered, and CMS encouraged, directed payments to be used as a vehicle to transition prior passthrough payments and expiring Section 1115 supplemental payments into directed payments. This was viewed as a way to more closely tie supplemental

payments to quality and utilization.

Several states we spoke to indicated that one of the primary goals of their directed payment arrangements was to reserve funding to providers that were previously made through pass-throughs that were being phased out. While many states transitioned prior payments into directed payments, often in similar amounts, and sometimes with existing financing arrangements in place, we heard that the distribution of payments to providers is often different than prior payments because of this tie to utilization. So directed payments aren't always an exact replacement for these prior payments.

It's also clear that while directed payments were originally developed as a mechanism to transition or continue previous fee-for-service supplemental payments, states have increasingly shifted to developing new arrangements to increase payment to providers that are not related to previous payments, and this has contributed to the rapid growth in the use of and the spending associated with directed payments.

In our interviews, stakeholders stressed the importance of maintaining a certain level of funding for

Medicaid providers to ensure their financial viability and to ensure beneficiary access to services. Some noted that providers would be subject to significant payment reductions if directed payments were not continued or approved. It's also clear that especially for hospitals and hospital-affiliated positions, directed payments can represent a large share of total Medicaid payments.

Although it's difficult for us to analyze without provider-level data, we know that in some cases or in some states, directed payments can be larger than DSH or UPL payments to certain providers. In Ohio, one of their newer directed payments that targets four public hospitals results in payments that appear to be four times greater than what those providers received in UPL payments and about six and a half times greater than what they received in DSH payments in 2017.

In Michigan, directed payments were 40 percent of managed care payments to hospitals in the state in 2016.

When we asked states about their decision to use directed payments rather than increasing base payments to providers, a number of them noted that the ability of providers to contribute to the non-federal share, through

provider taxes or IGTs, often influenced their decision to use directed payments as opposed to increasing base payments, which more often rely on state dollars.

Unlike other types of supplemental payments, there's not a statutory or regulatory upper limit on directed payments. CMS officials confirmed that UPL limits in fee-for-service do not apply to managed care payments, and when we talked with actuaries, we learned that actuaries are not consistently involved in assessing or certifying that the amount of the directed payment itself is reasonable and appropriate to achieve its intended goals. As a result, it seems that actuarial soundness rules do not provide a clearly discernable limit.

Many states do use UPL principles as a benchmark to determine amounts for directed payments, but this is not required. For example, we see that most directed payments targeting hospital-based physicians make payments up to the average commercial rate, which is permissible for physicians in fee-for-service, but it's substantially higher than what Medicare would have paid, which is the upper payment limit for hospital services in fee-for-service.

In our review, we identified seven directed payments for hospital services that exceed the fee-for-service UPL limits. We also heard from actuaries and stakeholders that state interest in making payments above the UPL is growing. In reviewing directed payment proposals, CMS routinely asks states how these payments compare to UPL benchmarks, but it does not appear that payments are consistently disapproved on the basis of the amount, although we do understand from stakeholders that CMS typically applies greater scrutiny to proposals that exceed fee-for-service limits.

Of the 215 directed payment arrangements which could reasonably have evaluation results, meaning they've operated for more than a year and have been renewed at least once, only 48 arrangements have reported evaluation results. These are also not publicly available, but CMS provided them to us for the purpose of this work.

The findings raise a number of questions about how CMS uses the evaluation results in its review of arrangements, especially in cases where arrangements are renewed without evaluations of prior years or where the results are negative.

Directed payments have reported improvements in quality goals of varying magnitudes, and the results we observed have generally been mixed. Some arrangements showed incremental improvements year-over-year, and these were especially likely to be VBP arrangements that had been built upon previously existing quality-based payment programs, such as those authorized under DSRIP. Other arrangements reported negative outcomes, such as increases in hospital readmissions or time to appointment measures or decreased Medicaid utilization.

In addition, states and CMS officials noted a number of challenges with evaluating the effects of directed payments on specified quality and access goals. Data lags and delays in collecting and reporting data were a common theme, as well as challenges with the quality of encounter data. Since most directed payments are reviewed one year at a time, many interviewees also noted how difficult it can be to plan, implement, and evaluate an arrangement in a single year. Others noted that the selected measures of access are not always clearly aligned with the goals of the payment, making them difficult to evaluate.

The last thing I want to note that CMS is now allowing multiyear approval options for the VBP arrangements, which may alleviate some of the challenges with these data lags and with measuring and evaluating results in a single year.

For our final theme, I think it's important to note that the vast uptakeof directed payments wasn't anticipated and that this has presented a number of oversight challenges.

We heard from CMS that it's been challenging to review such a large volume of arrangements across 37 states. Also, state officials in return expressing frustration about lengthy review processes and uncertainty about what types of arrangements require pre-print approval or what the boundaries are in terms of what CMS would approve.

CMS issued new guidance in January 2021 as well as a more detailed pre-print template that asks for more information at the time of application up front, which may address some of these issues. States and stakeholders were generally optimistic that these changes were positive and would result in a more streamlined review process,

potentially reducing the amount of Q&A and back-and-forth between states and CMS.

Finally, I want to note as an oversight consideration that CMS does not track spending on directed payments after approval. So, again, we don't have a sight line into actual spending or expenditure amounts.

We saw in the case of one state, which provided reconciled amounts to us, that the actual spending was quite different than the projected spending, which is a concern.

Overall, our findings that directed payments continue to grow rapidly withoutlimits suggest several opportunities for the Commission to make recommendations in this area. I'm going to review a few potential policy approaches for your consideration, and each of these are elements that staff can develop further based on your feedback to potentially be included in the Commission's June report to Congress.

First, as a starting point, the Commission could recommend that CMS make directed payment information publicly available. This is consistent with the Commission's previous comments on the 2018 Managed Care

Rule, which addressed the transparency of directed payments. Specifically, a transparency recommendation like this could require that pre-print applications, associated approval documents, payment amounts, and evaluation results for directed payments all be publicly available in a format that enables analysis.

It could also include a recommendation that provider-level data be made available, similar to the requirement that Congress passed last year requiring provider-level data be collected and reported on supplemental payments in fee-for-service.

Without provider-level data, it's difficult to analyze the effect of directed payments on total Medicaid payment to providers as well as the relationship between the targeting and the financing of the payments.

Second, the Commission could recommend establishing an upper payment limit on directed payments, similar to the UPL in fee-for-service.

Given the growth and the use of directed payments and the lack of clear limits, directed payments have the potential to substantially increase federal spending, and it may be prudent to consider whether there should be

explicit limits. We could look at recommending limits that are the same as those in fee-for-service or could consider other limits, depending upon Commissioner views. Such a proposal could potentially result in federal savings, but we need to work with CBO to get an official estimate.

Finally, the Commission could recommend that CMS be more explicit in its guidance on how directed payments should relate to quality and access goals. This could include establishing criteria for how evaluation results should be used in the review of requests to renew directed payments or potentially setting standards for better measures of access that align with the state's quality strategy and access monitoring plan. And I would note that this work is already underway through the Commission's work on access monitoring, which we'll be discussing in several sessions later today and tomorrow.

As we move towards next steps, we'd appreciate your feedback on the issues raised in this presentation and the potential policy approaches I just summarized. Are these the right set of options? Are there things that should be removed or added, and is there any other information that you might need in order to support your

decision-making in these areas?

As I mentioned, we can work to address any of your questions and flesh out any policy options that you're interested in pursuing to present at a future meeting or potentially for including in a chapter next spring.

So, with that, I'll turn it back to the Commission for your discussion. Thank you.

CHAIR BELLA: Michelle, thank you very much. I feel like you've made my job easy because you've laid it out so clearly, and we have a concrete set of recommendations to go through.

I'm going to open it up. I'll start with Stacey and then Bill.

COMMISSIONER LAMPKIN: Thank you, Michelle and Rob. This was really, really good information.

This is a topic of particular interest to me from both my experience in a Medicaid agency during a time when we were making a major transition to risk-based managed care and participating in the struggles of how to use the funds that were associated with IGT and tax-based sources of non-federal share in that context. It was a real problem. Also in my role as an actuary, trying to think

about how these funds fit in a risk-based model and in an actuarial soundness construct.

Directed payments are an interesting approach to trying to solve some real challenges that states face, that historically supplemental payments challenge and way to influence MCO alignment with state goals is not the only way. And my understanding too is that some of the ARPA HCBS spending plans almost certainly rely on directed payment-type solutions to be able to spend the money.

But the fundamental problem from my perspective is the lack of transparency that we called out here. This is a soapbox I return to repeatedly when given the opportunity from our agenda. Medicaid funds are public funds, and taxpayers need to be able to understand what the program is buying and what the program is paying. To the extent that the payments are observable in encounter data, T-MSIS will hopefully start to allow more of that analysis, but other payment information should be published in a usable way, as we recommended in the past around supplemental payments, so some very similar issues that you've presented here with directed payments. Clearly, this is only becoming more important as the number of

arrangements grows.

The new 2021 pre-print is a step in the right direction in that it will be more consistently collecting key information, but that first policy option that you outlined, if you can flip back a slide, to me, this seems clearly necessary that approved pre-prints, evaluation results, payments amounts should be public.

Ultimately, we need the right kind of data to pull together all the different funding streams to particular providers and assess what the program is paying for what it's receiving. So I'm 100 percent in favor of that first policy approach on this slide.

I suppose it might be helpful to undertake what any counterargument might be. I'm just not aware of the counterargument here.

A secondary challenge with the whole directed payments, as they're currently implemented, is just thinking about what the growth in directed payments mean in the context of risk-based managed care and actuarial soundness requirements that already address consideration of network adequacy requirements and access. I think this goes to both of the other policy approaches you have on the

slide here.

If the proportion of managed care funding that directed payments represents continues to grow, does that affect plan's ability to manage the care effectively? Does that constrain the flexibility that this service delivery model was meant to provide? I'd be interested in hearing the health plan perspective on that.

And this feels relevant to me in the context of an upper limit as well as the program integrity aspects of the upper limit.

Would we think about the upper limit as similar to the UPL and fee-for-service, which is almost like an overall unit cost question, or are there other ways to think about it, like a proportion of capitation or a proportion of the amount of capitation associated with a particular provider or service, like hospital services or physician services, a couple of the provider types that you called out? I think it's worth talking about different kinds of metrics that we could think about in the context of an upper limit.

But I do generally think that there could be some place to go on some type of upper limit, and I think it

would help us understand, state by state, the consistency of approvals and some of the dynamics there a little bit as well.

You ask what else we would need to see to be able to move forward. On this one, I think I'd like to see whether we can cobble together anything more about what things look like along some of these metrics, and I know there's only so much data available, but if there's any way to understand what it represents as a proportion of capitation and/or particular kinds of services, I think that would be useful, also, what health plans think and what they feel like the impacts of the growth of directed payments is on their ability to manage care.

Finally, if we think an average commercial rate is really a useful and consistently calculable benchmark, I think what we've seen over the last few months in this space is that's a challenging benchmark for states and actuaries in the context of directed payments.

So a little more fleshing out of that if we think it's a useful benchmark would be, and I realize that there are several other people who want to comment. I could probably go on for the rest of our time on this topic, so

I'll yield the floor. I'm very eager to hear what other people have to say about this.

CHAIR BELLA: Thank you, Stacey.

We're going to do Bill, then Darin, then Fred, then Bob, then Tricia.

COMMISSIONER SCANLON: Okay. Thank you, and thank you, Michelle and Rob. What you have provided us is incredibly important because I think the heart here is what Stacey highlighted and which I totally agree with is that transparency in some respects is problem number one or issue number one. We do not have an adequate understanding of this, and before your work, there was a much bigger gap in terms of what we knew about directed payments.

There's an uncanny similarity here between the directed payments and our prior experiences, and this is partly because I have spent so much time in Medicaid with respect to provider taxes and IGTs. As you know, we have boundaries in both of those areas, and the boundaries came about after we understood better what was happening.

But when something grows to big, imposing boundaries becomes more difficult, and the issue of disruption and transitions becomes much more problematic,

and so, therefore, as you noted, the growth here is very significant. The need for more immediate transparency so that we can make better policy choices, it becomes sort of more immediate.

So, actually, I'm very supportive of the first potential recommendation sort of amended to a degree to say besides making public what information CMS currently has, what information should CMS be collecting besides what they have and make a joint recommendation there. I think that is what is essential now. It's after that we would be in a position to inform the Congress about what the status quo is and that they would be able to consider more appropriately what boundaries they think are appropriate because I think the boundaries are very much a policy decision.

Again, you have struck an incredible sort of area in terms of urgency because if this grows too much, making it serve beneficiaries and taxpayers well becomes much more difficult.

Thank you.

CHAIR BELLA: Darin, then Fred.

COMMISSIONER GORDON: Thank you, Michelle and

Rob, for doing this.

I agree with elements of what Stacey and Bill said primarily around the transparency part. I think that's a hard thing to argue against, particularly with as much funding that's going through this vehicle.

I do think around the transparency part, as an element that I think would be helpful or necessary before I move to some of the other potential recommendations, is I think it's important that we understand the why. Why are states using this vehicle versus whether it's going through the rates, the normal capitation rate process, or however else they want to think about it?

The reason I bring this up is because of certain lived experiences here. To some degree, I think some of the growth may be attributed to the fact that CMS has made the policy where they want to move things more to directed payments that may have been done in other vehicles that were previously allowed, and I want to give one example -- actually a couple of examples.

One was Tennessee did not have a DSH allotment like everyone else. So they had these supplemental payments, and it wasn't until the last few years where CMS

said they want to move the supplemental payments that were DSH-like, so the equivalent of what you see in other states for DSH into the directed payment approach.

So, before we look at any of these through a lens of something is going on here that doesn't smell right, I think we need to understand what are some of the reasons here, why are some of the states using these, because to the point of putting a limit in place, then you may be artificially limiting a state's equivalent to DSH. And I don't know if that's necessarily a great policy position for us to take.

A second thing that I think gets caught up in these as well -- and I do agree with Stacey. Some of the responses to COVID, I know, was caught up in this, and I don't think that's necessarily bad. But with the advent of value-based purchasing, you do see some more direction coming from the states in directing value-based purchasing and how that needs to work through their health plans. You also have situations where states set, which you highlight in the report, the minimums and the maximums of rates for various policy objectives that they're trying to achieve. Again, there's a rationale there I think that we just need

to better understand, and I get it. You can't do this for every state, but I do think we need to kind of get more into the why as part of that transparency element that you highlight.

I think when we do that, after doing that, similar to what Bill said, then I think we'd be in a better position to evaluate how or if a separate limit should be put in place, but before having that additional information, I worry about the unintended consequences of putting a limit in place and not knowing full well what the repercussions are with regards to that.

One other thing I should say that I do know has been an element -- we had these discussions with CMS when I was leading NAMD -- was that some states were moving from fee-for-service to managed care. They needed a vehicle or a way to carry some of the things they were doing in fee-for-service and managed care, otherwise they couldn't move to managed care. And so some of these things are the vehicle that allows them to transition from one payment model or one delivery system model to the other.

The other comment I want to make is about access, and I know I'm running a little bit long here. But we

talked about measuring access. I think one thing, we talked about improvement of access, that we didn't really have good evidence that it was improving access. I do think we need to look at access in the context whether it improved it or it was able to maintain it, because in some cases, it is in order to keep some providers participating in the Medicaid program that may otherwise have left, so just one last bit of feedback there.

Your third point, I will say I'd be more inclined to do that before we get the additional information in the second point, meaning the tying it more clearly to quality and access.

Thank you for the work, and it is a very rich topic. Like Stacey, I could talk about this one all day long.

CHAIR BELLA: Thank you, Darin.

I'm starting to feel like this should have been our after-lunch session because it's got everybody so energized.

All right. We do have a lot to say on this. I would like to ask the Commissioners when you speak, please be really clear about where you are on each of the three

recommendations. I'm hearing pretty strong support for one, not a lot of opposition to three, and some additional information being looked for, for two. So just kind of if you can help make sure your comments are coalescing in those areas, that would be helpful.

Fred, then Bob, then Tricia, then Kisha.

COMMISSIONER CERISE: Yeah. So I'll say supportive of one and two and not opposed to three.

Just to follow up on some of Darin's comments in terms of why it exists this way, I do think it's important to think about that.

When base payments are below Medicare and then states come back and pay supplementals -- and we've seen data on sort of all the aggregate payments and how that in many places exceeds Medicare -- it allows states to pay low and then rely on alternative means of financing to come back and try to make providers whole.

It just raises so many issues in terms of, you know, is that sound policy? Who's getting the payments? What's dependent upon IGTs and that sort of thing?

I certainly think transparency is a great place to start and putting the information on the table so we can

understand what's going on but also recognizing that we are kind of endorsing an approach that pays below Medicare and creates this differential between you pay a certain rate for old people and you pay a discounted rate for poor people. Attention to the base rate, I think, it's hard to avoid it in the supplemental payment discussions.

I think the means of financing issue, it's hard to dodge that as well because there's so much controversy around what's allowed there and how can that be applied, and is it applied consistently? There's not a lot of transparency around that as well, and so, as we look at transparency of how the payments are made and what payments are made, looking at the means of financing issue, I think, is important as well.

Then, finally, if you look at the payments -- so much of this is meant to replace other sources of funds. DSH is one. Some of the waiver payments you see is another one, and in that bucket, those two are covering payments for uninsured. I think what states end up doing is trying to -- you know, "I'm going to go to average commercial over here as a way to subsidize some of these other costs that I can't get federal share for, which includes the uninsured."

Rather than try to continue those cross-subsidies, one, I do think a cap at average commercial, it's hard to make sense of that for the reasons Stacey commented on, and a Medicare cap seems reasonable, but also recognizing that there are real costs associated with the uninsured that Medicaid already recognizes today in at least those two programs. Recognizing that in these supplemental payments, I think, is important so that you don't end up trying to get overpaid in one area to cover stuff that you're not getting paid for in another area.

Finally, if you're going to do that, then we've got to get better about what are the expected outcomes, particularly if you're going to cover the uninsured around access, and access can't just mean you see people in the emergency department when they show up but that you're serious about access and primary care and specialty care and drugs and things like that. But I think you have to throw that in the mix as well because with supplemental payments, you end up getting distorted in some areas because you don't pay for other areas, and I know it's Medicaid, but Medicaid already pays for uninsured in a number of programs.

CHAIR BELLA: Thank you, Fred.

Bob, then Tricia, then Kisha, then Toby, then Dennis.

COMMISSIONER DUNCAN: Yeah. Thank you, Michelle and Rob, both for the memo and the presentation today.

My basis is very similar to Darin. We're on the same wavelength of understanding the why.

In the memo you sent, on page 11, it says, "Despite these challenges, some states have reported improvement in quality or access for selected directed payment arrangements." So not only understanding why the states are choosing this methodology, but what are the states that are showing success -- what are they doing different than the others?

So it leads me more to number three on the options as well as, what feedback did we get from CMS when we made recommendations in the past on this trying to get to that why question that Darin was getting to?

CHAIR BELLA: Michelle or Rob.

MS. MILLERICK: Rob, since you did the UPL work last time, do you want to speak to that?

MR. NELB: Sure, yeah.

So a couple things. In terms of our previous comments, they were on the 2018 revisions to the Managed Care Rule, and we submitted a comment letter. CMS did not accept the comments to add more transparency. They didn't provide specific rationale why. I think there were a lot of other changes they were making, and the staff we spoke to seemed interested. There's an effort to improve this new pre-print process and collect more information. Hopefully, the efforts to improve transparency are not so much of a lift, and I think there are efforts underway regarding the UPL, new transparency requirements that may be instructive in thinking about what types of transparency CMS might be able to provide around directed payments.

COMMISSIONER DUNCAN: Thank you.

MR. NELB: I can add more on the evaluation piece. I think a lot of the ones that were more value based in their design -- like some of the previous DSRIP ones that continued to directed payments -- tended to show a little more improvements in quality where there was a clear tie to improvements in that quality measure to a payment, whereas we maybe saw less improvements in quality in some of the fee schedule increases that weren't actually

tied to improvement in a particular quality measure.

COMMISSIONER DUNCAN: All right. Thank you.

CHAIR BELLA: Thank you, Rob.

Tricia.

COMMISSIONER BROOKS: Thank you, Rob and Michelle. The background material was excellent, and this reminds me of the balloon analogy where you put pressure on the balloon at one end and the other end blows up, but we don't want to put so much pressure that it deflates the balloon entirely because the directed payments, particularly with pass-throughs being phased out, have really helped to keep the system afloat at a time when managed care has had less flexibility in terms of payment. So I don't think we want to pop the balloon entirely.

I'm definitely in favor of Number. 1. Number 2, I think I'd feel more comfortable in describing this as exploring the implications of an upper limit. When we put a definitive word on there like "establish" an upper limit, it sounds like we're already moving in that direction, and I'm not sure that I'm there yet.

Then, lastly, on Number 3, definitely we know the challenges that there are in accurately assessing quality

and access and how to improve it, but we have to keep plowing ahead on this.

I would also say I'd like to see that particular recommendation encompass how directed payments should be used to address health disparities.

CHAIR BELLA: Thank you, Tricia.

Kisha?

VICE CHAIR DAVIS: Thank you.

Thanks, Michelle and Robert.

I'm in alignment with everybody in terms of the need for more transparency, and I just want to make sure that we're expressing that it's not necessarily a bad thing that providers are getting these additional payments and that it's not necessarily an indication that there are bad actors at play here. Really, the signal here is that base payments aren't enough to maintain adequate access and quality and pushing on one part of the system to make up for a shortfall in another place. I think just recognizing that indication that as these directed payments are growing is an indication that there's a shortfall someplace else, and so my concern is about are the payments being used to do what we want them to do, and so the concern about

limited oversight and accountability for the payments, so certainly in favor of Number 1 having that information to be publicly available.

In terms of the second recommendation -- and I don't feel comfortable trying to set a limit yet, especially since we don't really know much about how states are using it and would want to have a better understanding of how it's getting used and what those numbers are before we can really try and set limits there. I think certainly in favor of Number 3 again really being explicit on the goals of the program and making sure that we are monitoring are the payments actually moving the needle on increasing quality and access and thinking of that from a health equity perspective. Are there winners and losers in terms of how these payments are being distributed?

CHAIR BELLA: Thank you, Kisha.

Toby and then Dennis.

COMMISSIONER DOUGLAS: Thanks.

First, great analysis. I'll just be brief. I align myself with Darin and Bob and Tricia and Kisha.

First, I just really think we need to understand the policy goals to the why, the idea of increasing base

payments, it could be really focusing on a more broad-based goal, but another way the states look at it is really targeting their goals and their objectives, and that's where directed payments come in. So what is it that's going on here?

So I see it too early to be focusing, even analyzing a UPL. As Tricia was saying, it kind of sends the wrong message. We don't know the why clearly, the policy intent, and need that transparency before we go down that path.

CHAIR BELLA: So, Toby, that's where you are on Number 2. Where are you on 1 and 3?

COMMISSIONER DOUGLAS: I'm supportive of those.

CHAIR BELLA: Okay.

COMMISSIONER DOUGLAS: Transparency, figuring this out, all supportive.

CHAIR BELLA: Michelle and Rob, are we saying that we'd have to come out of here with what the limit is or just recommending that there be a limit? I mean, there's a difference there, right? We kind of have limits on everything like this.

MS. MILLERICK: Yeah. I think that could be sort

of one of the considerations of the Commission. They could just say that we should establish one and defer to CMS or others to sort of set what that is, or we could come back with design considerations if the Commission wanted to think about what it should be, we could come back to you with some design considerations.

CHAIR BELLA: Okay.

Dennis.

COMMISSIONER HEAPHY: Yeah. This is really helpful.

I'm going to start with Number 2 and say I don't think we're there yet because I think we ought to be driving the payments and really the ability of the MCOs and the states to reach their goals, their quality goals and access goals, and with that, I think it's really important that we're looking at data transparency, that it's important we emphasize the importance of CMS providing guidance to the states on the data required to establish transparency, because it seems sometimes MCOs or the states are defining what they can provide rather than getting the guidance from CMS. That's why I think it's really important that the data drives increases in quality and

access to goals before we talk about Number 2.

So I'm very much in favor of Number 1 and Number 3, and as other folks have said, that as the primary goal to achieving equity. But I would like to see Number 3 driving everything else because that's what these payments are about is to clear goals and outcomes on those goals.

CHAIR BELLA: Thank you, Dennis.

Can I ask if anyone -- most everyone has spoken. Does anyone have concerns with Number 1 that need to be raised?

[No response.]

CHAIR BELLA: Let the record show there's a lot of head-shaking no.

Anyone who wants -- this is the time to raise any concerns with Number 1, otherwise we're going to say we're moving ahead there.

COMMISSIONER HEAPHY: This is Dennis.

The one thing I guess I would ask is balance and burden on the plans in the yearly renewal requirement, can we explore that? Would it be possible to have -- rather than having to look at the paperwork every year or have it provided again, is there a way to look at how to look at

performance instead? Performance of the goals rather than renewal of the paperwork each year and the submission.

CHAIR BELLA: Okay.

COMMISSIONER HEAPHY: Does that make sense, Michelle?

MS. MILLERICK: Yeah, yeah. That makes sense. Thank you.

CHAIR BELLA: How about Number 3? Are there concerns with Number 3 or anyone who isn't ready to support Number 3 yet?

Verlon.

COMMISSIONER JOHNSON: No, no. I definitely support Number 3. I'm always just cautious of the idea around providing additional requirements or saying that we need to focus on quality and access goals. I really want to have a better sense of how we can be more specific around that but definitely support it and wondering if our support of a Number 1 could actually help us have a better idea of what that Number 3 would look like.

CHAIR BELLA: Great point. Lots of nodding heads.

Anyone else want to comment on Number 3?

[No response.]

CHAIR BELLA: Okay. Before we go to Number 2 again, Stacey, let me ask since you kicked us off. Do you have any thoughts that you want to share after having heard all the rest of the comments?

COMMISSIONER LAMPKIN: Thank you. I appreciate that.

The one thing that I was struck by were the comments that related to the difference in the base rate and the directed payment and the MCO flexibility implications of that.

So, theoretically, in a risk-based service delivery model like we're talking about here, the MCOs, the plans negotiate with the providers to achieve the network adequacy standards that are set forth in the contract, and that negotiation process should put pressure on the base rate upward theoretically and kind of get to some sense of equilibrium such that you shouldn't have to have a directed payment to come along and improve access if your contractual standards are sufficient with respect to network adequacy and other roles that the MCO needs to follow.

But some of the historical financing of these dollars is part of what produces a challenge and the need for directed payments to specifically make sure that certain amounts of dollars go to providers or certain levels go to providers, at least that's my understanding of what's driving asignificant subset of these directed payments. And that's the area where I think it would be useful to explore -- agree, "explore" is the term -- what an upper limit might look like in terms of is there a balance you can strike between using that mechanism, recognizing the problems with some of our financing mechanisms in a capitated-based environment, but balance that with making sure that you're not letting it spiral out of control and you're still giving health plans enough flexibility to manage the care in the way that we want them to. So I felt that that string was maybe worth pulling a little bit further based on some of the concepts.

Thank you, Melanie.

CHAIR BELLA: Thank you, Stacey.

Other thoughts from Commissioners?

[No response.]

CHAIR BELLA: Okay. Michelle and Rob, what I'm

hearing is same thing you're hearing about 1 and 3, probably a little like tidying around the edges we can do on some of that, exploring a couple things, but there's no reason to say we can't move forward with 1 and 3, and particularly, once we get one in motion, that is going to really aid anything, any future work we do on 2.

Also, you have a long list of things that folks would like to see around Number 2. So what questions do you have back for us?

MS. MILLERICK: That was a really helpful discussion that I think gives us some concrete things to take back, and so we look forward to sort of fleshing that out and perhaps coming back with some more specifics at a future meeting.

CHAIR BELLA: Just so we're all clear on expectations, this could come back in the form of recommendations even in January probably on a couple, right?

MS. MILLERICK: Yeah.

CHAIR BELLA: And then you could come back to us in January and let us know of the things, I think, Stacey mentioned and the other Commissioners mentioned, which of

those you could find by when, and then we could figure out additional discussion we might have before March or April in that regard, and then the recommendations, however they end up, would be for June. Is that correct?

MS. MILLERICK: Yeah. I think that's exactly right in how we're thinking about it so we can flesh out some language around the transparency piece to bring back to you in January and then think through how we could do some analysis on the other items that Stacey and others raised.

CHAIR BELLA: Okay. Does that sound good to everyone?

[No response.]

CHAIR BELLA: Any last comments from Commissioners?

[No response.]

CHAIR BELLA: I can't believe we have six minutes left. This is a testament to how well written the materials were and how much you sort of laid things out for us, so thank you very much.

If there are no additional comments from Commissioners, we can move into the next session.

Thank you, Michelle and Rob, very much.

MS. MILLERICK: Thank you.

CHAIR BELLA: This session, Kristal is joining us. Welcome, Kristal.

We're going to finish our conversation, continue our conversation about Money Follows the Person and the qualified residence criteria. We have a decision to make in front of us about whether we want to make a recommendation. I just want to remind the Commissioners and the public, the requirement that we look at this issue does not carry a requirement that we make a recommendation. If we have some consensus and we feel that we have the information we need to make a recommendation, that's fine. If we don't, that's also fine. We're going to make a great contribution in the descriptive analysis that we put forward, and particularly, if we're not clear on a recommendation, we will lay out the tradeoffs very clearly in what we put forward to be in compliance with our requirement.

So, with that, I will turn it over to Kristal.

MANDATED REPORT ON MONEY FOLLOWS THE PERSON QUALIFIED RESIDENCE CRITERIA: POLICY OPTIONS

* DR. VARDAMAN: Thank you. Good morning, Commissioners.

Today I'm going to review two policy options for your mandated study on Money Follows the Person. I'll first quickly recap where we've been over the past few months and then go into outlining the two policy options.

As you know, Money Follows the Person, or MFP, is a demonstration that has provided participating states with flexibility and enhanced funding to support transitioning over 100,000 Medicaid beneficiaries from institutions to the community.

MFP participants must be transitioned into settings that meet its qualified residence criteria, which are narrower than HCBS standards in the home- and community-based services, or HCBS settings rule.

In the Consolidated Appropriations Act of 2021, Congress directed MACPAC to examine these differences, and if appropriate, the Commission can recommend policies that would align MFP residence criteria with the HCBS settings rule.

In September, we reviewed background on MFP and the settings rule, and in October, Tamara and I brought you

results of our analytic work in this area, which had three streams.

First, we reviewed data on MFP transitions. We also surveyed state MFP program directors, and finally, we conducted stakeholder interviews.

At the October meeting, Commissioners provided differing opinions on whether you were interested in making a recommendation, and so we went back and did some additional follow-up work. And we've also just tried to clarify the two main options and the rationale for each in order to assist your deliberations.

So I'll start by walking through the first policy option, which is to maintain the existing MFP criteria, and as a reminder, as Melanie just went over, the Commission could choose to issue a report without recommendations that would weigh the advantages and disadvantages of the current criteria. Alternatively, the Commission could affirmatively indicate support for maintaining the current criteria.

So, in terms of background, your materials outline some of the context on MFP as part of federal and state efforts around institutionalization and rebalancing

long-term services and supports.

Many of these activities have come about following the Olmstead decision, which concluded that states must provide treatment for individuals with disabilities in the most integrated setting possible.

Since then, rebalancing efforts in Medicaid have worked to uphold Olmstead by providing beneficiaries with home- and community-based services and transitioning individuals out of institutions.

It's in this context that the Money Follows the Demonstration was created in the Deficit Reduction Act of 2005. One advocate we spoke with who was active in the discussions noted that its criteria were designed to allow beneficiary control rather than provider control.

The background materials also review the different types of residential settings and their effect on the degree of beneficiary choice over their everyday lives. In general, smaller settings provide people with more autonomy and beneficiary preferences and satisfaction surveys report these settings are preferred, and they are the settings, of course, that MFP is focused on.

So we also talked with a lot of stakeholders who

noted to us that people who were residing in institutions can quickly lose access to their prior community residence, and so transitions back to the community require a significant investment of resources.

For example, a transition of services provided under MFP or other options can include having a housing coordinator who helps identify resident's options, provides lease assistance, also ranging from home modifications and the purchase of home goods like kitchenware and bed linens.

MFP is one tool that's available to transition beneficiaries. States can and do build transition services into other HCBS programs, such as waivers. These options do not have the restrictions that are in place under MFP in terms of the settings. So they are available but not incentivized in the way that MFP is for small settings.

So, in outlining the rationale for this policy option, the Commission could in its report describe the advantage of the criteria and focusing on small and highly integrated community settings, again, could emphasize that other Medicaid authorities can be used to transition beneficiaries without restrictions but aren’t rewarded with the additional funds provided under MFP.

The report could also discuss how MFP could incentivize states to shift their HCBS programs towards smaller residences, and it could also outline some of the disadvantages of this option, which is primarily that the pool of eligible settings is limited, and states have to administer two standards for HCBS settings.

In terms of implications, because this is the current status quo, we really don't predict an effect on spending or changes in administration. We'd expect similar numbers of transitions to continue and that beneficiary residences will continue to be limited to the settings under the current criteria, which again seem to be congruent with some of the satisfaction surveys and beneficiary preferences that we outline in the report. This would, of course, have no direct effect on plans and providers since it is the status quo.

Next, I'll move on to the second option which is to align the MFP criteria with the HCBS settings rule. As we've discussed in prior months, the settings rule establishes a threshold for all HCBS settings, both residential and nonresidential.

The intent of the rule is to ensure that HCBS

settings are different from institutions, and settings with characteristics that isolate beneficiaries from the broader community of people who don't receive HCBS will be ineligible for Medicaid HCBS payment after March of 2023 unless those characteristics are sufficiently mitigated.

So, in our interviews, we talked to a number of states, several of which predicted that they would be able to make more MFP transitions if the requirements were aligned, and this primarily revolved around larger congregate settings, those with more than four unrelated persons as well as expanded options for assisted living with some of the requirements around things like having a full kitchen being removed.

Some interviewees said that any setting that meets the needs of an individual's person-centered plan should be permitted, and some stakeholders also said that having a single definition of HCBS would avoid confusion and operational challenges.

The Commission could make this recommendation that the MFP qualified residence criteria be aligned with this settings rule. Again, this could open up more settings to HCBS transitions, like larger congregate

settings, as long as they meet the requirements of the rule and removing those restrictions that can prevent some transitions to assisted living.

The disadvantage of this option is that it removes MFP's focus on the smaller settings that have some of the greatest opportunities for autonomy.

In terms of the implications, first, for federal spending, we did consult with our colleagues at the Congressional Budget Office and thank them for their time. It was their assessment that this could change the timing of federal spending but that over a 10-year budget window, the effect would net to zero.

This could also be easier for states to administer. One of the states that we spoke with talked about having a common definition among stakeholders, including assessors and managed care plans would be beneficial and allow their operational processes to be the same.

The implications on beneficiaries are that there could be more transitions, and then we wouldn't expect a direct effect on plans and providers. It's hard to say really how many transitions would go to new providers since

they may have already received transitions but not with the enhanced MFP funding in the past.

In terms of next steps, today you can all decide whether or not you'd like to make a recommendation, and either way, I'd be back with a presentation of a draft chapter in January. And if you do decide to make a recommendation, there would be a formal vote at that time, and then the expectation would be that we would be publishing the chapter in the March report to Congress.

With that, I'll turn it back to the chair.

CHAIR BELLA: Thank you, Kristal. I appreciate you laying that out so clearly.

I'll turn to Commissioners for comments. We have a pretty clear question in front of us. So, if you could frame your remarks, recommendation, and know what you're thinking, that would be helpful.

Martha?

COMMISSIONER CARTER: Thank you for laying out those policy options.

My default tends to be the option that best suits the individual. So embedded in that is that there has to be a good system for individualized care plans.

Unfortunately, though, it's unclear to me of the various recommendations, then, which is best because what's really best is what's best for the individual. So I think I'm in line with laying out the pros and cons of each option and stressing how important it is that the care is individualized.

CHAIR BELLA: Thank you, Martha.

Darin? And then, Dennis, I'm going to go to you after Darin, if that works.

COMMISSIONER GORDON: Yeah. I'm leaning toward Option 2 for some of the feedback that you hear from stakeholders and some states about aligning that criteria because my sense -- and by all means, correct me if I'm wrong, Kristal, but allowing that alignment doesn't necessarily -- you know, the way that I know the process works at least in a few states doesn't mean the member doesn't have a choice. It just creates more options or choices for which to offer a member that's in a transition from an institutional setting. So because of that, I do believe offering more choices, the alignment, the potential for more people to be assisted with MFP, I'm aligned more with the Option 2.

CHAIR BELLA: Thank you, Darin.

Dennis?

COMMISSIONER HEAPHY: Yeah. I am really opposed to Option 2, and there are a number of reasons. One is it's important that we not water down Olmstead. We need to avoid medicalizing Olmstead using terms like care goals or treatment and really go back to the fundamentals of Olmstead, which were based in Plessy v. Ferguson, separate but equal is not equal, and all of a sudden, it comes to result -- it came to result in a lawsuit in which people with disabilities were deprived of the right to receive service, the most integrated services, at least in the most integrated settings. This really reduced what all of this about to like a medical model.

I think it's on page 16 and 17 of the memo, and it says, at noted above, individuals living in their own homes or family home have the greatest community living in choice and outcomes across HCBS settings. Group homes with fewer residents offer more economy community integration, and assisted living facilities vary significantly -- create a standard to ensure that beneficiaries have privacy and choice, but that control -- if the control is within the

living facilities themselves and not with the individual.

So it would really be -- and my personal opinion is we'd be flipping Olmstead and giving the power over to the living facilities and to the medical system as opposed to really doing what's supposed to be doing, which is really providing control and putting that in the hands of the folks with disabilities who this is meant for.

CHAIR BELLA: Thank you, Dennis.

Martha?

COMMISSIONER CARTER: Can we see the policy options?

CHAIR BELLA: Yeah. Can we go to show the policy options on the slides, please? So can you to go Policy Option 1, please?

DR. VARDAMAN: Sure.

CHAIR BELLA: Thank you.

So it's basically maintain --

COMMISSIONER HEAPHY: Correct.

CHAIR BELLA: -- align, or again, we don't have to make a recommendation. So, Martha, does that answer your question?

[No response.]

CHAIR BELLA: Okay. I feel like in trying to find the slides, I missed someone's hand. If you would like to speak, can you raise your hand again?

Heidi.

COMMISSIONER ALLEN: So, as the conversation last month and this follow-up has been really helpful, I want to thank the staff for that.

In the briefing materials on Option 1, it says, as we discussed in October, Money Follows the Person transitions have declined in recent years during uncertainty and Money Follows the Person program funding. Can somebody remind me why the program funding is uncertain? If we were to pick Policy Option 1, would that uncertainty grow? Would it stay the same? Would we expect to continue to see a decline in the use of the program, or would we expect it to stay about the same?

CHAIR BELLA: Kristal, can you take that?

DR. VARDAMAN: Sure. So MFP has been funded in a number of pieces of legislation, and it's usually for a certain period of time. There was a time where the last authorized year was fiscal year 2016, but states have, under the DRA, four additional fiscal years to spend those

funds, and so, based on that timeline, the expiration of the funding was to come essentially around the end of 2018, states were supposed to have stopped transitioning beneficiaries.

But Congress has since then extended first with short-term funding. So there were times, there were only a couple of months of additional funding that was extended, and then enough funding to take the program through fiscal year 2023 -- during that time, some of these short-term extensions -- and now having it reauthorized through 2023, but again with perhaps a couple additional years to use those funds, during that time, there's been this uncertainty because it wasn't clear sort of at each point for how long MFP was going to be extended or whether it was going to be extended with new funding.

So, because of that, when we talk to states, they mention that it's hard to maintain transition coordinators when the funding is running out and they weren't sure whether Congress was going to grant new funding. So, at that time, they may have lost staff to support transitions, and again, they were expected to wind down transitions for the time when it wasn't clear that MFP was going to be

extended.

COMMISSIONER ALLEN: So just a follow-up question, then. If we were to support aligning these two criteria, would that produce more consistency? What I'm trying to understand is if it isn't aligned and there's concern about funding mechanisms and you're working for somebody to get them transitioned, you may have to put a pause on that until you're more certain of the funding; whereas, if it's aligned, couldn't you use the other funding to continue to move forward? Does my question make sense at all? I'm just trying to kind of understand whether or not it would create a more steady stream of people moving into community settings if they were aligned, even if the funding for the specific program was less secure.

DR. VARDAMAN: So the MFP program, it is authorized for a certain pot of funds, and so, as we discussed in terms of our discussions with CBO, overall, it wouldn't have an effect on funding at all because it is authorized for a specific pot of money.

It could mean that if states transition more beneficiaries sooner, they could be drawing down their

awards of it faster, but overall, there is really a pool of money that's available for MFP, so that wouldn't change.

I'm not sure if that answers your question. I saw Anne's hand up. So I don't know if she wanted to jump in too.

COMMISSIONER HEAPHY: This is Dennis. I'm sorry.

EXECUTIVE DIRECTOR SCHWARTZ: The extra amount of money through MFP specifically to support transition is not really affected by where you can transition to . The value is adding those extra supports. That's a separate issue and there's been a lot of effort to sustain the funding. So that's not the issue. If MFP were to go away, I think most states would consider that a loss, but they would still be able to support people under HCBS settings rule if they could figure out how to get someone out of an institution and into another place. So those really are sort of separate issues.

COMMISSIONER HEAPHY: I just wanted --

DR. VARDAMAN: I also noted earlier that states do have options to transition people through waivers, and so that wouldn't be affected by making changes to the criteria for MFP.

CHAIR BELLA: Dennis and then --

COMMISSIONER HEAPHY: One other piece of information -- I apologize -- and that is right now, nationally, the disabled community is really pressing for Build Back Better legislation to include MFP dollars consistently, and so these are ways MFP is central to the disability rights movement and something that's continually being fought for, and so I would not want to be part of a decision that would undermine or water it down what the disability community is really struggling for right now, legislatively and on all fronts. So I think to do this would actually be contrary to what the disability community is struggling for in terms of as a group fighting for its civil rights.

CHAIR BELLA: Thank you, Dennis.

Toby, then Tricia.

COMMISSIONER DOUGLAS: So I'm extremely torn on these policy options. We had a great discussion last time, and, Dennis, I really appreciated your perspective and again what you're saying. Still, I see both sides, and I think your last point, I would say as Commissioners, we have to take hard -- you have to balance all the policy

objectives and issues.

I would say we have to step back too, that there are many other rules within Medicaid that govern and protect around Olmstead, in addition to just Olmstead itself, and one of the big intents here is for Money Follows the Person to be successful and continue to increase transitions, and I fear that with staying in the same that we're going to end up without a program altogether.

So I would support Policy Option 2, with one change, though. I wonder, is there a way we can put some type of evaluation, something to evaluate? Because we don't know what we're talking about, hypothetical unknowns of what could happen. Why don't we evaluate? States, again, there are other protections, interests, as well as the advocacy that could be working as buffers to prevent some of these unintended consequences, and why not after five years with sunset or evaluate? So that would be my only tinkering.

CHAIR BELLA: Tricia? Thanks, Toby.

COMMISSIONER BROOKS: Yeah. So I think where Toby is torn here between these two options, what would be

helpful or me to hear or hear again, if I missed it along the way, as I understand it, if we were to align to the HCBS settings that we would have more options for beneficiaries, which always sounds like a good thing, and alignment with other parts of how Medicaid works is always a good thing.

My question is, who gets to decide where the beneficiaries go? What voice do they have? Because if they don't want to go into a slightly larger setting, do they have the right to say, "No. I'm not going to do that," or do states get to control this by potentially reducing the other qualified settings and sticking with what's in HCBS? Does that make sense as a question?

CHAIR BELLA: It does make sense as a question.

Kristal, do you want to make a comment?

DR. VARDAMAN: Sure. So I would say that the current rules around Medicaid and HCBS keep beneficiary choice at the center, particularly around the settings rule, and as Dennis has brought up, Olmstead as well.

I'm just thinking about an example we heard that was somewhat different, kind of in the other direction. We asked states, what happens if someone -- what happens when

it's difficult to find a placement that qualifies under the MFP settings rule? What happens with that person? Are they at risk of staying an institution, or can a state find another setting for them, just not through MFP? The response was that, yes, that transition coordinators and state would be helping someone find an alternative setting, which may not qualify under MFP, and that even if perhaps like a person chooses, they would prefer to have that slightly larger setting, that that is a choice that they have to make, and it would just be a matter of they wouldn't have the enhanced services and funding under MFP, but they always have the option to make that choice.

COMMISSIONER BROOKS: Thank you.

CHAIR BELLA: Dennis, do you want to make a comment on that? Because I have to admit that's what -- I mean, it does seem like at the end of the day, there is a choice. Is the sentiment in the community that it's a false choice, or how is that --

COMMISSIONER HEAPHY: Exactly right. That's exactly what I was going to say. It's a false choice, because if you limit the choices, then it becomes either stay in a large institution or go to a setting that you

would prefer not to be in, but it's not as bad as being in a large institution. So the choices are really there.

I guess what this as well will be perpetuated inequities in where people go. Will we see certain populations be in settings that are less than institutions, large institutions, but still are institutionalized in terms of people having to do things at the same time and around meals, around going outside for -- and engaging in the community? We can see reduced choice in those settings, in fact, in certain populations or other populations.

CHAIR BELLA: Kristal, based on everything you heard, if we were to do Number 2, what problem are we solving? I've lost sight of what problem we're solving. There are important views for both of these things, but it's unclear to me exactly why we would make a recommendation if there are strong views on both sides and if there's a massive problem that we're trying to solve today by making a recommendation, which Number 2 I'm asking about because that would be the one to recommend something different than we're doing today.

DR. VARDAMAN: Right. So I would say based on

interviews that we did, particularly with states, there are constraints on the settings that they can use to transition beneficiaries into, and so I think the strongest arguments that we heard was around -- you know, for some states, their HCBS systems are already oriented towards group homes and the congregate settings of a certain size. So I think last time we spoke, I mentioned a state that said that providers had found that five was the optimal size for sustainability, and so there are states where they felt like the constraints on the current settings didn't match with the market that's available in their state, and so this would allow transitions into those settings. I think that that is the biggest implication for across what we heard.

We heard mixed views, I think, from the beneficiary perspective, with some feeling strongly that the settings should remain the way they are under the existing qualified residence criteria. There were some who said that if these settings rule were enforced as strongly as possible that they were comfortable with aligning the criteria, but they had some reservations about how the rule is being implemented. And there were others who felt like

there are settings that, again, as long as something needs someone's person-centered plan, that is a true choice for beneficiaries that it should be open to all settings under the settings rule.

COMMISSIONER HEAPHY: If I could just add one more piece, based on Massachusetts and other states. The number one barrier to folks being in a setting of choice is really affordable housing. The housing market is really what stands in the way of folks getting access, and so the issue is not necessarily MFP itself, but having a choice of housing settings to go to. I just think that's important to raise here.

CHAIR BELLA: Thank you, Dennis.

Can I just take the pulse of the group? I'm going to ask for folks -- I need to ask folks, who wants to make a recommendation? A show of hands, please.

Maybe I'm asking the wrong question. Who wants to recommend Number 1?

Who wants to recommend Number 2?

Who is not sure if they want to make a recommendation?

Okay. This is a new -- I don't think I've had

this opportunity as Chair where we're kind of almost proportionately split among the three. When we have situations like this, we are generally not trying to force the will of the group towards a recommendation. So my inclination is that we have some more work to do before we could make a recommendation, and we could add to the debate and perhaps take this back up if we wanted to, but for now, we could fulfill our requirement by putting this information out, by putting both of these options out, by stating what we've heard, and by stating what those tradeoffs are. There's where I feel like we are, but does anyone strongly oppose that path for moving forward?

Laura.

COMMISSIONER HERRERA SCOTT: I'm not opposed, but to Martha's point early on, getting more information as to -- so we have comparison.

I would also say with COVID-19 ongoing and the challenges the congregate settings have created, is the timing the right time, given that we're still addressing COVID?

CHAIR BELLA: Thank you.

Brian? Brian, you're on mute.

COMMISSIONER BURWELL: I think that when we were directed by Congress to conduct the study or to evaluate this policy option, I think it was done partly because they thought MACPAC would be a better decision-maker on this sensitive issue than Congress itself or some other entity.

I think if we write a report back to Congress that doesn't come with a recommendation, it will be deferring this decision to some other entity other than ourselves. So I feel somehow, we won't fulfill the mission if we don't make a recommendation.

CHAIR BELLA: I'll just remind us, Congress is not shy about telling us to make recommendations when they want recommendations. So that is in the back of my mind too. I appreciate that point, Brian.

I'm going to actually go to the public. Martha, we can come back to you. I want to see if there's any public comment that we want to hear. So if we could see if there's anyone in the public that would like to speak, please raise your hand thing. We will call on you and reminder to folks that we have a three-minute limit on comments please.

PUBLIC COMMENT

* [No response.]

MS. HUGHES: No hands at this time, Melanie

CHAIR BELLA: Okay. Martha, over to you, please.

COMMISSIONER CARTER: I've been mulling over Dennis' comment on housing and also, of course, workforce and wondering how these bigger issues that are not directly Medicaid are tied into this question that we have before us and whether either of these options would somehow help those external situations. Would aligning the criteria improve because there may be more funding available? Would that improve housing options? Would it improve the workforce lack that we have, or is there anything else that we can -- I'm sort of broadening the pot here. Because it's not just alignment of policy, there's a lot more that goes into making sure that somebody is in the optimum housing situation.

Do we have any levers? Are any of our potential recommendations going to help that situation?

CHAIR BELLA: Anne, I'll let you speak to that.

I think, Martha, we have a very specific thing that we're trying to do here, and what you're suggesting is very important but a lot broader. We need to fulfill this

piece, and it doesn't mean we can't make more pieces as part of our other HCBS and community-based work, but, Anne, I'll let you comment.

EXECUTIVE DIRECTOR SCHWARTZ: Well, I think I agree with both of you. Martha has raised the workforce, and Dennis raised the issues around affordable housing, and then I think that it could be in this report, a mention that MFP transitions are, in part, a function of the capacity of the system independent of the MFP program itself. So we could mention those things without attempting to solve for those things as part of this report.

DR. VARDAMAN: And I'll just jump in to mention that when we talked to stakeholders, we did ask them about broader challenges to the MFP program, and those were the two things that came up time and time again, workforce and housing, which is reinforced by really all the work we've done on HCBS recently. So we would have comments to speak to from our stakeholder interviews about those issues.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie had to step away. So, Brian, why don't you go ahead.

COMMISSIONER BURWELL: So I've been very quiet

today about this decision because I come at this from a somewhat different direction in that I am supportive of Option 2 in the context of much broader HCBS system reform.

I believe that the MFP program is and was intended as a demonstration to focus resources and attention on persons who were in institutional facilities and do not have an opportunity to transition to the community for a variety of reasons, but I think states under MFP have learned how to develop the infrastructure needed to identify persons and institutions who would rather live in the community, setting up housing situations and support situations where they can be supported in the community. And I think it has been a successful program.

I now personally believe that having accomplished its objective, the MFP program should dwindle and fade away and just be mainstreamed into the HCBS system. I think one of the reasons why people were not being transitioned previously was the lack of resources, also a lack of capacity of states to have the infrastructure to do that, but with the ARPA funding, with the Build Back Better resources that may follow, I think there are both the resources and the expertise for people to continue to focus

on this on persons in institutions.

From reading the HCBS bedding plans that they're still -- many of the state initiatives do still focus on transitioning people in settings, in appropriate settings out of those settings, whether they're mental health settings, settings for elder persons or settings for persons with other types of disabilities. So I believe the settings rule was a set of rules to define what it means to be in a community setting, and that those rules were vetted extensively with a broad number of stakeholders. They may not be perfect. They may allow for settings that are not appropriate for some people, but I think those are the rules we have, and we should live by those rules.

We can change those rules if we don't think they're appropriate.

CHAIR BELLA: Brian, I'm going to stop you there. Thank you.

COMMISSIONER BURWELL: All right.

CHAIR BELLA: We just need to keep moving.

The issue at hand is whether we're making a recommendation and what we're putting forward on our MFP task by Congress.

I'm going to ask again. Is there consensus to support Recommendation Number 1? Please give me a show of hands if you want Recommendation Number 1.

COMMISSIONER HEAPHY: I do.

CHAIR BELLA: Show of hands for Recommendation Number 2, and show of hands for no recommendation.

Okay. We are in the same spot. I would like to suggest that we -- we need to bring this to closure. It does not mean that we can't talk about the settings rule. It does not mean we can't continue to talk about MFP. It does not mean we're not going to be very involved in issues about making sure people have choice and can be in the community, but for this specific assignment, we need to bring it to closure. So I am again recommending that to bring it to closure, we move forward putting out all of the information we have gleaned, indicating what possible options we deliberated, that we didn't choose one, but that these are the considerations.

And if Congress would like us to come back and make a decision of a recommendation, they also have the liberty to ask us to do that. But does anyone have concerns with that approach?

COMMISSIONER HEAPHY: Melanie, I'm wondering if it's also possible in the recommendation that we would like to look at another way to approach this issue, so that we're not done with it yet, but that we want to explore other ways of examining MFP within a larger context of deinstitutionalization.

CHAIR BELLA: I think we certainly can talk about that in the chapter. Thank you.

COMMISSIONER HEAPHY: I just wonder if Kristal thinks that that's something.

CHAIR BELLA: I'm going to say that we're not going to try to put another recommendation on the table right now.

COMMISSIONER HEAPHY: Okay.

CHAIR BELLA: But it certainly is something that we can mention in the chapter as part of what came up.

Heidi for the last comment, and then I'm going to wrap this up.

COMMISSIONER ALLEN: I was just going to say if asked to choose between Policy Option 1 and Policy Option 2, I pick Policy Option 1, but I'm totally fine with what you described as Policy Option 3, which is just producing

the chapter and talking about the nuances of issues.

CHAIR BELLA: Okay. And I don't want people to feel like it's just a cop-out. We've talked about this several times, though, and we're in pretty different places, and so we can always come back to this work, but we do need to fulfill this specific piece.

Kristal, do you have any last comments or questions for us?

DR. VARDAMAN: No. That was a really helpful discussion, and we will definitely take it into consideration as we try to present both the advantages and disadvantages of maintaining the existing criteria in the chapter so that people understand both sides. Thanks.

CHAIR BELLA: Okay. And we will have a chance to look at that chapter as well, which will be helpful.

Absent any other comments from Commissioners, we're going to wrap up this session. We've already asked for public comment. We're going to come back at one o'clock. So I would ask everyone to please return promptly at 1:00 p.m., and we'll see you then. Thank you.

* [Whereupon, at 12:07 p.m., the meeting was recessed for lunch, to reconvene at 1:00 p.m. this same

day.]

AFTERNOON SESSION

[1:01 p.m.]

VICE CHAIR DAVIS: Let's get started. Hi, everyone. Thanks. Welcome back, everybody, from lunch. We'll get started with our afternoon session here. We have a great panel of folks who are going to be joining us, and this is continuing our conversation on access monitoring.

The Commission will remember that we've been taking multiple bites at this apple. We had a panel in September and then again in October, and today we'll be focusing on design implications and hearing from state considerations in that process.

We have four panelists with us today. We will have questions for the panelists, and then we'll have some time after that just for the Commissioners. Just a reminder, we will have some more time tomorrow to talk additionally about access monitoring, bringing it into the conversation that we've had earlier in the year.

So, with that, I will turn it over to Linn to introduce our panelists and get us started.

[No response.]

VICE CHAIR DAVIS: Linn, you're on mute. We can't hear you.

PANEL DISCUSSION: DESIGNING AND IMPLEMENTING AN APPROACH FOR MONITORING ACCESS TO CARE AMONG MEDICAID BENEFICIARIES

* MX. JENNINGS: Thank you.

Good afternoon, Commissioners. This cycle we've been focusing on the current approach to monitoring access and considerations for designing and implementing a new access monitoring system.

In September, staff presented background on the current access monitoring systems in Medicaid, and in October, we focused on the data available to monitor access, and an expert panel discussed the data gaps and limitations and approaches to addressing these gaps.

Today we'll focus on the challenges with the current access monitoring system and the design and implementation considerations for a new system based on funding from stakeholder interviews, with states, CMS, plans, providers, beneficiary advocates, and experts. We'll also hear from another expert panel, and they'll

provide additional insight on considerations for designing and implementing a new system.

Jim, if you could just switch to the next slide. Thank you.

So, to begin, I'll give an overview of the challenges with the current access monitoring system.

If I can get these slides -- sorry about that. Great.

So, to begin, I'll give an overview of the challenges with the current access monitoring system. These challenges have been discussed in prior MACPAC work as well as in comments on the current rules on access monitoring and in our stakeholder interviews.

One of the key challenges with the current system is that the requirements differ by delivery systems. There are two rules for monitoring access, one for monitoring access under fee-for-service and one for ensuring provider network adequacy under managed care. Both rules were designed to provide states and plans with the flexibility to design adequate access and to design measures to assess access rather than providing states and plans with standardized measures. This has also led to inconsistent

measure development, and by having two separate rules with different requirements and built-in flexibility, the measures don't align and aren't comparable across states in delivery systems.

Additionally, as discussed in October, there are many gaps and limitations with the existing access data, and states measure access based on their states' data availability and their priorities. This has led to a limited amount of actionable information on access measures of key importance to the programs and to beneficiaries.

Next slide. In our interviews, stakeholders discussed the roles and responsibilities of CMS, states, and plans in the design and implementation of a new monitoring access system in order to address some of the challenges with the existing system.

If we could just go one slide back to follow along. In designing a new system, interviewees generally agreed that CMS should take a primary role in designing the goals, requirements, and access measures for a new access monitoring system, but they should also solicit input from states and plans to design a system that's meaningful for them and to secure their support.

In collecting and analyzing of data, there was consensus that states should collect state-level access data focusing on existing data collection methods and measures that can be collected consistently across states. However, there was less agreement regarding who should be responsible for calculating and analyzing these measures, and states and experts noted that if states were to take the lead, they would need additional analytical and financial support.

In establishing benchmarks, the majority supported CMS establishing them, given that they would be useful for making comparisons across states and delivery systems, but there was less agreement over how they should be set, and some suggested CMS could calculate baseline measures over a multiyear period to provide a range of state-level results to determine reasonable and meaningful benchmarks for improved access over time.

A number of stakeholders also suggested that oversight mechanisms should be strengthened and that changes in the statute or regulation would be needed for enhanced enforcement. Stakeholders raised potential incentives for states to meet minimum requirements such as

public reporting, state rankings, and matching funds or loss of funding. Also, in our interviews, stakeholders supported having a safe implementation of a new access monitoring system to provide states and plans with ample time to establish processes and to collect and analyze data.

Now I am excited to introduce our four panelists, and I'll briefly introduce each panelist, and you also have their full bios in your materials. Each panelist will have seven minutes to talk to the Commission about their considerations for designing and implementing a new monitoring system, and after the panelists present, the Commission will have time to ask them questions. There were also be additional time after the panelists leave for the Commissioners to discuss these considerations and the roles of CMS, states, and plans in the design and implementation of a new access monitoring system.

First, we'll hear from Karen LLanos, director of the Medicaid Innovation Accelerator Program at the Center for Medicaid and CHIP Services at CMS. Then we will hear from Elizabeth Lukanen, deputy director at the State Health Access Data Assistance Center, SHADAC, at the University of

Minnesota. Then we'll hear from Abby Coursolle, a senior attorney at the National Health Law Program in the Los Angeles office; and finally, you'll hear from Jennifer McGuigan Babcock, senior vice president for Medicaid Policy, ACAP.

Thank you all so much for being here. First, I'll hand it over to Karen LLanos.

* MS. LLANOS: Sure. Thank you, and good afternoon.

I am really excited to talk to you all about some of our lessons learned and to share with you the work that we're undertaking. When I was first talking to MACPAC staff about this panel, I said, well, I can talk about my trouble with measuring access but not the approach because we haven't gotten there yet. In fact, we probably learned more about what isn't meaningful along with the types of data that we'd love to have but don't currently have, but that's a discovery in itself as well. So I'm sure many of you can appreciate that.

Before I delve into some of our work related to measuring access or using metrics to look at access, I wanted to take a few minutes just to talk about our center

and our agency's broader access goals and work because I think it frames things really well, and all of the findings that Linn just mentioned really resonates because it is things that we're thinking about.

Our overarching goal is that all eligible individuals can enroll and retain coverage through Medicaid and CHIP and that beneficiaries have access to high-quality health care services with a greater emphasis on health equity and improved health outcomes, and the way that we want to do that is by really improving equitable access for Medicaid and CHIP beneficiaries across all of our payment systems. So fee-for-service, managed care, as well as an HCBS service, community-based service programs, through the development, implementation of a comprehensive Medicaid and CHIP access strategy.

Since access covers so many assets of our work, we have the great opportunity to build off some of our previous activities, including work on our fee-for-service payment rule, which addressed access in some limited ways, our recent managed care regulations, and certainly all of the investments and progress that have occurred by states and CMS related to standardized data and measurement over

the last 10 years because that certainly plays a really big role.

I am batting away my kitten who is very excited about being on the call today.

The vision for our comprehensive access strategy is more robust probably than what we've used in the past when we think about access. So, when we think about three different domains in the elements for our comprehensive access strategy, we think about how someone gets on to health care, so access to coverage. Once they're on, we look at access to services -- and that has a bunch of different corresponding domains as well -- and then also maintaining coverage because if we don't have someone in all access, a focus on access across all of these domains, then we don't really have true access. We have a little piece of that perspective, but we want to make sure that we're capturing access through our strategy and our activities in a way that really corresponds to how folks get on to coverage, get to services, and maintain coverage and all of the access barriers and challenges that are associated with that.

Within each of these domains, we know that as we

start thinking through and assessing what the current regulations are and where we want to go, we know that there is a need to focus on, most likely, accompanying regulatory, monitoring, or compliance actions, which sounds very relevant to what MACPAC has found, in order to ensure that health care access is achieved and maintained.

Within that access to services domain that I just mentioned, I will say it's pretty complicated. The way that we're thinking about this is to really leverage the Urban Institute's Medicaid access and measurement monitoring plan framework. That does a really nice job of thinking about access to services in ways that are important and meaningful and impactful. So they look at potential access. So that is provider availability and accessibility, which is tricky from a CMS perspective because we don't necessarily have all of those data available. They look at realized access, which is beneficiary utilization. There, we tend to have a little bit more metrics than data through the COVID-19 data and related foregone payer datasets, through our traditional quality measurement core set work, and then finally perceived access, beneficiaries' perspective and

experiences. And that feels like it gets really impactful and meaningful, and certainly, we have tools like consumer patient experience surveys, HCBS CAHPS surveys, and those types of things that can help us get to that type of perspective a little bit more than before. So, when we think about access to services, that's what we mean, and that's where we intend to really kind of delve down into that.

So that's the high level of our approach to developing a comprehensive access strategy. It sounds super simple, but where do we begin to tackle a really large and complex topic like this and do it in a way that is truly comprehensive?

We've recently developed an RFI that will be released on Medicaid.gov mid to late January, and in the RFI, we ask questions related to that broader access strategy, so the access to coverages, access to services, maintaining coverage. In the RFI, we don't specifically ask about how to measure access, but rather, we ask about the data needs and the support that can aid states and CMS in assessing access. And we really wanted to make sure that we were capturing a broad range of questions, and when

it gets to asking about specific measures, that doesn't always have the best outcomes in an RFI. So we have other avenues to do that.

In addition to the RFI, we'll be working on other activities to get a better beneficiary -- a sense of beneficiary perspectives and barriers to access because, again, it's a little bit one of those topics. It's a little bit harder to get through an RFI.

The last thing I wanted to cover that I think is particularly relevant for your conversations today is another short-term activity, and that is our work on an access data brief. At CMCS, we wanted to see what we could say about an aspect of access with the data we currently have. This access brief is not meant to be an access measurement set. We really want to see what's the story that we can tell through the data that we have and think of and using that to help us understand what additional data do we need. Is this helpful in terms of a message?

We had been working with NAMD Scorecard Advisory Group, which is a group of state stakeholders that have been incredibly helpful to CMCS on measurement-related discussions about the scorecard. They really focus on

impactful, meaningful measurement, and that's exactly the type of feedback that is going to be really relevant here.

So, first, in terms of starting, we pulled a range of measures that looked at utilization in different ways, patient experience service data, looked at quality measures such as avoidable hospitalizations as a potential marker for access to primary care, and the initial feedback was you're trying to cover too many aspects of access. Focus on a population or a clinical topic where we know access issues are present and to see where those benchmarks are. Start there, which is not an easy task either.

So we've taken that information, and we've been revising it. Most recently, I led an access breakout session for NAMD with states and proposed this is what we're thinking about in terms of this access brief, again, to get a broader sense from our state partners in terms of measuring access, and this is, I think, really good feedback that can serve all of our work in this aspect.

The most important aspect or indicator of access that state groups said was true provider availability, not what's on paper but real wait times. Certainly, we've all heard states that had been using EQRO's EQRs, the secret

shoppers. One state noted that they have a full-time employee whose only job is to call providers to assess their true wait times, and we also know that states are struggling with accurate provider directories. And that certainly speaks to that piece of access to care, that potential access to services that I referenced a little bit earlier. That feels, based on some of the feedback that we've gotten so far, as the really meaningful pieces of data and measurement that can talk about access.

In addition to that, I probed a little further and said, "Well, what about all of these review centers that we have? Can we use that? How is that meaningful?" Certainly, we can use it, and again, this is limited feedback that we've gotten. But some of the feedback was the more traditional quality measurement, as we all know, is point in time, and those measures tend to be limited when it comes to being actionable on things related to access. They wanted us to focus more on outcomes measures, which are few and far between but not completely unavailable. They, again, reemphasized true wait times as being a really helpful indicator, and then they also raised the issue of data that needs -- availability of data

stratified by race, ethnicity, urban/rural, gender, et cetera, as being able to add that other layer that can potentially provide an additional perspective into access.

The final thing that I'll share is that we've seen so much about how telehealth has impacted health care access during the PHE. Some of the states shared that telehealth data, while really helpful, they may not be completely accurate. Some of our state partners are finding that the providers are not billing correctly. So the numbers of their telehealth data might not be the best way to look at improved access.

The last point I want to underscore is when it comes to access, measurement is truly helpful if it gets to the most meaningful measures and the most meaningful issues, and that's certainly something that I'm sure everyone would agree with. And those tend to be mainly around beneficiaries' experiences with accessing care; for example, getting and maintaining access to health care, being able to see a doctor and certainly your experiences while in that doctor's office.

That gives a little bit of glimpse into what we are hearing and what we're struggling with and our

challenges, and I want to thank you for the opportunity to share how we're approaching this big, complex, and very important topic of access.

MX. JENNINGS: Thank you so much, and now I'll hand it over to Elizabeth Lukanen.

* MS. LUKANEN: Thanks, Linn. I just want to thank the Commission for the invitation to participate in this discussion.

I'm going to talk about consideration and challenges that states might face in implementing an access monitoring plan, and the topics I'm going to cover today are based on SHADAC's experience providing technical assistance to states, which gives us a unique view into the day-to-day issues and barriers that states encounter related to those issues. However, I want to stress I can't speak on behalf of all states. As you know well, every state is unique. They vary tremendously in their capacity to collect and process data, how they prioritize populations and even in the language that they use to discuss their goals.

As an example, we know that some states have entire departments dedicated to Medicaid data reporting and

analytics, and some have single employees responsible for it all. So any plan will need to be intentional about that state variation.

I'm going to present five points for your consideration today, each of which are guided by the same principle that any monitoring plan should seek to minimize burden on state agencies.

First, this is a simple one, but I think important, considering iterative approach. No measurement plan will meet everyone's perfect vision, but we cannot continue to let the perfect be the enemy of the good if we're going to move this monitoring effort from concept to reality. I would recommend a phased approach, one that starts with a limited number of measures and expands over time. This will require difficult tradeoffs regarding priorities, but I think these tradeoffs are worth it if the first iteration is achievable for a wide range of states. As the plan develops and more complicated measurement concepts are added, it should engage leading states by including them in conversations about the additional measures added and incentivizing them to participate in pilots that test the collection and analysis of data so

that they can share concrete implementation lessons with other states.

Second, and this has been mentioned many times, start by using existing data but also to support states to improve those data. At the last Commission meeting, MACPAC heard from an excellent panel on data availability. There are existing data streams to draw on, and while none are perfect, a successful plan should first focus on improving those. One tangible way to improve states' existing data is to support data disaggregation efforts. There's a renewed focus and energy to promote equity within Medicaid and calls from stakeholders to cede data about important groups of interest. This includes an interest in better data by race, ethnicity, sexual orientation, gender identity, disability, geography, just to name a few. Improving existing data streams to better support disaggregation is a good investment and one that will meet multiple demands.

As an example, T-MSIS will likely play a role in monitoring service use, but there are concerns regarding the existing quality and completeness of the race, ethnicity data. We have worked with several states who are

trying to improve the collection of their race, ethnicity data in Medicaid. They're doing things like modifying question wording and expanding response options to better represent the populations they serve. They're making technical changes to better capture the data as well as modifying instructional language and even scripts for enrollment assisters to make them stronger partners in data collection, and they're doing all of this with community input.

But they continue to face challenges in this work. For example, current OMB standards for demographics are dated. They don't align with the most current research. In addition, rules for collecting race, ethnicity data are not uniform across federal programs. A new access monitoring effort could serve as further impetus for federal agencies to revise the guidance on race, ethnicity, and for states to take action to improve existing data collection to address this critical gap.

Third, states need both funding and direct technical assistance to support this work. This needs to go beyond documentation and uniform measure specification. To do this well, states should have access to experts who

can provide practical hands-on advice that's responsive to their specific needs. The type of assistance needed will vary. I can envision states with sophisticated analytic teams seeking out advice on how to improve the collection of underlying data, like I just discussed, or asking for sample code or help troubleshooting a particular coding challenge, but other states may need more fundamental support like just walking through the requirements to assess staffing and training, setting priorities, help developing contract amendments or writing RFPs. Based on my work, I'd also recommend that any TA effort include a form for states to discuss implementation challenges with their peers. This seems pretty basic, but some of the most impactful technical assistance I have provided, just setting up a phone line so that states can communicate with one another.

The funding associated with technical assistance should also be flexible. It should support direct costs like system modification but also things like stakeholder engagement, which is critical both to iteration and improvement of the monitoring plan and related data collection but will also allow the results of this

monitoring to be shared in a meaningful way.

This effort could also be used to address what many states often ask SHADOC for: people, people power, staff, staff with the right expertise to actually do the analytic work.

For example, I can envision a prestigious program like the Presidential Management Fellows Program but one that places new graduates in state governments. This would bolster state analytic capacity and create a workforce that better understands the challenges and opportunities within state agencies.

Fourth, some areas of monitoring are just going to be best addressed through federal data collection. I think an access monitoring effort would benefit from a periodic fielding of the 50 state Medicaid CAHPS survey administrated by the federal government. The federal government has a long and successful track record of fielding high-quality surveys that produce 50 state estimates for all states, including a one-time national Medicaid result task survey. To me, this seems like the most efficient way to collect comparable information on important facets of access like the enrollee experience and

a starting point for comparing individuals enrolling in fee-for-service versus managed care.

Finally, it's critical to treat states as a full partner in this process. It goes without saying that they should be consulted in the development of the monitoring plan, but they should also be consulted when the data are being released, preferably beforehand. Ideally, they should have access to analytic files so that they can do their own data run and share customized findings with stakeholders. We often hear from states that they are the last to know when reports using their data are published. This is a demoralizing place to be in and does not incent engagement in the process, but the only thing worse than being surprised by the release of data about your state is to spend time and resources submitting data that never sees the light of day. So, once the data are collected, there should be a commitment that these data are published or released in some format and in a timely manner.

With that, I will conclude and just want to thank you again for the opportunity.

[Pause.]

MX. JENNINGS: Sorry about that.

Next, we'll have Abigail Coursolle. Thank you.

* MS. COURSOLLE: Thank you. Thank you so much, and thank you to the Commission for having me here today.

My name is Abby Coursolle, and I am with the National Health Law Program. We are a public interest law firm that protects and expands the health care rights of low-income and underserved populations. For over 50 years, we have advocated for and defended the rights of low-income individuals, particularly Medicaid beneficiaries to access medically necessary services in a timely and affordable way. So I'm here to provide a beneficiary advocate perspective on access.

I wanted to start by emphasizing that before the end of the public health emergency, I really want to encourage us to look at the data we've collected and determine which flexibilities have supported an expanded access, such that we should continue them even when the emergency ends, and of course, we also need to make sure that states have strong processes in place to review eligibility and ensure that people are not improperly terminated from Medicaid, because one of the largest barriers to access we see is actually issues with

eligibility and people turning on and off the program, which, of course, has a huge impact on their access to care and their health outcome.

We're really pleased to hear today again, CMS affirming health equity as a core value in its Quality Strategy that calls eliminating racial and equity disparities a foundational principle, and access is really a key component to ensuring that we achieve our goals with respect to health equity.

Already, there are many gaps that my colleagues have mentioned in the data that could help us home in on access disparities. So however we're measuring access, it's really important that we consistently collect and monitor demographic data, which is really crucial not only to addressing access but also to our larger vision of making Medicaid more equitable.

From a beneficiary perspective, equity also means thinking about access beyond just things like time and distance standards, provider directory accuracy, or appointment wait times. So those things are all extremely important, but for example, we also need to think about facility accessibility. For example, here in California,

we have a very detailed facility site review tool that the state uses to evaluate -- the state or plan, I should say, a view to evaluate the physical accessibility of the providers who participate in the managed care program and also to designate the accessibility features in the provider directory so people with disabilities know in advance whether they will be able to physically access a provider's office.

Similarly, language. For managed care, of course, we already have a requirement to designate language that's spoken in the provider directory, but there's no real requirement that the state or plan ensure a competency in the language. In addition, it's just not going to be possible to have providers in every specialty who speaks every language. So there's also a need for robust programs in place to timely arrange and coordinate interpreters so that access isn't delayed due to problems securing an interpreter.

Finally, cultural competency. Too often, Medicaid beneficiaries have a negative experience with a provider who fails to provide culturally competent care, and that discourages them from seeking care at all. For

example, transgender beneficiaries will see a provider who uses the wrong name or pronouns, ask invasive clinically irrelevant questions about their genitals, and they decided that it's better to go without care than to continue to experience trauma. So part of access is really ensuring that Medicaid programs have robust systems in place to train their provider and provider staff to ensure that all beneficiaries receive appropriate and culturally competent care.

From a beneficiary perspective, we believe that when it comes to access, we really need a strong federal role and consistent national standards. Access needs do not depend on where a person lives or what delivery system they're enrolled in. Thus, we recommend that CMS establish a framework and set a floor for access. CMS should collect data from states and make it publicly available and easily understandable so that people can see and understand what is happening in different states with different plans and in development delivery systems. CMS also has a role to play to work with states on monitoring access and ensuring that appropriate, timely, and corrective action is taken where there are access problems, and of course, the process

to establish such a framework should involve input from key stakeholders and should be public and transparent.

At the same time, any approach to measuring and monitoring will need to account for the wide amount of variation at the state and local level. We have different delivery systems, different models, different enrollments, different carveouts, different specialty plans, et cetera, but regardless, monitoring must be robust and ongoing. But, as my colleagues have mentioned, there is a lot of work that has already been done that we can build on; for example, HEDIS measures. We should look at the measures that exist and that states are already using and also acknowledge that there are limitations to those measures. They only capture data for people who have been continuously enrolled in the program, and as I mentioned before, eligibility churn is a huge factor and a huge barrier to access. So those measures aren't even capturing data for people who are going on and off the program.

Also, HEDIS measures tend to be focused on process, since that's easier to measure, and as my colleagues have mentioned, ultimately, we need to develop data measures to measure real health outcomes and hone in

on access for key populations such as people with chronic health conditions and people with severe behavioral health conditions.

Time and distance standards are very useful and relatively easy to measure and track. They're also really easy for beneficiaries to understand, but this is an area where we need to make sure that exceptions do not follow the rule. Exceptions should be limited to situations where there really is not a provider available within the time and distance standard.

Grievance and complaint data. This is another area that is necessary but not sufficient. We know that for every person who files a grievance, there are probably 10 more who have the exact same problem but never makes a complaint about it, and unfortunately, when it comes to access, in many places, beneficiaries have just become used to a broken system and don't even think to complain unless the access problem they are experiencing is incredibly severe. So any number of smaller access problems never result in a complaint or a grievance, and as I mentioned above, there are people who just become so traumatized or frustrated by their experience with the system that they

give up on seeking care completely. So it's really important to look at grievance data, and that can be a good way to identify trends, but by itself, it's not enough.

Of course, we need basic information about what providers accept Medicaid or accept a particular plan, how many are accepting new patients, what is the scope of services that they offer, and we have to set benchmarks to ensure that the provider network is acceptable and offers a full range of covered services.

Many states and plans ought to use secret shopper surveys to assess the availability of their providers, and that's a really important tool since it closely approximates the beneficiary's experience of trying to get a service. It could be a way to uncover so-called "guilty networks," if it doesn't do a beneficiary any good if their providers who accept Medicaid or their plan in theory, but there's no real way to reach them or make an appointment to access care. So secret shopper surveys are important to uncovering those kinds of barriers.

But it's also important to move the systems that track this data in an ongoing way and tell us when did somebody request an appointment and when was it actually

scheduled so that we have that ongoing data about timeliness instead of just appointed time snapshots.

Finally, as we continue to work on ensuring that we are monitoring and enforcing beneficiary's right to access covered services, we really need to move to an intersectional approach where we think about access holistically. Again, it really doesn't do a beneficiary good if there's a provider right next door to their home, but that provider never has appointments available or cannot coordinate with an interpreter to offer services in a beneficiary's language or doesn't offer the specific service that a beneficiary needs. So measuring and monitoring each individual component of access is crucial, but ultimately, we need to make sure that all of the pieces fit together.

Thank you again.

MX. JENNINGS: Thank you so much, and finally, we have Jennifer Babcock.

* MS. BABCOCK: Hi, and thank you very much for having me. I'm Jenny Babcock. I work at the Association for Community Affiliated Plans. I really feel privileged to be here and have greatly enjoyed hearing from the first

three panelists.

Quickly, ACAP is an association of, right now, 78, what we call, safety net health plans. These are not-for-profit, mission-oriented, and community-based Medicaid health plans. Most operate within a single region, within a single state, or they might be statewide in that state, but they are finite in terms of their reach across this nation. That said, they do operate in 30-plus states across the nation, and while they might be smaller individually than the big national plans, collectively, they represent about 30 percent of everyone that's in a fully capitated managed care plan. So, again, I'm thrilled to be here.

After listening to my colleagues speak, I realize that my remarks are about to come off as a combination of practical and aspirational. The plans do really have concerns about how access standards and provider network adequacy standards are rolled out, and I'll talk to you about that. But we're also in a special moment in time, I think. We're focused on equity, and we should be focused on equity, and we're focused on a way to improve our health care system, particularly for people who get their coverage

through Medicaid and CHIP. And we have an opportunity, I think, collectively, to really make some progress here.

So my comments will focus on three main prongs. One, I think that an updated federal framework for access should acknowledge specifically where people with Medicaid coverage now are experiencing barriers to access and then strive to fix those barriers. Two, as we've heard from our colleagues, any framework should be both practical and usable, reflecting current realities, even as we consider a longer-term vision for improvement; and then, three, any framework should really reflect CMS's and our broader health system's broader goals related to equity, in particular, I think.

So, working on that first one, as we all know, this is not new work, and this is not a new conversation. All of us on this call have been talking about access and provider network adequacy and have been impacting that, I think, in our own roles for years, for decades, right? So I think we've heard from the other panelists that there are lots of things out there already right now that we can access to bring into a framework that will work, despite the gaps that do exist.

So I too am going to focus on something. Any of you who have heard ACAP talk about anything in any venue will have heard us talk about continuous eligibility and eligibility churn. It is our raison d'etre in many ways, and we have heard from all of the prior panelists that you don't have access to care for the most part in this country or access to appropriate care without access to coverage.

We know that eligibility churn in Medicaid and CHIP is a massive problem. We were thrilled to see the chapter, the report that came out of MACPAC in October, and have already made good use for it in our advocacy on the Hill. We've been working on this issue ourselves for a very long time. In 2020, for example, we commissioned a report from George Washington University that compared states with continuous eligibility for children in Medicaid versus those without and found that if all states were to implement a policy of 12-month continuous eligibility for children, which is now a state option, over 750,000 children would be more likely to receive a primary care or specialty care visit. This is something that leads to access.

So another thing that is already out there -- and

I think we heard Karen talk about this already -- is the fact that states voluntarily report on a long list of core measures, both for pediatric and adult populations. Not all of those measures are related to access, but some of them are, and many states are already reporting on those. On top of that, all states will be required starting in 2024 to report on every one of the pediatric core measures as well as the adult behavioral health core measures, and part of ACAP's advocacy is to encourage Congress to require states to report on the remaining adult measures as well. Again, some of those are access related and some are not, but this is data that is available in some way, form, or another that could be used now.

And I do want to piggyback on something that Abby said too. It's a very specific point, but it relates also to the equity question, particularly related to access to care for people with disabilities. Abby mentioned in California, there is a robust facility review process to ensure that provider sites, the sites of providers that are included in health plans' provider networks are accessible to people with physical disabilities. That actually is a federal requirement in Section 438.10(h) of the Managed

Care rule that was finalized in 2016. All managed care plans are required to include in their machine-readable provider network manuals a notation as to whether a provider site is accessible to people with physical disabilities. I don't know much about machine readability, but my understanding is that there might be an opportunity here to assess now how accessible Medicaid providers are for people with disabilities.

So my second prong is the federal framework should also be practical, reflecting current realities. Even while we keep an eye on our broader vision for access, any federal framework should be implemented based on what is realistic and practical, and we heard Elizabeth talk a lot about this. We should always be asking ourselves what can CMS and states and plans and provider actually achieve in the here and now, even as we look toward how we might improve things in the future, maybe a five-year or ten-year plan. This supports the idea that both the federal government and states should engage very closely. They're partners in development and implementation of access strategies. The federal government should, of course, treat states as partners, as we heard from Elizabeth, and

states must also recognize that input by health plans and providers is really critical.

You all know this, but 83 percent of the 80 million individuals who are covered by Medicaid are in health plans right now. So it bears mentioning. I would be remiss if I didn't mention this that actuarial soundness in plan rate setting is an important access issue. When actuarial soundness standards are not met, plans may be underpaid and may be led then to either encourage providers to accept inadequate payments, which is a common critique among policymakers who are concerned about Medicaid access, or drop out of networks altogether.

Also, ACAP agrees with the panelists who went before me that any federal framework or state strategy focus on a finite number of high-value measures or indicators, relying on those as much as we can that are already utilized for access monitoring, quality assessment, accreditation, or other uses.

As mentioned previously, the pediatric core measure set and the adult behavioral health measures, some of which relate to access to care, will soon be required of all states.

We also recognize that those measures, as Karen explained to us, are amended annually by experts, reminding us that as targets shift, so much how and what we measure shift. This is an important lesson, suggesting that an access framework should be expected to change over time as federal and state priorities shift, or also as existing goals are met, hopefully, leaving room for new goals.

Then lastly -- and this is also a point that Elizabeth made -- whatever is collected should be made available and usable in a practical way by all stakeholders. I have to say we at ACAP really do enjoy reading the scorecard every time it comes out, and we very much love watching as CMS issues its Chart Packs related to the pediatric and adult core measure sets. That's very useful to us, and I would hope that it's useful to other folks as well. It's a good model.

Very lastly, all of the prior panelists have mentioned the importance of focusing on equity. It goes without saying that the White House and HHS and CMS and every office have indicated their support for promoting equity and health care right now. So this is a time for all of us to support that.

In addition to those signals from the administration, many, many stakeholders from across the nation's health care system have also committed to addressing longstanding inequities based on race, ethnicity, LGBTQI status, and disability status. We think that to achieve this, it will be important for an access framework to start with a strong federal floor so that all states are at least encouraged to strive toward improving equitable access for people with Medicaid coverage. Such a floor will also allow for comparisons between states.

We also think that the federal framework should employ the same standards for fee-for-service and managed care Medicaid. A small number of people are still providing coverage through fee-for-service Medicaid, but allowing for comparisons will ensure that the access to care of all Medicaid and CHIP enrollees is treated as equally important.

So, lastly, we recognize that there are challenges in focusing on equity. Not least of these is the deficit in demographic data that we have heard the prior panelists discuss, and I can talk more about this in the Q&A section. But there are perhaps ways that we can

all work together to improve those demographic data, which are so foundational for assessing and addressing inequities and disparities.

So, with that, I'll stop, and I'm looking forward to your Q&A. Thank you.

VICE CHAIR DAVIS: Thank you, Jenny. Thank you to all of the panelists.

We will open it now to Commissioner comments and questions. We heard lots of synergy in the comments that you guys have made, especially around that floor of guidance from invest in the states and in terms of direction and need for collaboration and really a focus on equity and disaggregation of data across it.

But looking to Commissioners for additional questions to our panelists. I see Bob and the Laura.

COMMISSIONER DUNCAN: Good afternoon. I too would like to thank the panelists and their comments. I really appreciate that. Jennifer, I appreciate the aspirational because I think we need to be aspirational as we think about the beneficiaries that we serve.

First, a statement. As a parent of two kids with special needs, I heard the distance and time to appointment

and those things. So, as we think about access, I think we also have to think about kids with special needs, particularly complex, and we sometimes have to look outside the state to access those services and making sure that those are appropriate services and can be accessed.

But the real question I have has to deal with the pandemic that we're currently seeing, not with COVID but in the mental and behavioral health space. As we think about that and access to mental and behavioral health for kids right now, are there some measures that you have thought about? And I know we mentioned earlier, HEDIS and building on those, but we need to think about around mental and behavioral health will give us a better insight into our kids and families accessing those services that are so desperately needed now.

MS. LLANOS: Okay. I can kick off. I've got some reactions. I will say I think that, though, you've heard a lot about the child and adult core sets, and certainly when we're thinking about the children's side, a standardized measurement -- and again, this is the measure sets that are supposed to be voluntary currently, right? So they are not required. They do offer a starting point

to think about measures that could be helpful for not just CMS but health plans and other stakeholders.

There are several measures in there related to follow-up after hospitalization. It's probably not to the extent that you would think, and certainly, as part of our COVID dataset, we've released pretty regularly since the start of the pandemic, there are service utilization numbers related to mental health services for both children and adults.

I think that service utilization pieces are super helpful, but it doesn't have a benchmark. So you don't know if that IRO is where it's supposed to be, but it offers a good sense of whether or not care is occurring or services are being used.

So I think there's lots of starting points, Bob. I'm not sure the measures that I think would seem like they would be super more meaningful and impactful are ones that are used widely.

COMMISSIONER DUNCAN: Thank you.

MS. BABCOCK: If I could jump in, I'll say just something that you already know, Bob, and that is we consistently hear from our health plan members that gaps in

care are particularly egregious in a couple of areas. One, of course, is dental, and two is behavioral health, particularly for the pediatric population.

So I'm just suggesting that the problem is very real, and the solution has much to do probably with workforce issues as it does with measuring access, which is a bigger, also long-term situation.

We do know that a lot of our health plans have tried to bolster access to behavioral health care services by making use of telehealth flexibilities, both the flexibility that was included in the 2016 final Medicaid managed care regulation and now the telehealth flexibilities that have been sort of enhanced during the pandemic.

So one idea, of course, might be to extent the flexibilities, the telehealth flexibilities that are allowable under state plan amendment -- emergency SPAs or other policy.

VICE CHAIR DAVIS: Thank you. Going to Laura -- oh, go ahead, Elizabeth.

MS. LUKANEN: Oh, I was just going to add that, Bob, I think that you raised something that I didn't touch

on, which is there are going to be issues that are so complex, like children with special health care needs, that I'm not sure a standardized 50 state framework is the right place. I had a whole section that I removed because it gets into the details, but I think there are going to be areas where qualitative data collection really targeted efforts within states or maybe at the federal level that need to happen, because the sample is so small and the statistical power so small that it is not something that is going to lend itself well to comparability.

VICE CHAIR DAVIS: Thank you.

Laura.

COMMISSIONER HERRERA SCOTT: Yeah. Elizabeth, just building off of that comment and your presentation, one, are there any states that are doing it well today? That's one. Then, two, thinking about the iterative process you described in the existing data, are there any common denominators across the existing data that you could at least start establishing the floor, for lack of a better description, of access measures that we could start building off of?

MS. LUKANEN: Yeah. That's a really great

question. I would hate to highlight one state because I think, you know, some states are really strong because they have strong internal capacities. Some states are strong because they have excellent state-university partnerships. Some states are strong because they have great contractors that they pay to do the work.

I think the 2016 Urban Institute report that has been mentioned is a good place to start, and T-MSIS is a good place to start because, although it isn't perfect, states are contributing to that. So I think that and the core set measures -- I mean, I really think the Urban Institute report is a good place to start, but I think then that needs to be -- those specific things should be brought to states again, and input should be given about how many of these could you do on day one and have a really tough -- probably tough conversation about what is feasible on day one, what's going to need six months to a year for them to ramp up. But I think there has been some hard work already done, and that report is a great place to start.

MS. LLANOS: And I'll also add to that. When we have shared with our state partners most recently, some of the measures that we're looking at related to the access

data rate that I mentioned, you know, we got a lot of pushback on the fact that some of the access in states is very political, potentially, and very diverse in terms of the areas or the topics that are of interest.

We have very rural states where access and distance to service providers and things like that becomes much more important than in a highly populated city.

So I think some of the pieces to that -- and I completely agree with Elizabeth. Much like when we released the initial child and adult core sets, it was a phased-in approach driven by stakeholder input that we knew was just going to be the starting point, that it wouldn't be everything to everyone, but it was a good way to start thinking about a particular set of clinical topics. So I agree with that.

I would just underscore that some of our initial feedback is this is going to be a pretty complex topic to get to some of that common denominator based on the differences in the priorities that folks put on access across the states.

VICE CHAIR DAVIS: Thanks.

I see Heidi. Dennis, were you getting in line?

[No response.]

VICE CHAIR DAVIS: Heidi and then Dennis.

COMMISSIONER ALLEN: Thank you so much for these presentations. It's very heartening to hear that there's so much care and thought going into this issue.

I am a health access researcher who studies Medicaid, and I often ask myself why don't I study Medicare. Because there is so much data for Medicare.

I serve on the NIH study section for health care and health disparities, and I would say the vast majority of our proposals that use any kind of secondary data come from Medicare, and it's not because Medicare is necessarily the most interesting population from a health disparities perspective. They're certainly important, but they're not more important than people who are not elderly or people who are in the Medicaid program but because there's data. There's claims data. There's CAHPS data, and people can put together really rigorous study designs on a fixed budget, on an NIH study-like level to do a rigorous evaluation of an issue with Medicare.

What's disappointing about that is that Medicare doesn't have a lot of variation. It's a federal program,

and Medicaid is our learning lab or what we like to think of as our learning lab for a lot of issues, including health equity, and yet the complexity of doing any kind of rigorous analysis using a Medicaid population and the cost is prohibitive.

I'm right now trying to get IRB approval for six states and New York City for a data collection effort and to put in data use agreements for each of these states, and it's extremely hard. It's extremely complex, and it's extremely expensive.

I'm just so curious why there's been such a robust investment in Medicare with so little investment in Medicaid, and particularly from evaluating health equity, there's so much information that we can't get at all like the uninsured and people who move from being uninsured into Medicaid.

A lot of us will try to use claims data, like all payer claims databases to try to benchmark access for commercially insured populations to Medicaid populations, but the uninsured aren't in those at all. So you can't even see what happens when somebody gains coverage and moves into one of these programs. And you only see care

received. You don't see any deferred care or care needed.

So I'm just curious to hear what you think would be a real radical but substantive set forward in having a national research agenda focused on access to care in Medicaid.

MS. LLANOS: I mean, I would say, I think, just based on the fact that we're having these types of conversations, MACPAC is focused on this pretty strongly, and certainly, at CMS, we've been talking since early summer on what we're doing as it relates to this. So it feels like something more tangible, certainly our agency's full force of work in these areas. I can't speak to the funding piece.

But I will say that many of us have worked in Medicaid measurement for a really long time. Things have happened slow and quickly at the same time. It feels very slow, but if you look back over 10 years, it feels like a lot has happened, particularly around the advent of T-MSIS, robust T-MSIS, the T-MSIS analytic files and those types of things. Certainly, from a standardized measurement piece, we don't compare quite the same level of detail and range that Medicare measurement has available to it, but we've

certainly come a long way. It's just a little bit harder because our populations are more complex. It just takes a little bit more time, data, and availability, slows down the measurement process and the testing process.

I'm not sure I answered your question, Heidi, but I feel like we get some credit in this area, and I think particularly going forward --

COMMISSIONER ALLEN: For sure.

MS. LLANOS: -- it feels like a really good place to be, particularly with the overall importance on equity.

MS. COURSOLLE: I really agree with that, Karen, and I would just add. Similar to the response to Bob's question, I think one thing from a beneficiary perspective we'd really like to see is really some deep thinking about what type of access do we want to see. What are the types of outcomes that we're trying to achieve? Because, of course, access is not just access for its own sake but really to make sure that people are getting the services they need and achieving health outcomes. So I think sort of long term, we want to be thinking really holistically about what are the types of services we expect people to be accessing and are we meeting those benchmarks, and then,

ultimately, does meeting those benchmarks achieve the types of health outcomes that we want to see?

VICE CHAIR DAVIS: Thank you.

MS. LUKANEN: I think I included some -- you know, if I had blank-check ideas in my remarks, I mean, one would be a national CAHPS survey focused on Medicaid, that I hated to even bring that up because I realize it's easier to say, much harder to do. I think fully funding and having consistent and long-term funding for federal surveys like the National Health Interview Survey, the National Ambulatory Care Medical Survey, I mean, those things not only capture information about Medicaid but the benchmarks that we want to someday compare against.

Then I really do feel like having more health services researchers, both master's and PhD level, work in state government will mean that when the researchers go out in the world, they understand, like I said, the challenges and opportunities of state resources.

I was a state analyst. I was a health economist in Minnesota, and that's an incredibly resource-rich state. So even my viewpoint, I think, is really skewed for states that have a lot less. So maybe, like I said, a federal

program that has the prestige around it that puts people in state government and has them work within those resource constraints and helps them out. So that's my pie-in-the-sky response.

VICE CHAIR DAVIS: Other comments on this one?

[No response.]

VICE CHAIR DAVIS: I think Dennis is up next and then Tricia.

COMMISSIONER HEAPHY: Sure. Thank you for the panel. That was really interesting. Elizabeth, my list would be longer than yours with pie in the sky because I would like to see MCID included, particularly for the populations with such high intersectionality between poor access for folks from racial and ethnic backgrounds, African Americans, Black folks in general getting services if they have disabilities.

And then the importance of collecting racial and ethnic data, I sit on several quality measure committees in Massachusetts, and it's really challenging to get full agreement on what measures to use but also to get buy-in from insurers. It's extremely difficult to get that buy-in from insurers, and around race and ethnicity, collecting

the data, we're struggling to get consensus on collection of data, like how is it done properly, how is it done in a culturally competent way. Plans or insurers have their own ways of collecting data and their own ways that they use the data, and so how can we get consensus among the plans?

Then how do we move from contract and process measures to outcome measures? I say contract measures because we go through these quality measures and say, "Oh, my God, this is a contract requirement," where contract requirements and access included in the quality measures and then process measures moving to outcome measures.

The other thing I would bring up is how do we engage participatory action research into the development of quality measures so that you have it directly from the voices of beneficiaries in the process, so people are actually helping to shape and design the measures of access, because folks who are geographically isolated or folks in urban settings, linguistic issues, like there are just so many different complex variables that go into developing quality measures that I think it's important to also up front and not at the back end to engage folks who would be most affected by or most benefit from the quality

measures.

So just those are thoughts that are going on in my mind. Yeah. Thanks. I don't know if anyone on the panel has thoughts on that, but listening to you guys, that's what I'm hearing or thinking.

MS. BABCOCK: I can start, but I feel like I can't even begin to address all of the concepts that you raised there. They are all critically important, and they're all -- my head in some ways -- they're part of the aspirational work that I think we do need to keep our eyes on.

I'll say just a couple of things. I'm a policy person and not a data person. So I can tell you we talk to our member plans frequently, and I've published a couple of reports over the past 12 months that are very high-level case studies about what some of our health plan members are doing to address equity in terms of race and ethnicity and then LGBTQI status. The foundational lesson learned from both of those reports from conversations with every single one of our plans is that the data, the demographic data, are an issue.

There's a few ways I can go here. One, the plans

tell us that they put in place at their very local level workarounds to collect data as they see fit on various variables from their members, and then they employ those data for the purpose of their interventions or their outreach. The data may not match the state's concept of demographic data or the federal government's concept of demographic data, but it's growing up in sort of a patchwork quilt kind of way.

It might be that the complicated conversation at the federal level with all of the stakeholders that need to be involved, including the voices of enrollees, people who are on the program, standardize that some way. One thing that they kept us looking at is a section of the Affordable Care Act that was never fully implemented at Section 4302 that would have required the Health and Human Services Secretary to establish a strategy for collecting and reporting on and also analyzing demographic data in five domains: race, ethnicity, sex, language, and disability status. And it's never been fully implemented because it was never funded by Congress. So we're taking a look at that. I know that many other groups across the country are taking a look at that to see if we can reinvigorate that

effort to create some standard.

I'll also mention that the NAIC, I think, with the great help of SHADAC, if I'm not mistaken, is engaging right now in a special committee on race for the purpose of finding some standards to encourage health plans to collect these data. I can't speak to that in any great detail, but I think there is a little bit of work underway. But, again, I think it's aspirational, you know.

COMMISSIONER HEAPHY: I appreciate what you just said about HHS, and I think that might possibly be a direction to move if anyone was interested in that because that is where the frustrations are that we have. It's that there are in place these requirements, and yet they're not moving a long, a lot of it due to funding, I think. Elizabeth talked about Minnesota being a state with a lot of resources, so any help to other states that don't have those resources, implement the HHS requirements.

MS. COURSOLLE: I'd also want to speak to it. I really appreciate your raising this issue, Dennis. I think it's crucially important, and I think it really goes beyond just quality measures as well. It's really how do we look at access in a really holistic way and make sure that the

beneficiary population and the whole population has access, and that's going to mean different things for different segments of the population.

So I agree with Jenny that it's aspirational, but it's also work that's really crucial, and that we need to start now so that we can eventually realize those aspirations.

VICE CHAIR DAVIS: Thank you both.

I think Tricia was up next.

COMMISSIONER BROOKS: Thank you. I really appreciate the comments today, and it just illustrates how complicated this is and we want all of this data. Then we have to synthesize the data and figure out where to go with it from there.

I know that there's limited real estate, if you will, on the measures, and we certainly heard from several of the panelists of the need to sort of focus on a core set of measures, not the core set, per se, and advance our work from there.

But there's so many competing interests, if you will. I want to see pediatric measures. When the Managed Care rules were going through, we didn't feel like there

was a strong enough focus on pediatric access. Then you look at things like the child core set. I served on the annual review work group of the core set. We retired the access to primary care physicians back a year or two ago or recommended that because all of the states were in the 90 percent range, and one of the reasons you got to move stuff out of that limited real estate in order to move on to something where it's showing reflecting more need.

But I just really want to emphasize Elizabeth's point about surveys in particular because I think what we want to understand best is unmet need. I don't know how much of that we get from the standardized quality measures, and the surveys enable us to perhaps get better demographic data. But, at some point, no matter how visionary we want to be in this, we are certainly going to be limited by the reliability of data when you start to chuck it down. We want it by plan. We want it by plan, by race and ethnicity and other demographic measures. In small states, that's just not going to be very useful.

So my emphasis is really on better understanding unmet need and taking that as sort of the marching orders for what we need to look at and what improvements need to

be made to improve access.

VICE CHAIR DAVIS: I think that's a great point, Tricia. Sometimes we want the perfect could be the enemy of the good, and if we don't have it all, then we don't start. So I think a lot of this conversation is the data is imperfect, and we don't have all of it. But we still need something to move forward.

As we get ready to wrap up, I just want to invite our panelists, if you have a final word for us that you would like to leave us with. We'll be transitioning into comments amongst ourselves, but if there's any final comments that our panelists would like to make?

MS. LLANOS: I'll just say our RFI is slated to come out in months. So I'll make a pledge now. It will talk about many of the dimensions that all of the panelists have heard, access to coverage, access to services, maintaining coverage, and certainly, that's an opportunity not just to get feedback in ways that we can -- that CMS can take this actionable -- it's just one of the things that we're going to be doing, understanding that not everyone has time to fill out an RFI. So we'll also have other activities where we're going to try to get more of

the beneficiary perspective as part of our work.

MS. LUKANEN: Yeah. I would just say I think Tricia makes such a good point. I mean, if this is going to feel incomplete to everybody, to somebody, that's why I really think maybe feasibility is how you prioritize because that means at the end of the day, you have something.

And thank you again for your interest and effort on this topic and for the ability to participate.

MS. BABCOCK: I also would just like to say thank you very much. I'm convinced I learned far more from everyone else on this call than I brought to the call, so thank you for having me here.

Also, it is a pleasure to watch MACPAC in its wisdom set up a list of agenda items for the last few meetings that are so closely correlated, the continuous eligibility piece, equity, and access. So I feel certain that we're in good hands. I can't wait to see your recommendations but feel certain that we're in good hands with the work that you are doing.

MS. COURSOLLE: I also want to thank the Commission for your attention to this matter. It's so

crucially important, and to echo the comments of the other panelists and Commission members, I think this is a good opportunity to think both about what you can do right away and then think about what are the long-term goals and how you get from here to there. I'd really encourage you to do both of those things. Thanks again.

VICE CHAIR DAVIS: Thank you to all of our panelists. You've really given us some good things to think about and some kind of direction as we think about design.

We're going to be inviting Martha and Ashley to join us now for the conversation with Commissioners. I want to open it up to folks. Really this conversation is to think about design and the implementation. From what we've heard from our panelists as we start to march towards a recommendation and chapter in the June report, what additional clarifying questions and direction can we give to the staff?

CHAIR BELLA: Can I make just one comment, Kisha? It seems like some folks are experiencing audio issues. Jim is aware. You can with wait it out or drop off and come right back on. We will hold your place in line if

you're interested in talking and for some reason you're having trouble. I'd just appreciate everybody's flexibility.

Sorry, Kisha. Go ahead.

VICE CHAIR DAVIS: Thanks. Yeah, myself included. I had to call in on the phone.

Yeah, Fred.

FURTHER DISCUSSION BY THE COMMISSION

* COMMISSIONER CERISE: Actually, I have a question for Heidi. Your comment struck me on the movement from uninsured to getting Medicaid, and in the context of sort of the lack of a really robust standardized set of data that can support people to do Medicaid -- research on this topic in Medicaid, I'm wondering that when you look at the outcome study in Medicaid and you see things like higher cost and utilization, how much of that is impacted by people who are uninsured who then as a result of their illness or their utilization then gain access to Medicaid? Is that something that is standardly adjusted for? Because there's no other plan. It doesn't happen in Medicaid. It doesn't happen with commercial, and I'm just wondering if that's an issue in Medicaid that contributes to some of the

sense that it's a more costly or program with higher utilization.

COMMISSIONER ALLEN: So I assume that you're talking about like pent-up demand?

COMMISSIONER CERISE: Yeah.

COMMISSIONER ALLEN: Yeah. So one of the studies that I did called the Oregon Health Insurance Experiment, we surveyed people who won the Medicaid lottery in Oregon. It was about 10 years ago. We did 35,000 surveys. So it was a big mail survey, and we did over 12,000 in-person interviews, and we had utilization data for several years, both hospitals, emergency departments. We found that when people got Medicaid, they had an increase in utilization and all types of utilization, and it was sustained over time. I think the fact is that people who are uninsured use less care than people who have insurance.

The issue, though, is that it's not benchmarked against commercial insurance. I have had three papers out in the last year or so comparing people who gained coverage in Colorado in 2014, and we compared very narrowly over the eligibility income of people who went into Medicaid versus people who went into marketplace coverage. What we found

is that commercial or marketplace coverage had higher utilization overall than Medicaid, and we matched on everything we could match on. Again, this is a very narrow income band. So you wouldn't expect income itself to be the explaining variable, but actually people on Medicaid did have more emergency department visits, not a lot, but statistically significant, and people in commercial insurance had more overall outpatient visits, including more prescriptions.

I think the idea that people on Medicaid use more care than people on commercial insurance probably isn't true, but it's just been very hard to study. But the fact that people on Medicaid use more care than the uninsured, I think, is very fair.

VICE CHAIR DAVIS: Thank you, Heidi.

COMMISSIONER ALLEN: Could I just add one thing? I think this speaks to the importance of also have mixed methods is when we interviewed people who got coverage, my interviewers kept coming back and saying that people told them that they had emergency-only Medicaid. I could not for the life of me figure out why they thought that because they had regular Medicaid. It was all the benefits of

Medicaid, but it just kept happening. So I asked them to go and really dig in, trying to figure out why people were saying that, and it was that the first thing that people did when they got Medicaid was they called to make a dental appointment. And they would be told by the person who answered the phone that they had emergency-only Medicaid, meaning that for dental, they only pulled teeth. They didn't provide any preventive care. People would hear that and they would think, "Oh, I have emergency-only Medicaid," and that meant that they thought, you know, "This is all I get."

So I think that those are the kind of things that are so important from a programmatic perspective that are just really hard to capture unless you talk to people.

VICE CHAIR DAVIS: Thanks, Heidi. That's such an important perspective.

Martha.

COMMISSIONER CARTER: Thanks.

It was either today's materials or tomorrow's materials, there was some recommendation or some -- it wasn't a recommendation, but some possibility that -- and I think we also heard from the panelists today that we start

by looking at the areas where there are problems, that we know there's problems. I couldn't find that list right now, pediatrics, behavioral health, maternal health, maybe oral health. I think it would be interesting to flesh out that list and then match that with our data available. I really think starting somewhere is really important and an iterative approach, building on what we can do and what we know now and what we can then add to it.

So that's how it would make sense to me to start. We're pretty sure there are already problems -- I mean, there are problems everywhere, but where are the most significant problems, and then where do we have some data that we can start with?

VICE CHAIR DAVIS: Thanks, Martha. That's a great way to just think about kind of the framing-up of where do we start because it feels so huge in a lot of ways.

Bob.

COMMISSIONER DUNCAN: Yeah. Building on that and being relatively new, what does the T-MSIS data provide for us as we think about this framework? Is there something there, a core that we can work from to start this work?

VICE CHAIR DAVIS: Linn, Martha, or Ashley, do you want to address kind of where we are with T-MSIS?

MX. JENNINGS: Yeah. So it seems that based on what we talked about also in October, it's a really good source for looking at beneficiary use, but as some of the panelists brought up, there are limitations if you want to look at race and ethnicity or other demographics, and there are also -- something that came up in interviews with discrepancies on -- or the definitions of different services, and so I think those are areas that would need to be improved on to use it in a more robust way.

Martha or Ashley, do you want to add anything?

[No response.]

VICE CHAIR DAVIS: Thanks, Linn.

Tricia?

COMMISSIONER BROOKS: Yeah. I just wanted to comment on that, and it's a point that I lifted up at our -- I think it was the last meeting when Jenny Kenney and others from Urban and others who were there. Accessing T-MSIS data is hugely expensive, and it is going to be a significant barrier to having academic researchers and others go in and mine the data on specific studies that are

of interest to their stakeholders, constituencies, or whatever.

I hope at some point we can actually make that point. I know that collecting and claiming these data, it's an extensive process, but even when we have the data, if we can't afford to use it and analyze it to do something with it, then it's not going to be terribly meaningful in the long run.

VICE CHAIR DAVIS: Other comments? I think folks are winding down here, but really hearing that having the right guide and importance of collaboration, starting somewhere, not trying to boil the ocean, getting some good kind of benchmarks and examples of who is doing it well and sharing that out.

Other comments? Yeah, go ahead, Heidi.

COMMISSIONER ALLEN: I'm sorry, Dennis. Go ahead.

COMMISSIONER HEAPHY: No. Go ahead, Heidi.

COMMISSIONER ALLEN: I would like to see us recommend that the federal government do a Medicaid CAHPS, and I'm not sure if that's possible for us to recommend. But if it is, then that would definitely be something that

I -- because that would be affordable. People would be able to access that. If it could be merged with T-MSIS, that would be incredible because you could look at the care that people used in their unmet need. That would be a kind of my number one priority.

VICE CHAIR DAVIS: I see several nodding heads here. Darin, to that point?

COMMISSIONER GORDON: So, Heidi, help me understand what you get from that than you would from state CAHPS. What do you get additionally, or is it to fill in gaps where states aren't doing CAHPS? That's what I'm trying to get at.

COMMISSIONER ALLEN: Yeah. I think it's to create a dataset that is a core dataset that can be used for comparison and hopefully would have adequate sample for cross-state analysis and within race and ethnicity and hopefully gender identity and sexual orientation.

COMMISSIONER GORDON: Yeah. I think why I asked the question was because I often would get into a swirl where we had to try to compare local surveys that were asking similar things but on a larger sample at the state level to some national surveys that had smaller samples in

our states, and it just really -- it probably wasn't the best use of anyone's time because now we're arguing over which survey was right. So what I would not want to see happen is that we do this national thing and you have a state CAHPS survey that's got a larger sample size being compared to the national one and we get in this kind of whose data is better versus saying states do CAHPS and here are the things that need to be included in that, or that if there's a national one that the sample size is sufficient, that it is more on par with what you would get from states who are already doing it.

You're clearly light-years ahead of me in understanding a good way to do a survey and a bad way. I'm just talking about my practical experience of having to deal with competing surveys.

COMMISSIONER ALLEN: I think competing surveys is a tough thing, but I think that in Medicaid and trying to evaluate the impact of Medicaid policy on beneficiaries, it's really been not enough information, not too much information. And I think that having some standardization in a coherent sampling frame and to be able to get it in one place versus going to each state asking permission to

use their data, I think those are the strengths that from a research perspective would really matter.

VICE CHAIR DAVIS: Yeah. Anne?

EXECUTIVE DIRECTOR SCHWARTZ: I was just going to say exactly what Heidi just said. A Medicaid CAHPS like that could be certainly used for monitoring purposes. But it could be leveraged for a variety of other purposes as well including having more people doing research on Medicaid, which can be helpful, even if it's not a priority in a specific state to look at a specific issue. So it has multiple purposes.

VICE CHAIR DAVIS: Go ahead, Dennis.

Thank you, Anne.

COMMISSIONER HEAPHY: No, I was just going to say that whatever is done, I like Heidi's idea, and then to follow up on that, that what we do, that we build a framework from the start through an equity lens so that we're dealing with those challenges up front and basically frontload equity as a priority, and that will actually help, I think, drive the direction of the quality measures that are developed or used over time.

VICE CHAIR DAVIS: Thank you, Dennis.

Go ahead, Verlon.

COMMISSIONER JOHNSON: Yes. Can you hear me? Okay. So just a follow-up question, I guess, to Heidi as well and to Anne.

I love that idea, and I'm just thinking as we're looking at this slide here, are we thinking that Medicaid CAHPS can actually answer some of those questions, collecting the data report and the data, analyzing the measures, and making it again more standardized? I'm just making sure that I understand that point.

EXECUTIVE DIRECTOR SCHWARTZ: I don't think it could do all of the work.

COMMISSIONER JOHNSON: Okay, okay.

EXECUTIVE DIRECTOR SCHWARTZ: You can't get unmet need from claims data.

COMMISSIONER JOHNSON: I just want to make sure I understood that. Thank you.

VICE CHAIR DAVIS: Thanks, everybody.

Linn, Martha, Ashley, anything else that you are looking for from the Commissioners?

MX. JENNINGS: No. This was very helpful, and we look forward to continuing the conversation tomorrow.

VICE CHAIR DAVIS: Thank you.

And I will toss it back to Melanie to take our public comment.

CHAIR BELLA: Great. Thank you, Kisha, and thank you to Martha, Linn, and Ashley.

We are going to open it up now for public comment on this session that we just had. So, if you would like to comment, please indicate with your icon, and a reminder to please introduce yourself and your organization and to limit your comments to three minutes. We'll just give it a second.

It looks like we have one person so far. Go ahead. Arvind, we'll try to unmute you. You're welcome to speak.

PUBLIC COMMENT

* DR. GOYAL: Yes. Thank you very kindly. My name is Arvind Goyal. I am the medical director for Illinois Medicaid Program, nine years on the job, tenth in process.

I want to address my comment to MACPAC Commissioners, Dr. Anne Schwartz, staff, and panelists for a very stimulating discussion. I have learned a lot from your comments today, but I wanted to make some comments.

Having previously served in multiple medical leadership positions and also teaching position as a medical school and having been a chief medical officer at a teaching FQHC, with that background, I wanted to say that the access for Medicaid patients is a significant issue, as all of you have mentioned, partly because of low payments and partly because of geography. The patients are clustered in certain areas of the state, and the providers are clustered in another area of the state. And there is a significant disparity in all of that.

It is not a data issue. There is no matter that will ever accurately determine access or lack of access. Any such efforts are probably unrealistic, unachievable, and symptomatic. Our waiting time while we try and hunt for a solution, think about the effects of EMTALA in emergency room access. Think about the FQHC and rural health centers' approach doing a lot to augment access.

I would add a couple thoughts to your deliberations. One is to create incentive, incentive payments for outpatient practices who open up their practices to Medicaid and uninsured patients and are not allowed as a condition of that incentive payment to ask for

insurance until the conclusion of the visit at the checkout time.

I would also say that a robust beneficiary education program is necessary, combined with a hotline where records of adverse experiences and access to primary care as well as specialists, et cetera, can be recorded by patients on the spot.

I would conclude that by saying, again, thank you for the opportunity to attend and learn from all of you.

CHAIR BELLA: Thank you for your comments and for what you do for the state of Illinois. Appreciate you joining us.

Other folks who would like to make any comments?

[No response.]

CHAIR BELLA: Okay. Any last comments from Commissioners or Anne?

[No response.]

CHAIR BELLA: All right. We'll go ahead and -- I think, Anne, go ahead and break because I don't think we want to restart too early. So we're going to go ahead and take a break. We're coming back at three o'clock. We'll come back at three o'clock and talk for a little bit about

MACStats, and then we'll go into our final session on behavioral health IT.

So thank you all. See you back here at 3:00 p.m.

* [Recess.]

CHAIR BELLA: Welcome back, everybody. We're in the home stretch. Welcome, Jerry. Did we just lose Jerry? No, you're right in front of me.

Why don't we go ahead and get started. Although you have only a very short period of time, we know you have a lot of information that we will use and so looking forward to this update.

HIGHLIGHTS FROM THE 2021 EDITION OF MACSTATS

* MR. MI: Great. Thank you.

Good afternoon. MACStats is scheduled for release next Wednesday, December 15th, for members of the public. We'll have MACStats both compiled as a resource and separated into individual tables on our website. Most of the tables will have both Excel and PDF versions for your convenience.

So MACStats is a regularly updated end-of-year publication that compiles a broad range of Medicaid and CHIP statistics from multiple data sources, including

Census Enrollment Survey and national- and state-level administrative data. Listed on this slide are the six sections of MACStats.

The 2021 edition of MACStats includes eight updated tables on beneficiary characteristics, health service use, and access to care. They used the 2019 National Health Interview Survey, or NHIS data. Due to the significant redesign of the 2019 NHIS, users should be very cautious about making any comparisons to NHIS data from prior years. In addition, Exhibit 12 has not been updated due to a delay in the release of health care spending projections from the National Health Expenditure Accounts. We plan on updating this table once the new data is released.

Key statistics of this year's MACStats show similar results to last year's. These key statistics focus on Medicaid and CHIP enrollment and spending compared to other payers, Medicaid's share of state budgets, and more. I'll discuss some of these findings in more detail in the upcoming slides.

So moving into the trends of the data. Over the last eight years, Medicaid and CHIP enrollment has

increased by about 44 percent. Most of this change happened in the first initial years after the bulk of ACA expansion. Most recently, enrollment in Medicaid and CHIP increased by about 8.9 percent from July 2020 to May 2021. This follows a 6.1 percent increase in Medicaid and CHIP enrollment from July 2019 to July 2020. Much of this increase from July 2019 is attributable to the economic downturn created by the COVID-19 pandemic as well as the continuous coverage requirement attached to the federal medical assistance percentage increase under the Families First Coronavirus Virus Response Act.

Furthermore, this graph shows growth trends in Medicaid enrollment and spending. Overall, spending and enrollment have had complementary trends, both rising and falling compared to policy changes and economic conditions, such as economic recessions and expansions.

In this graph, spending for health programs are compared with spending for other components of the federal budget for fiscal years 1965 through 2020. In general, the share of the federal budget devoted to Medicaid and Medicare has grown steadily since the programs were enacted in 1965.

In 2020, CHIP was 0.3 percent of the total federal outlays, a decrease from 0.4 percent in 2019. Medicaid share also decreased slightly from 2019 to 7 percent of total federal outlays, which is still less than Medicare's share at about 12 percent. Both Medicaid's and Medicare's share of the federal budget are lower than in prior years because of a large increase of mandatory program spending in 2020. This is due to pandemic-related relief such as unemployment compensation, coronavirus tax relief, and economic impact payments and other housing credits.

In Fiscal Year 2019, we see that almost 70 percent of enrollees are enrolled in comprehensive managed care, and this accounts for over 50 percent of Medicaid benefit spending. Long-term services and support users accounted for only 5.4 percent of Medicaid enrollees but almost one third of all Medicaid spending. That is $187.6 billion was spent on services for these 4.4 million enrollees. DSH, upper payment limit, and other types of supplemental payments accounted for over half of fee-for-service payments to hospitals in Fiscal Year 2020.

Total spending for full-year equivalent enrollee

across all service categories ranged from $3,336 for children to $21,368 for the disabled eligibility group. Total spending for full-year equivalent enrollee was highest for the managed care service group across all eligibility groups.

In 2019, 40 percent of Medicaid enrollees had annual incomes less than 100 percent of the federal poverty level, and 60 percent had incomes below 138 percent of the federal poverty level. As of July 2021, 37 states and D.C., two more states than last year, are now covering the new adult group.

MACStats also reports on beneficiary health service use and access to care using survey data from the NHIS and the Medical Expenditure Panel Survey, or MEPS.

In 2019, children and adults with Medicaid or CHIP coverage were less likely to be in excellent or very good health than those who are privately covered. Individuals with Medicaid or CHIP coverage were as likely to report seeing a doctor or having a well-child checkup as those with private coverage and more likely than those who were uninsured. These exhibits from MACStats complement recently published MACPAC access and briefs on adult and

children's experiences in accessing medical care.

And that's it.

CHAIR BELLA: All right. That was very quick, but we know it's dense and full of good information that many people in the public use, so a heads-up to all of you listening that this is coming.

Does anybody have any questions for Jerry while we have him?

[No response.]

CHAIR BELLA: So was there anything, Jerry, that was like super surprising to you this time around?

MR. MI: I think in some of the NHIS data, it was very interesting that this year a lot of the outcomes, health outcomes such as seeing a doctor or having a well-child checkup for individuals with Medicaid or CHIP were about the same as private coverage; whereas, in previous years, individuals with Medicaid or CHIP coverage were significantly less likely to report seeing a doctor compared to those with private coverage.

CHAIR BELLA: That's a great call-out.

COMMISSIONER CARTER: Well, so, Jerry, did the percentage of people with private coverage go down or the

percentage of Medicaid go up or both?

MR. MI: So I think the difference between private coverage and Medicaid were a lot closer than in previous years. I think the percentage of Medicaid went up this year.

COMMISSIONER HERRERA SCOTT: Did you count telehealth as part of a visit or no?

MR. MI: I am not sure, but I could get back to you on that.

CHAIR BELLA: Okay. Any other questions or comments?

[No response.]

CHAIR BELLA: Jerry, thank you very much for all the work on this.

MR. MI: Thank you very much.

CHAIR BELLA: All right. Kisha, I am going to turn it over to you to take us home.

VICE CHAIR DAVIS: All right. We are in the final stretch. We will invite Aaron to join us to talk on our final session for integrating behavioral health care through health IT, and just a reminder, we are starting to build towards potentially making recommendations in this

area.

Off to you, Aaron.

OPTIONS TO STRENGTHEN INTEGRATION OF BEHAVIORAL HEALTH SERVICES THROUGH HEALTH INFORMATION TECHNOLOGY

* MR. PERVIN: Thank you, Kisha. Thank you, Commissioners.

Good afternoon. Let me just make sure I can advance the slides, and I think I can. Okay.

Last summer, MACPAC released a report outlining the value of EHRs and improving quality of care, especially for behavioral health beneficiaries. In September, Commissioners heard from an expert panel about the value of EHRs within behavioral health and the effects that it has on patient safety, clinical quality, and provider operations. Panelists agreed that states generally have the Medicaid authorities to improve behavioral health data sharing but may lack the understanding and capacity to use them. Panelists also agree that federal standards for behavioral health could be improved -- behavioral health IT could be improved.

This session builds off that discussion by

presenting policy options to address EHR adoption and behavioral health integration. The Commission is interested in including these as recommendations in the June report. We'll return in March with specific language for you all to vote on.

So, as a little bit of background, as the Commission is aware, Medicaid is the largest payer for behavioral health services in the U.S. Behavioral health providers were left out of previous EHR incentive payment programs. Our previous reports to Congress discussed how EHRs and information sharing can improve patient safety and care quality, but that behavioral health providers have largely missed out on these benefits.

We also wanted to briefly point out that the Commission has previously discussed 42 CFR Part 2, or substance use disorder private protections, and the implications they have for sharing SUD information. It's important to note that under last year's CARES Act, SAMHSA is in the process of promulgating rules aligning Part 2 and HIPAA, and this is something that the Commission will continue to monitor.

In our previous report to Congress, we saw three

buckets of policy issues. The first is EHRs are designed more for physical health instead of behavioral health. In behavioral health, EHRs tend to be at the lower quality. As a consequence, behavioral health providers may not have the tools that facilitate progress in the areas that the Commission is focused on. This includes participating in value-based purchasing and helping providers gather patient information that helps them to address health disparities.

The second is that states lack guidance on how to use Medicaid to support behavioral health interoperability, and specifically, information sharing for Medicaid beneficiaries, analysts noted that there might be value in clarifying and updating some of this guidance.

The third is that there are federal Medicaid opportunities that do exist but are not being taken advantage of in order to incent EHR adoption for this class of providers.

To help with assessing these options, we gathered Commissioner feedback, which helped staff come up with different ways to assess these options. First, does the option improve the system capacity to integrate care and improve quality of care for beneficiaries with behavioral

health needs. Secondly, does the option create a financial incentive for certified EHR technology, or CEHRT adoption. And, finally, does the option improve information sharing will maintaining patient privacy?

So, to dig in on this first policy issue, health IT standards are not aligned with behavioral health. Behavioral health IT has unique technological requirements. For example, providers need to segment SUD information. They also need to segment some types of therapy notes, and they also need decision support tools related to crisis care.

Furthermore, many health information exchanges and non-Part 2 providers do not have the ability to segment SUD information. This causes SUD providers to simply not participate in health information exchanges. As you heard in the September panel, this lack of information sharing can have serious implications for care quality and patient safety for Medicaid patients with behavioral health needs.

Lastly, SAMHSA and ONC have jointly developed SUD consent management tools for health IT, but they are not used extensively, which further inhibits information sharing.

One way to address this issue is to improve federal standards for behavior health IT. This can be done either through certification requirements or through voluntary standards. The two options on this slide are mutually exclusive. Improving the standards could provide a non-financial incentive for behavioral health providers to adopt an EHR.

These standards could help providers know what products to buy that meets their specific needs. Like we heard in the September panel, a lot of behavioral health providers often buy products that don't work for them. The market is filled with non-certified behavioral health EHRs, and providers often don't know what to buy.

Also, it's important to note that this option builds on prior recommendations requesting additional guidance to clarify provider and plan requirements under Part 2. For example, in our prior Part 2 recommendation from 2018, we noted how many providers are confused by what kind of patient information is protected under Part 2 versus not. New standards could help clarify what specific patient data elements require protection under Part 2 and what can be shared freely.

As the Commission decides on which option to move forward, this slide discusses tradeoffs with certification requirements versus voluntary standards. Certification requirements would ensure that state-run health information exchanges have the capability to segment Part 2-protected information. It would also encourage non-Part 2 providers to upgrade their systems and become compliant. Furthermore, SAMHSA and ONC have already developed SUD consent management tools. This includes the data segmentation for privacy framework and the consent to share software applications. Both of these could be introduced in the certification requirements.

A downside to this option is that stakeholders have noted that upgrading to a Part 2-compliant system is costly and resource intensive. As you heard from New Jersey in the September panel, it is especially challenging for health information exchanges to develop these consent management platforms.

The other approach is to keep this all voluntary. In your reading materials, we've highlighted how this was done recently for pediatric care. A voluntary standard could reinforce what is protected Part 2 information versus

what is not. It would also help states that are developing their own EHR incentive program to point to a federal standard instead of developing one on their own. Again, we heard about this at the panel. New Jersey had to design its own standards for its own EHR incentive program. It couldn't just point to federal guidance.

One downside to a voluntary approach is that health information exchanges and non-Part 2 providers may be sought out for their systems, which could potentially impede information sharing, which again has implications for care quality and patient safety.

The second policy issue is that there is unclear guidance on behavioral health interoperability. Connection to a health information exchange can be prohibitively expensive for many providers. There are often legal fees and subscriber fees to participate in an exchange. Guidance has outlined how the federal match can be used to connect behavioral health providers to health information exchanges, but this guidance often refers to outdated information.

Our September panel also noted that improved clarity on how to braid Medicaid with other federal sources

could be used to promote information exchange connections. States don't have a playbook right now for how to do all of this under current Medicaid authorities. Should the Commission decide to move forward, a recommendation in this area could build on our previous recommendation outlining how states can use health IT for behavioral health crisis continuum, which we recommended in our prior June report.

This brings us to our second policy option. Commissioners could request that HHS issue joint guidance clarifying how to connect behavioral health providers to health information exchanges. CMS has 1115 guidance for demonstrations for serious mental illness, serious emotional disturbance, and SUD that requires states to come up with a health IT plan that promotes health interoperability. However, it is unclear how states can achieve this interoperability when affected providers lack an EHR. HHS could help clarify this. HHS could also outline how to braid federal resources with Medicaid funding to promote behavioral health interoperability. Much of this information is scattered in many different, separate guidance documents, but states can be well served if it was compiled into a single resource to use

application.

However, we wanted to point out that this guidance would not provide an adoption incentive because federal policy is fairly clear that the federal match cannot be used to pay for an EHR. Furthermore, without improvements to health IT standards, SUD providers may continue to be reluctant to share information with non-Part 2 systems.

The final policy issue of note is that there are federal opportunities in existence that are not being taken advantage of. The SUPPORT Act gave the Center for Medicare and Medicaid Innovation the ability to test EHR incentive payments for behavioral health providers that participate in Medicaid, and there's a large degree of stakeholder interest, yet no public plan to do so.

To address this, the Commission could request that HHS use its authority. This option would provide a financial incentive for EHR adoption, and it also could be used to test the consent management tools that were previously developed by ONC and SAMHSA. The only drawback to this approach is that it would only support providers that participate in the demonstrate. So demonstration

evaluations could be used to inform future policy on Medicaid behavioral health IT.

As a next step, we are hoping to get a sense of your interest in developing these options and turning them into recommendations for the June report. Based on your feedback, we will revise these options and bring them back during the Match meeting.

I'm going to leave this table up because it summarizes the staff's assessment of the different options. Options 1a and 1b, which again are mutually exclusive, and also Option 2 would help Medicaid better integrate care. Option 3 would provide a direct financial incentive for CEHRT adoption but only for providers that participate in the CMMI demo. Meanwhile, all policy options would promote information sharing but to varying degrees.

Thank you for your time, and with that, I turn it over back to Commissioners.

VICE CHAIR DAVIS: Thank you so much, Aaron. That was really helpful, and we will just leave this slide up to help keep us oriented.

I think we want to start with kind of questions in general and then move to the policy options in more

detail, and we'll turn to Toby to really kick us off in the conversation.

COMMISSIONER DOUGLAS: Sure. Although I will kind of frame it overall, not just questions.

So, first of all, great analysis and presentation, Aaron. What I would say is just great job by the staff, the panel, as well as the interviews. It really further solidifies the need to use health IT to strengthen efforts around integration, and it's really been great to explore how we can think about EHRs facilitating this integration.

When we think about it in terms of both the financial and non-financial, it really does to me get, as Commissioners, to the complexities of the policy analysis and how we weigh in and where we best suit it for addressing these underlying issues, because we're both -- as a payer, is it our role to be delving into standards and certification? Where I land when I look at this policy option in its first -- there are, as Aaron points out, a lot of levers that states have today to improve integration through the NIDA and SAMHSA as well as -- well, we talked about directed payments earlier today and how you use

directed payments that could help in this frame.

So I would say it's a little premature to be going into new policies outside those current levers and what can we do to better inform, to use some and build on what we've done in terms of other guidance and be more consistent with kind of what we've done on previous recommendations and stay in that swim lane and see if it works, and then before seeing if that's the way to drive incentives rather than delving into standards, certifications, or CMMI.

VICE CHAIR DAVIS: Thank you, Toby.

Others to that point or how we should approach it more broadly?

Yeah, Martha.

COMMISSIONER CARTER: I don't have questions. I think I'm ready to make a stand on something. So if you're ready for that --

VICE CHAIR DAVIS: Go right ahead.

COMMISSIONER CARTER: The issue of being able to use health IT, electronic health records, in an integrated setting is something that I've been working on maybe for a decade, certainly since 2014, and so it's really clear to

me that market forces aren't going to change what vendors do with their EHR systems unless there is some requirement to do so.

I think this does get to access and quality issues. In that community health center where I was the CEO, it's a certified EHR, and I've talked about this a little bit. It's a certified EHR, but there's no way to limit access to medication records. There's no good way to do a records release that segments information, and so people who don't want their whole team to have access to their whole record can't come to that practice. I mean, basically, it shuts out people who don't want to share.

Most people are going to say, "Yes, I want my primary care team to know everything about me," but there are situations -- and we absolutely have to respect that -- that people want to limit access for any number of reasons. So that has to be built into the system, and if it's not, then you just -- I don't know what to say. You can't do it. You just can't do it.

So I think we want to highlight three areas. One is, in behavioral health, there needs to be a way to segment or limit access to psychotherapy notes, and people

who do behavioral health counseling understand the definition of psychotherapy notes and know that that's a legal term that they have a responsibility to limit access to. That has to be there.

I don't want to get the EHR vendors down on my case, because I'm sure there are some that have this capability, but they don't all, and so that's a problem.

The other is the entirety of the behavioral health and SUD records have to be able to be limited access, and that includes problem lists. That includes med lists, not just the visit notes.

Third, when people do want to release their records, there has to be an easy way for the staff to click the boxes and say "I release this, and I don't release that." So I'm really coming down on the side of 1a that there's a requirement for EHR systems to be compliant with Part 2, and I'd go a little step farther and say that they support integrated behavioral health, because we know that's really the best route. for people seeking behavioral health services.

VICE CHAIR DAVIS: Thank you, Martha. And do you have a stance on 2 and 3?

A reminder to everyone, we can make a recommendation on all of these or none of these. So we don't have to come down affirmatively on the others.

COMMISSIONER CARTER: Not right now, Kisha. I think I've got some ideas, but I'm actually interested in hearing what other people think about some of the others.

VICE CHAIR DAVIS: Sure. Thanks.

Laura and then Fred.

COMMISSIONER HERRERA SCOTT: So I agree on 1a for what Martha just reviewed. I don't think we're ready for 2. We don't have enough providers that have an electronic health record, one, and two, most of the providers that are connected to an HIE facility -- so we're mostly getting emergent and urgent care through admission discharge transfer records, but we're not really getting ambulatory outpatient records. Unless the behavioral health providers are working in an emergent, urgent area, I don't know that even the HIEs, because of records changing and being updated in the way the feeds are generated that the HIEs are ready for that, let alone the behavioral health providers, because they're not on an EHR.

I do think CMMI doing some kind of testing with

an EHR incentive could fast-track or be the enzyme to help move this forward faster.

VICE CHAIR DAVIS: Thank you, Laura. That's helpful.

Fred?

COMMISSIONER CERISE: Yeah. I just wanted to ask Aaron his thoughts on 1a. I mean, I think it makes total sense that you would have standards that would incorporate the behavioral health components. It's sort of emblematic of how we look at behavioral health that we've developed this entire infrastructure and then we're coming back around to how does behavioral health fit in, and we've paid a lot of money and the government has paid a lot of money to providers to adopt these systems. But now there's a critical missing component.

My question, Aaron, from a practical perspective, what does it mean when we say we would require standards that these systems incorporate the components that would allow segregation of data and consent up front for what gets shared, what doesn't get shared? Because most of the behavioral health providers don't have them to begin with. So, if that middle column is not checked, I'm concerned

that the behavioral health providers are still not going to adopt them, and then what's the implication from a cost perspective on everybody else that already has adopted them?

MR. PERVIN: Sure. So I think that's one of the reasons, if I'm understanding your question correctly -- that's one of the reasons that we have both a certification versus a voluntary standard. Certification would kind of change all the EHRs that are out there on the market. This would be non-behavioral health providers and also behavioral health providers would need to have an EHR that is certified, has the stamp of ONC's approval.

Voluntary standards is more similar to what was done for pediatric care a couple years ago. ONC led a stakeholder-driven process because pediatricians were concerned that the EHRs were not really built for their specific specialty, and so what we would be saying for a voluntary standard is that at least there's some kind of an ONC guidance that shows either these are the important behavioral health data elements, these are the important clinical protocols, and so it would kind of give the EHR vendors something to look at, and there would also be kind

of technical specifications and programming notes that vendors could look at that create in the EHR, that sculpts the behavioral health, but it's still interoperable with the rest of the system.

So I think that's one piece, and I think the second part of your question, though, is about kind of cost. I will say that for a lot of behavioral health providers, EHRs are very expensive. They can't really afford them to begin with because these providers have fairly low resources, but at least the voluntary standards gives them an idea that if we do have resources, we have a better idea of what to purchase.

Does that answer your question, or am I kind of going in the wrong direction?

COMMISSIONER CERISE: Yeah. No, no. It does. It does. From a requirement, a standards requirement, is the idea then that the existing systems would need to change? So, when next version comes out, there's got to be an updated version, and then all the people who own Epic right now would eventually migrate to their updated standards?

MR. PERVIN: Yes, that is correct. You would

need to upgrade your system to meet the new certification requirements. Everyone would.

VICE CHAIR DAVIS: But that still wouldn't necessarily get at the folks who aren't on the EHR in the first place.

MR. PERVIN: That is true. That would not affect the people who don't have an EHR to begin with because they don't have any technology, and so they don't have anything. They don't have certified. They don't have anything, and so they wouldn't need to upgrade anything.

VICE CHAIR DAVIS: Thanks.

Toby and then Martha.

COMMISSIONER DOUGLAS: Well, I'll talk now and then wait, but I guess I'm just going to keep no pushing back. I just struggle how we see as Commissioners our role to be getting into the issue of standards versus incenting and driving just broader adoption and then moving -- that would facilitate these others, but as a Medicaid, as a payer, hitting and staying in that swim lane of using our guidance to really drive how can MITA be used in a way to use FFP, federal financial participation, for adoption, different ways, but while we're evaluating directed

payments, there could be ways if there's guidance, how those could be directed in a way that are used for EHR adoption.

Where does Medicaid -- and maybe this is a question back for you, Aaron. Where do we delve? Are there other examples where we've gone into this role of setting up standards?

MR. PERVIN: I can take a first crack at that. I think we really see this as building on our previous recommendations on 42 CFR Part 2. So, if you recall, in 2018, our previous recommendation on 42 CFR Part 2 is that both SAMHSA and CMS need to provide joint guidance on how what are plan and provider requirements under Part 2, and so improving standards or changing the standards around behavioral health IT would at least -- would provide kind of more direct implementation guidance that kind of specifically outlines this is Part 2 protected information and this is not Part 2 protected information. So I think we see this as kind of an extension on a past 2018 recommendation as opposed to something new around -- as opposed to where we haven't really commented on before.

VICE CHAIR DAVIS: Martha and then Bob.

COMMISSIONER CARTER: Speaking as somebody who has hired psychiatrists, doctoral psychologists, clinical social workers, and licensed professional counselors, they all come with a pretty good knowledge of HIPAA, and if they do psychotherapy, they understand the requirements for psychotherapy notes, and they understand -- if they've ever done SUD, they understand, at least have a rudimentary understanding of Part 2.

So, if the system doesn't help them comply with those standards that have been drilled into them, then they're not going to buy the system. So I think it's sort of a circular problem. We don't have good uptake among the behavioral health providers because the systems aren't responsive and because they haven't gotten the financial incentives.

So I think the whole thing has to move. The EHR systems have to be completely responsive, and they should be built with it, with input from the end users, and then there have to be some financial incentives to get all those folks that are not currently using EHRs into the system. I think that is what's going to make a difference.

VICE CHAIR DAVIS: Thanks, Martha.

Go to you, Bob.

COMMISSIONER DUNCAN: Thank you.

A question. Toby talked about MACPAC's role. In the past, we haven't done the requirement for the certification. My thought and question is, one, we just spent a lot of time discussing access and data and the inconsistencies and continuity of data. Can MACPAC make a recommendation for 1a that we think there should be a certification, but we're not designing what that certification is?

VICE CHAIR DAVIS: Yes.

COMMISSIONER DUNCAN: Okay. Thank you. Because I think that brings --

VICE CHAIR DAVIS: Bob, I vote for you to recommend that pathway.

Go ahead, Anne.

EXECUTIVE DIRECTOR SCHWARTZ: I think what would be consistent with what we've done in the past is that we would say -- you know, we would be suggesting that somebody else does the standards, but we would say something about what we think the top-level elements would be. So it's not just like standards without any direction. We give some

sense around that, but we absolutely would not develop the standards themselves.

VICE CHAIR DAVIS: In terms of this first policy, there's some support for 1a and some hesitation also. Are there others who want to talk about the voluntary path?

Fred.

COMMISSIONER CERISE: I guess in formulating my ideas, in following up on some of Toby's comments, because it seems like a very big deal to go from no standards to mandatory standards, that perhaps a reasonable approach is to put out some guidance, which may be in the way of voluntary standards, but then pair that with -- it seems like there's got to be some payment mechanisms in there for providers to adopt, so whether that's to directed payments or other guidance, but using 2 and 3 as a way to sort of guide people to adoption and then maybe migrate into some required standards, but voluntary standards as a way to get started seems reasonable to me.

VICE CHAIR DAVIS: Thanks, Fred.

Yeah, Bill.

COMMISSIONER SCANLON: Yeah. I'm going to advocate strongly for mandatory standards. I've been

around sort of issues related to this for a long time, starting with HIPAA in 1996 and with HITECH.

We all really appreciate the fact that if you have an electric plug, you can plug it into almost any outlet in the U.S., okay? Things get standardized, and they're useful to everybody. HIPAA, even though it's, what, 26 years old, has never been fully implemented.

I was part of the National Committee on Vital Health Statistics, which is the advisory body for the Secretary on HIPAA, and we had endless testimonies about how things were not optimized in terms of being easy.

If you want to order something from Amazon or any other sort of company online, it's made easy. The whole process of dealing with paying claims and submitting claims has never been sort of standardized in a way that providers can minimize their administrative costs. This is just another example of an area where standardization will have incredible benefits.

Now, in terms of our role, we're not going to be the standard setters, but we can say among the consumers that are going to benefit and people that we're interested in are going to be among the consumers that are going to

benefit from this standardization. It's got to be done right. That's true. It's going to be others that do that, do it right, but again, I think it's something that absolutely needs to be done.

VICE CHAIR DAVIS: Thank you, Bill.

Go ahead, Darin.

COMMISSIONER GORDON: So I would like to hear from Aaron or others. They may have a perspective here, but when we think about standards, particularly when there are systems out in the marketplace, and we talk about setting new standards, I mean, would that not then ultimately result in some added costs for non-providers that have systems in place today? I'm just curious how that might play out, obviously, assuming that we're introducing new standards that may not be -- in essence, may make all existing systems noncompliant.

MR. PERVIN: I can jump in, and then I'd be curious about other Commissioners' thoughts.

But, yeah, Darin, that is correct. If you introduce these in the new certification requirements, then providers would need to upgrade their systems to kind of meet those new certification standards. That is accurate.

VICE CHAIR DAVIS: Heidi. Dennis, were you trying to jump in? Dennis and then Heidi.

COMMISSIONER HEAPHY: I'm in conversation with insurance companies. That is an argument that they make is they've already invested in this, and they're going to have to change their systems. But I do think we need to go for certification for behavioral health IT.

I'm wondering if there a way to create a glide path to that. Is there any way of combining 1a and b with providing some sort of financial incentives to support the transition, even if it's just the states? I think there have to be certification standards because you can see what a mess it is. If someone goes to the hospital and then one system does not communicate with another hospital, the records are just a mess. So we definitely need standardization or certification of standards.

But I do agree in terms of the financial hit that they're going to take, and I think if it's just a one-time hit, then it's not bad. But if there's a way to create a glide path towards that and include some financial incentives, I think that's a question for you, Aaron. You don't have to do it all today. Is there a way to build up

to it?

MR. PERVIN: So, based on our understanding, the only Medicaid-related option to provide like a glide path and incentives for CEHRT adoption would be through testing the EHR incentive payments through CMMI. There wouldn't really be any other -- the federal policy is pretty clear that the Medicaid federal match cannot be used to offset EHR adoption costs. That kind of went away with HITECH. There's a little bit of this going on under kind of the ARPA enhanced FMAP. Some states are doing an incentive program, but again, that's going to end in March 2022.

These authorities are expiring, and so there's not really any other way to provide a financial incentive for EHR adoption.

COMMISSIONER HEAPHY: Just quick, what about the 1115 waivers? I don't recall what you wrote in the report. Is there a way to do that through 1115 waivers?

MR. PERVIN: So, based on the guidance that we reviewed, the 1115 waivers could support connecting a behavioral health provider to a health information exchange or support connecting providers to each other so that they can share information, but there's not a way to provide --

to offset the provider's EHR costs.

COMMISSIONER HEAPHY: Okay. Thanks.

COMMISSIONER GORDON: I would appreciate just having some kind of datapoint, whether it's certain providers that are out there, just to understand their perspective with this, because I think what we're trying to do makes sense. I worry that we're overlooking the practical hurdles that we may be creating as a result and having sufficient provider perspective on something that we're talking about. Basically having them invest and re-tool some of their practices is probably a prudent thing to do.

VICE CHAIR DAVIS: Yeah. I think that's a great point, Darin.

We're going to go to Heidi, and then after Heidi's comment, I want us to just kind of do a straw poll to see where we are. We've had a lot of conversation around 1. I'm hearing folks, some folks strongly feel like we should make a recommendation and some not sure if we're ready to go on either side. So, Heidi, I want to hear from you and then get kind of a strawman here.

COMMISSIONER ALLEN: Thank you. I've really

appreciated this rich discussion and all the perspectives that people brought forward.

I would assume that the providers using these are constantly having new changes made and repaying for licenses and that this is actually something that is pretty routine, maybe not to this scope, but I assume these are not stagnant products, so that these products are constantly evolving. And this would be just some very clear standards on how to address this very specific issue, and that it wouldn't necessarily be a significant cost driver any more so than any other adaptation of technology and changes of practices over time.

So, for me, hearing everything that's been said before, I would support 1a and Number 3 policy option to help providers who currently don't have EHRs get some financial support to engage in that.

As Dennis said, certainly, to suggest the states that they could use their Section 1115 waivers to try to bring in other behavioral health providers, to incentivize and support their adoption of EHR as well.

So that's where I'm at.

VICE CHAIR DAVIS: Thank you, Heidi.

Verlon, real quick?

COMMISSIONER JOHNSON: Yeah, just real quick. So I guess my issue is more around our purpose. Is it to make sure that the standards that are going to be created eventually will meet exactly the need that we're looking for? In those cases, I would support potentially the CMMI initiative, potentially the volunteer. I guess that's where I'm a little bit confused is, are we basically saying we're ready to go with making sure that SAMHSA and ONC have exactly what they need to develop those standards, or do we feel like they may need more intel to be able to do that? Does that make sense?

I don't know, Aaron, if you have thoughts around that.

MR. PERVIN: Yes. So we do know that HIEs and EHRs can be upgraded to have consent management tools. New Jersey is developing a consent management tool. We know that D.C.'s health information exchange and also the Chesapeake Regional Information Exchange, they've developed consent management tools for SUD. So we know it definitely can be done. It's more a question of whether or not you want this to be required to be part of the EHR

certification process or make it more voluntary.

COMMISSIONER JOHNSON: Yeah, which is why I probably would not support the CMMI one, just because I feel like that is an opportunity to learn, so that's helpful. Thank you, Aaron. I appreciate that.

VICE CHAIR DAVIS: Thank you, Aaron. Thanks, Verlon.

I'd like to just see kind of where we are with Policy Option 1a versus b, having kind of a certification pathway versus voluntary standards. Just if folks could raise a hand if you're leaning towards 1a and certification.

Dennis, I see you nodding.

And then 1b?

COMMISSIONER CERISE: Kisha, again, I think 1a is probably where to go. I'm looking at this sentence from the current description that says about 1a, one major drawback is it's highly resource intensive and costly for providers in HIEs to upgrade, and so, to Darin's point, I guess I'd like to understand that a bit better. What is involved in that kind of upgrade?

I think it's the way we want to go. I just want

to understand what the practical implications are. For anybody who has implemented an EHR, it can be a painful process, and I want to know how much disruption this causes to know how to pace it. Do you know what I mean? Not whether we get there or not, but how do we get there?

VICE CHAIR DAVIS: Yeah, Martha, to this point.

COMMISSIONER CARTER: Yes. I think it depends on how your contract goes with the EHR vendor because there are some vendors that don't charge for upgrades. It's sort of spread out over the whole cost of the product. It would be a cost to the vendor, but it wouldn't necessarily be a cost to the end user or the practice that has adopted that particular EHR package.

Others, you pay for each upgrade. So I don't think we can say, across the board, yes, it's going to mean that each individual practice is going to take on a big cost. Surely, there's costs somewhere. Somebody has to do the work to adapt the systems, but where does it get passed on and to whom? I don't know that we have enough information to know that for sure, but it's not necessarily at the practice level.

VICE CHAIR DAVIS: What I see us leaning towards

is a path of certification, not that we are necessarily the ones who are creating those standards but recommending some of what should be in there.

But I think, Aaron, also, what I'm hearing from the group is for our next conversation, having some more information on the impact on EHR vendors and the providers that are going to be having to do those upgrades in terms of financial costs and workflow and workload and really having a better understanding of what that looks like.

COMMISSIONER CARTER: And, Kisha, if I might add, if there's cost to the HIEs, I'm suspecting not so much, but that's not my area of expertise, because I think they can just flip a switch and allow those data to flow in. But that would be something just to double-check.

MR. PERVIN: So, in our conversations with HIEs -- so, for example, in the September panel, New Jersey did talk about the challenge that they had with developing their SUD consensus. It was very expensive, and it was being done with HITECH funding, which was expiring, and so they were trying to figure out -- in the panel, they talked about this. They were trying to figure out how to continue those investments, and there were some challenges around

that. So I do think it is expensive for an HIE to develop these consent management tools and then implement them properly.

COMMISSIONER CARTER: Aaron, if the gateway is at the practice level, then there would be -- I guess there would be possibly still some at the HIE level. People may consent to share. It should be that at the practice level, where the patient is, where their data originates, that that's where the gateway would be, and by the time either it gets or doesn't get to the HIE, then it just flows.

VICE CHAIR DAVIS: Interesting point. I've seen just the CRISP system in Maryland where it's got many different inputs, and there's lots of other options where the patient may not have input. So pharmacy records are coming in, hospital, primary care. There's a lot of different inputs there.

Let's move to look at Policy Option 2. I'm not hearing strong consensus of folks feeling ready to make -- you know, put a stake in the ground on this, but let's just -- those who are in favor of the Policy Option 2 in our joint guidance outlining how Medicaid can connect behavioral health providers around making a recommendation

in that area.

I see Martha in favor.

COMMISSIONER DOUGLAS: That's where I think we should be starting is just focusing on the guidance.

VICE CHAIR DAVIS: Tricia.

Anybody opposed to it, or is it more not feeling ready?

Yes, Martha.

COMMISSIONER CARTER: I think it's actually too early because there are not a lot of behavioral health providers that have good compliant records, and so the guidance is going to change once there are actually compliant records available. So I think it's sort of putting the cart before the horse from my perspective.

VICE CHAIR DAVIS: Yeah. That sounds great.

And for Policy Option 3 around testing EHR incentive payments to CMMI, I've heard lots of support for there needs to be -- if you're going to make this transition, there needs to be some sort of financial support to help folks make that transition to EHRs. Is this something we want to put a stake in the ground around, whether it's specifically, you know, testing a payment

through CMMI? Folks strongly in favor of that, raise your hand if you're in favor of that.

COMMISSIONER JOHNSON: I think I would be in favor of it if it was combined with 1, another one. That's when I'd be in favor of it.

VICE CHAIR DAVIS: Seeing lots of nodding heads in agreement with that.

Anybody who's really opposed to 3 or others who feel just like we don't have enough information?

CHAIR BELLA: I mean, I guess I'll say on 3, I mean, everybody wants CMMI to test and pay for something, and so we just need to keep that in mind. Would this be the thing that we would want to go for and say -- maybe it is, but that's the only source of sort of quick authority and money right now, and so I don't want to be one of those groups that's like everybody goes to CMMI and thinks that they should do something with their money and their authority.

VICE CHAIR DAVIS: Laura and then Martha.

COMMISSIONER HERRERA SCOTT: Melanie, I hear you on that piece. The only thing without some dollars to do this right, you know, the behavioral health providers were

left behind, and so as we think about home health integration and really managing a person's behavioral and physical health, we really can't do it without an EHR. And there's a lot of ways that CMMI could do this through some value-based payment arrangements that's inclusive of the EHR. I mean, they could leverage other lessons learned in some of the other models here, pulling in the EHR, and it could be a win-win for a lot of different reasons.

CHAIR BELLA: Yeah. I think I'm just struggling because it feels like we're sort of -- we're a little all over the place in terms of some things we want, but we're too early, and other things that feel like we're too early, we feel good about. I just want to make sure that when we're ready to fund things where everybody is poised and ready to take back some advantage of that, and it's unclear to me of how big all of these things are. And it feels like we feel the need to make a recommendation, but we don't have to leave this meeting today with a recommendation. We can continue to work on it. So I'm just telling you what's thoughts in my head. That's all.

I completely hear you on supporting in the meeting to get this in the equation, particularly for

bringing all the pieces of care to get back to the complex populations in particular.

COMMISSIONER HEAPHY: This is Dennis. I'm thinking with COVID, the horizon with mental health needs, isolation, all that, there's really a charge to deal with this now because if there's another health care crisis or pandemic or anything that comes around, if we don't have the integrated records in place and some sort of standards or certification process, then we will be behind again, because that's one of the cases I think we had with COVID too is integration of all the health records, behavioral health and others. So I think it behooves us to do something, maybe not today, but I think the onus is on us to put forward a recommendation.

VICE CHAIR DAVIS: Stacey and then Martha, and then we're going to wrap up.

COMMISSIONER LAMPKIN: I agree with Melanie. Part of my challenge that I missed was chicken and the egg kind of thinking through sequencing here, and that's why I put my hand up for 1b because 1a is very costly, and yet we don't have any money flowing to providers to help them get into the system. It seemed like voluntary standards was at

least a stake in the ground, some progress, but without causing a lot of cost, we really couldn't tap into and take advantage of without incentive money. But it was very chicken and egg-y.

VICE CHAIR DAVIS: Thank you, Stacey.

Martha.

COMMISSIONER CARTER: Yeah. And I wanted to draw out Number 3 a little bit too. It may be too early. What I don't know is how many systems, if any, are currently compliant. Is there something to test with? Because, like I said, if you give the opportunity to behavioral health providers to adopt an EHR, there's nothing on the market that suits their needs, or worse, they'd spend money on something that doesn't suit their needs, then it's just a waste. So there's as little more background information I would like to know about Number 3.

I think, ultimately, the money has to go into the system somewhere to help this, but I'm not sure when that is.

MR. PERVIN: There are EHRs that are certified by ONC that are being used by behavioral health providers. It's just there's not -- sorry. Martha is --

COMMISSIONER CARTER: It doesn't mean they're compliant. It may mean that people have developed workarounds, manually. I mean, my staff had to manually print out the patient record and manually redact the behavioral health records when somebody said no. So they may be using them. They may have been adopted, but they're not really useful.

I'm sorry to interrupt you, Aaron. What I don't know is really the depth of the field and whether there really is something that's fully Part 2 compliant and also has that ability to limit access to certain parts of the behavioral health record like psychotherapy notes, as required by law.

MR. PERVIN: There's not a lot of data sources, but we could try to talk to EHR vendors again and see what they say about those.

Our understanding is it can be done. It's just very resource intensive.

VICE CHAIR DAVIS: Thank you, Aaron. Thank you, Martha.

I think as we kind of bring this session to a close, I am hearing clearly that folks want to create some

standardization.

I'm sorry if you guys are getting feedback. I'm hearing a little feedback in the sound.

But there is more information that needs to be discovered on really what the impact is for providers for EHR vendors and how that might impact patients. I haven't seen examples of anybody doing it well that we can really point to, but that would be helpful if, Aaron, you could bring a little bit more information about that. Commissioners, we'll be revisiting this again, and I hear us moving in the direction of certification and moving in the direction of some sort of funding support, but I don't know that we're going to be -- if the right direction is to come down strong with a firm recommendation, and it may be more just -- Aaron, are there other things that you would like to hear from the panel? I think you've gotten a lot from the Commissioners this afternoon.

MR. PERVIN: Yeah. I guess the thing that I struggle with is -- you brought this up. It's the chicken and the egg issue. It's the standards which -- you know, it's the certification which might make the products more costly because there's more bells and whistles involved,

and then they're not buying it because there's no money.

So I think one thing that staff will have to think about is -- I guess what I'm hearing is like is there a different way we should be sequencing this. It sounds like if we're going to do 1a, the idea is that we're definitely going to do 1a and 3, but then for 1d, we may or may not need a financial incentive because it's voluntary.

Where are Commissioners falling in that realm? Is that the idea of how we're going to move forward? We want to package two of these things together or do more of a voluntary -- go through more of a voluntary process?

VICE CHAIR DAVIS: I think I'm hearing the 1a and 3 packaged together, but that regardless, I think that there would need to be financial incentives, I'm hearing. Folks nod if you're in agreement that there would need to be some additional financial support for that to help mental health providers really to make that transition over to EHRs, and that that could even potentially stand on its own.

Any disagreement with that? Speak for the entire Commission.

MR. PERVIN: Thank you. That was helpful. Thank

you, Kisha.

COMMISSIONER HEAPHY: I have a question. I've got a question, Aaron. If there are going to be voluntary standards, would they be equivalent to the certification requirements in 1a? So, in other words, the level of requirement standards would be equivalent. One would just be voluntary? The other would be certified? The voluntary certification or certifications requirement?

MR. PERVIN: The model we're going for is the pediatric voluntary standards that were developed by ONC, and so what that is, like certification provides kind of your base layer, and then the voluntary standards are in addition to that to help pediatric providers know what kind of product they're going to buy, and so I think we're envisioning the same thing for behavioral health. Certification is kind of the floor, and then there's voluntary standards on top of that.

COMMISSIONER HEAPHY: Thank you.

CHAIR BELLA: Okay. Kisha, I think we might want to go to public comment. Is that good?

VICE CHAIR DAVIS: Yep. That sounds good.

Are there any --

CHAIR BELLA: Sorry. You go. You go.

VICE CHAIR DAVIS: No, go ahead.

CHAIR BELLA: Well, it's not the most exciting thing.

Would anyone like to make a public comment? Please indicate with your hand icon, and as a reminder, please introduce yourself or your organization, and keep your comments to three minutes or less. I think we have someone.

MS. HUGHES: We do. We have Alfonso. Alfonso, I'm going to unmute your line, and now you can make your comment.

PUBLIC COMMENT

* MR. GUIDA: Yes. Hi. My name is Al Guida. I represent the Behavioral Health Information Technology Coalition.

Just a few things, very briefly. Thank you so much for the Commission's focus on this issue. Aaron has a biblical level of patience. So, Aaron, thank you so much for your patience with us.

Three things, very briefly. There is IT. There is technology in the mental health and addiction treatment

space. It's just used for billing. So there isn't much. Many health IT systems in this space don't have a clinical capacity, and as Commissioner Carter noted, a significant amount of clinical information in this space is transmitted by a fax.

Secondly, there are health IT systems that are both compliant with the ONC 2015 certification standards and are also compliant with Part 2. So these, there are systems that do exist that meet the parameters that Commissioner Carter laid out.

Then lastly, thank you for your support for the CMMI demonstration that is in law. To address the concerns of Chair Bella, it's okay to say that CMMI needs additional resources in order to initiate that CMMI health IT demonstration, and there is statutory authorization for it, and of course, CMMI would be well within its rights to create some kind of a shared savings model around that incentive program.

So, again, thank you so much for your interest in this matter.

CHAIR BELLA: Thank you very much for your comments. So notes on CMMI and getting them more

resources.

Okay. Anyone else like to make comment from the public?

[No response.]

CHAIR BELLA: Kisha, do you want to do any more wrap-up?

VICE CHAIR DAVIS: I don't think so.

CHAIR BELLA: Okay. Aaron, you're going to work some magic on everything you've been told, and this is coming back, so thank you. Kisha, thank you for leading this session.

We are done for today, everybody. We are starting off tomorrow with a panel on health equity. As you know, all of our work, we're trying to make sure that we're applying a health equity lens, and we really need to push ourselves to understand what we mean when say that. So we'll kick off tomorrow morning with that panel. We will begin the public session at 10:30. Thanks to all who joined today. Thank you to staff and Anne and Jim, and we will see you all tomorrow morning. Have a nice evening.

* [Whereupon, at 4:09 p.m., the meeting was recessed to reconvene at 10:30 a.m. on Friday, December 10,

1 2021.]

PUBLIC MEETING

Via GoToMeeting

Friday, December 10, 2021
10:31 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
KISHA DAVIS, MD, MPH, Vice Chair
HEIDI L. ALLEN, PHD, MSW
TRICIA BROOKS, MBA
BRIAN BURWELL
MARTHA CARTER, DHSC, MBA, APRN, CNM
FREDERICK CERISE, MD, MPH
TOBY DOUGLAS, MPP, MPH
ROBERT DUNCAN, MBA
DARIN GORDON
DENNIS HEAPHY, MPH, MED, MDIV
VERLON JOHNSON, MPA
STACEY LAMPKIN, FSA, MAAA, MPA
WILLIAM SCANLON, PHD
LAURA HERRERA SCOTT, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:31 a.m.]

CHAIR BELLA: Good morning, everyone. Welcome to Day 2 of MACPAC's December meeting. We are really excited to kick today off with a panel talking about health equity, which is an incredibly critical -- the most critical piece of our work.

Sorry to the panelists, but I do have a quick announcement to make before the panel, and that is to say we have some personnel announcement for MACPAC. For almost 10 years now, since 2012, Anne Schwartz has led MACPAC with remarkable leadership. She has built an amazing team. The infrastructure is like no other. The work product that comes out of the organization, of course, I am biased, as are my fellow Commissioners, but we couldn't be more pleased with the leadership of Anne. And I am sad for MACPAC but very, very excited for Anne and to let the public know that Anne has decided that it's time to retire.

She has more than deserved this next step in her personal journey and will be greatly missed. Just so folks know -- and I'm not going to put Anne on the spot to say a few words. There will be plenty of time for that.

But we will be having a formal search. That formal search will kick off in January. There will be an announcement that will be going out today about Anne's retirement and that we'll be looking for a new leader, and there will be a pretty formal process to follow with a lot of specificity around that to come.

But right now, our job is to celebrate Anne and to thank Anne for her leadership, and so we're focused more on Anne than we are on the process. Then come January, we will be stalking all of you for names of folks that want to take the organization into the next 10 years or so.

So, with that, thank you for that. Excited now to turn to the panelists, and we'll go ahead and turn it over and get started. So thank you very much, all of you, for joining. Audrey, thank you. I think this is your first time presenting to us. Welcome, and the floor is yours.

PANEL DISCUSSION: APPLYING A HEALTH EQUITY LENS TO MEDICAID

* MS. NUAMAH: Thank you, Melanie. Good morning, everyone.

Given the ongoing conversations about the effects

of COVID-19 and the impact of racism on the Medicaid population, MACPAC has committed to examining how it can best contribute to combating systemic racism in the Medicaid population and addressing racial disparities in health care and health outcomes. This means we have been working to identify disparities that affect beneficiaries of color and are thinking about what it means to then use this information to reduce these disparities and ultimately advance health equity.

The current administration and CMS leadership have also prioritized advancing health equity across all of their policies. This is especially pertinent in the Medicaid population, given that 60 percent of its beneficiaries identify as people of color.

To break this down further, about 30 percent of beneficiaries identify as Hispanic, Latino; 20 percent identify as Black; and about 20 percent are made up of non-white racial and ethnic groups, such as Asian, Indigenous, and multiracial identities.

This meeting session will focus on health equity on the basis of race and ethnicity; however, we acknowledge that there are equity concerns for beneficiaries who are

marginalized based on other factors, such as age, geography, visibility, limited English proficiency, sexual orientation, and gender identity. We also recognize how intersectionality comes into play with these identities and race and ethnicity.

Staff work is underway to examine these issues. For example, we will be analyzing national survey data to describe the health care needs of and use of services by LGBTQ+ people as well as describing policy levers to strengthen the diversity of the home- and community-based services workforce.

In addition to the work noted above, staff will produce a chapter for the June 2022 report that articulates the Commission's vision on how Medicaid can advance health equity. While we often talk about the disparities, whether it be from COVID-19 or maternal morbidity and mortality or the prevalence of chronic conditions that Medicaid beneficiaries face, we spend less time talking about what it actually means to apply a health equity lens to address these problems.

If we could go to the next slide, please.

In order to help the Commission think concretely

about this as well as the policy levers that can be used to advance this work, we are very fortunate to have these distinguished experts joining us today. Our panel will provide insights on how to operationalize health equity efforts and what steps can be taken to ensure the Medicaid program itself doesn't further perpetuate inequities. Their full bios can be found in your meeting materials. So I will just briefly introduce our panelists now.

Dr. Cara James, who is currently at Grantmakers in Health, will also be leveraging her federal expertise from her former life as the director of Minority Health at CMS. Patrick Piggott will share his state experience at North Carolina Medicaid, and Monica Trevino, who is currently at Michigan Public Health Institute, will also speak to her experiences from her time at Michigan Medicaid and as a former Medicaid beneficiary.

I want to thank our panelists for sharing their time and expertise with us today as we aim to address these challenging issues.

As you're listening to today's discussion, it would be helpful for you to think more about which areas or specific policy levers either presented here today, or

others that you're aware of, warrant further examination, and if there are particular aspects of health equity where MACPAC should focus its attention.

So I just want to kick off our conversation today with a little bit of a level set about the definition of health equity and how we can think more about how to apply a health equity lens in this space.

Given that there are many definitions, I just want to read the Robert Wood Johnson Foundation definition for you all now, and that means "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to jobs with fair pay, quality education and housing, safe environments, and health care.

So I just want to open this question to all the panelists, just to begin with. From your federal and state perspective, how can this definition be applied to the Medicaid program and its policies? Whoever wants to take that question first can.

DR. JAMES: This is Cara. Maybe I will just

start us off, and I'm looking to see if Monica and Patrick were there.

I think that one of the things that's really important in this point at this time, that as you mentioned, Audrey, there are definitions that are out there, and I think some of what I have seen in these past kind of two years as more people are entering into this space is kind of an opportunity that people are taking to redefine health equity and I would say that we need consistency in common language.

So the definition that the Robert Wood Johnson Foundation has used has been well established, well adopted. World Health Organization also has a very similar definition -- or CDC's Healthy People initiative. So I would encourage people to use sort of one of the existing rather than having conversations about how do we define it for this population because, at its core, it does mean everyone is achieving their highest level of health and thinking about those barriers that are preventing that.

So, within the Medicaid space, it's an opportunity to think about some of the core populations that Medicaid serves and how there may be some unique

challenges that these communities need to achieve their highest level of health. When we think about people who have disabilities or live in rural communities, people of color that you mentioned who are disproportionately affected or tribal communities who have a large reliance on the Medicaid program, what are those unique challenges, barriers that may be inhibiting their health?

I think also one of the things that's important is Medicaid, at its core, is multiple programs because each state does its own thing, and so when we think about equity as a population as opposed to sort of equity within a state, there can be some disparities and challenges that we have when we have states that are leading and doing a lot of interesting and innovative things and others that may be struggling to try and figure out. So how do we help those at varying points along the continuum of their equity journey?

MS. NUAMAH: That's great.

Monica? Patrick?

MS. TREVINO: Sure. This is Monica.

I really appreciate your sort of level setting in that broader context, Cara, and I absolutely agree. I tend

to focus on definitions like the obstacles piece and finding solutions in that spirit first with defining what the obstacles are and who gets to define what those obstacles are.

My professional space is in performance assessment and improvement and measuring quality of care. If I get to define that, you're going to focus your efforts on where your evidence is.

Beneficiaries can and should be the best and only place where evidence stems from what those obstacles to the quality care truly are. So having an effective mechanism to get that feedback from beneficiaries is going to be important because if we don't fully understand what the obstacles are from the beneficiary perspective, the solutions we develop are not going to be the right fit. So that's where I tend to focus on the definitions and think that there are -- there are definitely things that can be done in the state and federal and sort of local health plan or health department space to better engage beneficiaries as the true experts in what, in fact, are those obstacles to care.

MR. PIGGOTT: This is Patrick Piggott from North

Carolina Medicaid.

I think what Monica and Cara said is very important. Definitely, focusing on the beneficiary, where the beneficiary -- where we could engage the beneficiary more, because the true obstacles, like Monica said, lies with the beneficiaries and how they share their experiences and stories and the data to support what they are presenting. We really need to engage with them to a degree where we are really addressing many of the obstacles that we think exist, and then there may be some we did not even consider, so definitely, engaging the beneficiaries.

I think the definition is a really good definition that the Robert Wood Johnson Foundation puts out. North Carolina is exploring that definition even more and deciding whether we need to expand or add to that definition, and we are also bringing in a vendor to help North Carolina with some of the work that we're doing around health equity to level-set in our state what it is that we're doing and to, again, do the same thing, come together with many of the state departments and divisions on defining health equity for the state and making sure that we have consistent language across the state of North

Carolina. And even more important, it would be nice to have that consistent language across the United States so that we are all working from the same playing field and focusing on those same issues that we need to address when it comes down to health equity.

I think with the different types of non-drivers of health, we really need to focus on those specific areas, and a lot of times, those are the areas where we see much of the inequities that exist and preventing individuals from very good health outcomes and a healthier life.

MS. NUAMAH: Oh, that's awesome, and there are so many good points that you just elaborated here that I'm going to touch back, especially the beneficiary engagement piece.

But before we get there, Cara, can you elaborate a little bit more about from your time in the federal policy space, what are some important considerations for putting a racial health equity lens into practice?

DR. JAMES: Sure. So I think there are a couple, and one of them, I think health equity starts with the data. So, as Monica mentioned, our ability to even understand where we have disparities and challenges is

varied across all of the states, and we look at some of the data that CMCS has put from T-MSIS. We had 22 states whose T-MSIS data on race and ethnicity is highly concerning or unusable. So that means we don't have insight into what's going on there and those challenges. So I think starting to make sure that we're focusing on the data and how we can help to make sure we're monitoring and tracking is important.

I think one of the other things that's really important is we have a focus, in some respects, on value-based care. We tend to focus value on cost, and that can be cost reductions, can actually at some points be ad hoc lens. And we think about those communities or populations who may have not had the access that they needed, that there may be more care that needs to be provided to address those barriers or other challenges.

So, when we're in cost restrictions or focusing on just the cost restrictions, looking at what that outcome of how we're measuring value and juxtaposing that with some of the equity can be also a challenge.

Then I think, of course, as everyone on this call knows, there is not as much the federal government can do

in the Medicaid space as they can in the Medicare space, so leverage those opportunities using the bully pulpit, technical assistance, other resources that can help to move states along is one of the things that is challenging.

I would say from my eight years at CMS, it was easier, in some respects, to move things in Medicare than it was in Medicaid, although Medicaid is so critically important, particularly when you're talking about race and ethnicity, because of that intersection of income and outcomes in our communities.

MS. NUAMAH: Thank you.

I just want to follow up here with a little bit more about what you said. Are there specific areas that are especially ripe for addressing?

DR. JAMES: So I do think the data space is one where there are a lot of people who are thinking about this. A lot of states are trying to think about that.

There is opportunity to move forward, so making sure that applications for the states are using the current data standards of which there are the HHS data standards that were put forward in response to the Affordable Care Act, Section 4302, aligning(there a lot of the states that

are using the same application as the marketplace) are in alignment, but there are some others that are not.

I think educating people around the importance of collecting this information and also to the beneficiaries of why it's important to provide the information, how it will not be used to impact coverage determinations, but how it can be used to ensure that we are providing high-quality care and making sure that people are getting the services.

I think one of the other spaces, when we think about with the Medicaid scorecard and those opportunities, how are we embedding equity into those scorecards, looking at whether or not the data are being reported, disaggregated, whether or not we are including a measure of health equity in that scorecard to really signal that this is something that is important is another space, I think, that we could look to.

Then, also, helping to educate the states around the opportunities for that match on technical assistance and on the equipment infrastructure to be able to upgrade systems, I think, are a couple of the things that can help in continuing the push on the social determinants of health and the drivers that a lot of the states are already

working on but helping to move forward on that.

MS. NUAMAH: That's great.

Speaking of the state's piece, I would love to turn it to Patrick now. Could you share some more specific examples of what North Carolina Medicaid is doing? I know you just mentioned that you're working with a vendor right now, but what else are you guys doing in the state of North Carolina?

[No response.]

MS. NUAMAH: Patrick, you're muted.

MR. PIGGOTT: Yes. I'm sorry.

In North Carolina, we have several health equity initiatives. We are actually embedding health equity in all aspects of the North Carolina Medicaid program. Some of the areas that we have started out with is our health equity enhanced Carolina Access payments. That is where we used targeted payments to ensure access to high-quality care for our providers serving historically marginalized populations.

Additional per member per month payments are made to eligible state primary care practice networks known as Carolina Access Providers, and we use Census data on

poverty. Providers serving more beneficiaries who live in high-poverty areas of the states were eligible for those payments. We have that initiative that's going on. Under that initiative, payments went out to the providers in April through June of 2021, and we are beginning to really monitor that closely to see how the providers are using their health equity payments to advance health equity in their practices. That is what's happening now.

We have standard plans that went live, standard health plans that went live July 1, 2021, and in their contract amendments, part of their contract amendments include incentivizing health plans to invest in initiatives that advance health equity. So it requires the managed care plans to actively consider input from historically marginalized populations as well as in their program design and to train staff and providers on cultural competency and implicit bias.

We also have some work in leveraging actuarial tools where we are trying to see if we can impact health equity and advance health equity in the actuarial space in terms of looking at the data and looking at how we could make adjustments to per member per month based on advancing

health equity.

There are some other initiatives that we have as well. We're looking at translation services and language where we are improving translation services availability and access for our beneficiaries who need translation services for their medical care. In all, there is aspects of care treatment services and supports.

We also have early childhood initiatives, and we are planning two additional initiatives, moving into the next state fiscal year. However, the one that we have right now is called Reach Out and Read Program to improve early childhood literacy and to also impact those individuals from historically marginalized populations who need it-- that then where there's some disparity, and we know reading and that really helps with improving individual's health and understanding individual's health and options as they move along in the continuum of receiving medical care and health care.

We are actually looking at our application process and our applications to ensure that we can have improvements along the line to collect data and make more user-friendly applications and make uniform those questions

that are around demographics. That will definitely help the state in terms of the data. You heard a little bit about the data and capturing the data. Well, a lot of programs across the state have that issue of collecting data on specific areas that impact health equity in the populations that are impacted by various health disparities and where their health equities exist, and sometimes you have to be able to have the data, really all the time, to support the areas that you need to be looking at the most and where there are disparate needs.

We are also looking at our clinical policies and analyzing our clinical policies to determine the need for change and the way that we structure our policies, the way that we write our policies, and who our policies impact, and also, from a beneficiary standpoint, to engage them in helping us to look at the policies from a different lens, because a lot of times, we are looking at a lens from where we are needing to provide the care and get the care out to the beneficiaries. But we know that the beneficiaries are the ones who are receiving the care, and we need to hear from them and hear the different obstacles that they are encountering. In order to prevent those obstacles, we need

to know what they are, the true obstacles versus the ones that we try to ascertain via data and sometimes ascertain via broad data from different sources.

We also had a wonderful internship program this past year, this past summer from a health equity standpoint. Many of those interns we had did work around various topics such as dermatology in the health equity space as well as value-added services, justice-involved individuals, maternal mortality, dual-eligibles, and cultural competency training. So we have data to support some of the work that they did and they gathered to present to North Carolina some potentially best practices and some ways to consider looking at health equity from different lenses and different perspectives.

MS. NUAMAH: Oh, that's great, Patrick, and I'm sure there's many more initiatives that North Carolina is doing. If you want to speak to them, I'm sure the Commissioners would love to ask you more questions about that.

One thing that you had mentioned is some of the embedding of equity requirements in your managed care organizations (MCO) contracts that went out this past July.

Monica, from your time -- and you're at Michigan, I know -- you were also working in this space of embedding equity language into the MCO contracts. How did you and your team back then think about holding the MCOs accountable to this, and how did you determine if any of these efforts were effective?

MS. TREVINO: First of all, thank you, Patrick, for sharing all of the amazing things. I've got to remember to touch base with you to get the recap of that.

In Michigan, we actually started the conversation about equity with the data before it was even in the contract, and one of the things that Michigan did at the time, and I would think still does now, is try at least in the equity space to have a transparent relationship with its health plans. So I think transparency and accountability go hand in hand.

So we started the conversations around the health equity project, which is just a disaggregating of administrative HEDIS data by race and ethnicity for a subset of measures for the plans. We started those conversations back in 2010, and we didn't publish a report until 2 years later. So having that conversation up front

with the plans about what we were doing, the fact that Michigan was moving in this direction, this thing is coming, and we want you folks to help us develop it. But knowing that, accountability is coming down the line. Right now, we're going to spend the next 12 to 18 months getting on the same page in terms of the methodology, the definitions of race and ethnicity and who's in what category, the definition of equity and how you measure things.

That took a really long time, and we did that as transparently as we possibly could, having all of the conversations with the health plans, letting them weigh in and taking the time to try to be as collaborative with them as possible, knowing that in time, we're going to get on the same page with the definitions and the methodology, and then we're going to move into the accountability piece.

So it took three or four years of public reporting on equity data for the state to finally move in the direction of: "now we're going to tie some incentive dollars to this". So tying incentive dollars to the reduction in disparities for a subset of measures, Michigan has been doing for a number of years now.

The pandemic in 2020 so severely impacted quality measurements that some states just decided to forego their performance bonus because there were no standards. Michigan actually decided to measure based on equity and internal plan performance. So, for fiscal -- I think it's fiscal '21, the performance bonus incentive for health plans specific to equity and reducing disparities is going to be $23 or $25 million for that one year. It's a component of the overall bonus.

So, again, Michigan started with the conversation, a transparent conversation about what the methodology is going to be, knowing that years down the line, we will get to the place of accountability. So I think having those conversations up front, giving the health plans enough time to institute new processes and procedures internally, to have conversations with their provider networks, if they need to expand their networks, to change their provider contracts, they need time to do that. Just like states need time to change their contracts with their MCOs, MCOs need time to change their contracts with providers, and if you want sustainable change, it has to be in that contract mechanism. It's why states are

moving to that.

The same is said for health plans and their provider networks. So, if you want to encourage sustainability, give them enough time to plan ahead for those things, but let them know on the front end that accountability is coming. But it won't be a surprise. The numbers won't be a surprise. The mechanism won't be a surprise. They will see it all coming, and it will come.

MS. NUAMAH: Oh, that's really helpful, and there's so many good initiatives-- and like I said one thread I just want to pick back up that was mentioned at the top of the conversation was this piece about beneficiary engagement. I know in these health equity circles, we hear a lot about this call for "nothing about us without us" and how important it is to really authentically engage Medicaid beneficiaries.

Monica, can you share a little bit more about what it means for state Medicaid agencies to authentically with beneficiaries in this policy process? Are there specific examples of how this has been done or could be done?

MS. TREVINO: Yeah, of course. So I think,

generally speaking, I have yet to hear of a great mechanism that a state Medicaid agency has found to engage consistently with beneficiaries. The CAHPS survey is a very good place to start. Disaggregating those results by race, ethnicity, is a good place to start. It is not the place to end. You really need authentic high-quality engagement with beneficiaries where they get an opportunity to weigh in on a particular piece.

In Michigan, back in '14 or '15, I think, we started as part of the procurement process. There was a requirement in there about reducing ED utilization, as every state legislature wants Medicaid to do, so that the performance improvement project that we developed was a three-year project for health plans laid out in rough form at the beginning of the intervention to say, "Health plans, eventually, we're going to be measuring what exactly your reduction in ED utilization is, but first, you will do a literature review. We will include a couple of key elements of literature that you must include. You do your own literature review." Then you pull your own health plan data on ED utilization, disaggregate it, and then you engage beneficiaries with your data, with what you learned

from the data, with what you learned from the literature. Then you engage beneficiaries.

Typically, it was in a focus group, and we told them, again, years in advance, "You do this work up front. Then establish an intervention. Tell us what it is. We're going to tell you whether or not we think it's appropriate based on what your beneficiaries said and what your data said, and then you get permission to move forward. And then we're going to measure the reduction." So building beneficiary engagement in the form of focus groups around a specific topic and then the state retaining ownership over whether or not they believe the interventions and programs proposed by the health plan are truly meeting what the beneficiary said and truly a way to engage what the data and the literature said.

So I think that's sort of a good micro example, but what the states don't have is, frankly, a strong federal push to do it well. I think every state probably has a care advisory committee (CAC) that includes, to some extent, Medicaid beneficiaries. Michigan didn't historically have great engagement with those beneficiaries, but there were an awful lot of advocates and

trade associations that did very much engage in those conversations. I think that if the state were to be stronger in its language or the Feds were to be stronger in their language to the states and frankly provide technical assistance and guidance, the states can be stronger in their requirements for the health plans and again filter down that technical assistance to the plans, but it takes time, and it takes resources. If a state agency is truly wanting to engage beneficiaries, they have to make those things available, and I would say the same with the Feds.

MS. NUAMAH: Yeah. On that federal piece, actually, this is a perfect segue to asking Cara, what are your thoughts about on this beneficiary engagement at the federal level? What are some of the challenges in doing so? I know Monica just outlined some, but any other thoughts you may have about this?

DR. JAMES: So it was interesting because in the time that I was at CMS, I would say that we were on a journey of doing a better job of engaging beneficiaries, primarily in the Medicare space. But one of the biggest hurdles that we had to overcome, I would say, is a perception that beneficiaries would be intimidated by us or

that they wouldn't want to share their information or that they -- you know, whatever the case may be, and I think that that is one that is a barrier that we often hear whenever you want to engage community beneficiaries, whomever.

And I think that one of the things that Monica and Patrick mentioned is approaching beneficiaries authentically, and that also can mean working through trusted sources. You know, that a joke where the Feds are here to help, nobody wants to answer the door with that, but understanding, working through the groups that are already trusted and engaging with them to partner with them.

When we developed the CMS rural health strategy, we went into community and did several listening sessions with rural beneficiaries to ask them what they wanted us to focus on in developing that strategy. That was through, again, organizations that had a better sort of reputation and respect within there that could pull people together.

I think also in engaging in the process, CMS more recently when on a journey map with nursing homes to help understand from the beneficiaries' perspective and so many

others what that process looks like, and I think that what you heard Monica say is that push and the desire to do it can mean that you can actually do this and do this well.

Patrick mentioned the language needs and making sure that you are engaging people through interpretation. Just in this space of this past year and a half, Zoom now has interpreter capability. So you can do this virtually in a way that engages patients wherever, beneficiaries wherever they are so they don't have to come to a state Medicaid office or whatever the case may be.

I think the other thing is to think about those other opportunities. In the Medicare space, we have the state health insurance counselors, and those are individuals who work one on one with the Medicaid office. So they're already engaging with them and know what some of those challenges are. Through, again, sort of the complaints and appeals, you can sort of understand a little bit more and delve deeper that there's some opportunities there. So I think there's some lessons that can be applied from the Medicare engagement to the Medicaid program, but humility and sort of approach in community through that space of understanding that they have a lot of expertise to

provide, making sure you're working with trusted partners, making this part of your standard operating procedure as well, that it's not just for this program we're going to reach out or figure out that, but we're looking at how we engage and then thinking again about making sure that the representation of the different beneficiaries that are served by the program are being tapped into at different places and at different points in time that have a full representation and not one that might be skewed one group or another.

MS. NUAMAH: That's great.

I just have one last question here before I turn it over to the Commissioners to ask you questions on all the many points that you all have made, and you know that health equity is a major priority right now, and you can go to any kind of meeting or session without health equity being brought up as one of these topics, but what do you all believe are some specific areas that can be accomplished during this time before folks lose interest?

I know the panelists, you guys will be working on this until the day you die, but before the general population loses interest, is there anything in particular

that you think we could be doing to really lay the groundwork to make this effort sustainable?

MR. PIGGOTT: I think one of the things is really considering social determinants of health and opportunities and funding around that piece in terms of how to get that piece for the states to have support in terms of advancing health equity.

Like, in North Carolina right now, we have a program that's called Health Opportunities. It's solely addressing social determinants of health with our Medicaid population, and right now, we have pilots in three specific regions of our state, and that actually goes live January 1. But it is a pilot right now. We believe that that is going to help advance health equity in many ways, more than one, although it's addressing social determinants of health too.

We're expecting that individuals will get better, their health will improve, and they will have healthier lives, but definitely addressing social determinants of health, we know is a huge aspect of health equity along the way.

MS. TREVINO: And I'll just say quickly, to

piggyback on your point, Patrick, I think that in terms of getting funding and permission, state agencies, getting that permission to move forward with those initiatives to address the social determinants, the process to get a state plan amendment approved or a waiver approved is months and months and tens of thousands, if not hundreds of thousands of dollars.

I think conversely, through the advanced planning document, or the APD funding process, technology, if you write one or two well-worded paragraphs in the APD, the state agencies can get gobs or match, federal match money to invest in technology solutions. So that mismatch between the effort it takes to buy food for a hungry Medicaid beneficiary versus to put in place the technology to tell 10 more people that you have a hungry Medicaid beneficiary, I think that it's just an inherent mismatch.

I think if we want to live in a space that is easier and it's -- the system is more conducive to supporting Medicaid agencies in supporting beneficiaries to address those social determinants, I think some of those federal mechanisms, we should take a good hard look at them and how some solutions have an easier pathway forward than

others.

DR. JAMES: I would just add that I think that a couple things I would lift up -- so, one, there is real opportunity in the data space to do a better job on the data. Let's move forward with that.

I think one of the other tips that I would sort of provide, given sort of my time at CMS, is work in the areas where there's interest. So there are priorities that people are focusing on. There is always a way that you can apply an equity lens to that work. Look at what's being done there. Work in those areas where there's already engagement.

Monica mentioned the social determinants of health. Everybody is focused on those, and I think there are ways to build an equity lens into that.

The other thing I would say is look at how you bake this into standard operating procedures so that when that window of opportunity closes, this work continues, and it is just what we do as part of our normal standard business.

Then lastly is, don't wait for the perfect. We need some innovation opportunity and expansion. Try things

out and see because we still are -- when we think about quality space then crossing the quality chasm, there were six pillars of a high-quality health system. Equity was one of those.

We focus as a country in five areas, really did not do a lot in that sixth area. So it's a little bit lagged. We need to do some of that testing and trying it out. So don't wait until we have perfect data or the perfect response for that, but let's figure it out and learn from those lessons and move forward in that space.

MS. NUAMAH: Thank you so much to all the panelists. That's all the questions that I have here today. So I will turn it back to the Commissioners to ask your questions as well.

CHAIR BELLA: Thank you, Audrey, and thanks to our panelists. Cara, nice to see you again. It's been a while.

Bob, I saw your hand first.

COMMISSIONER DUNCAN: First of all, thank you for the presentation of information. It's exciting to hear what's taking place in a lot of states, and I really appreciate putting the beneficiary first. You talked about

focus groups. One suggestion I have is utilizing the CDC's REACH model. We've utilized that some in Wisconsin. We have found that that has been effective, but one question I have, as we talk about addressing social determinants in health equity and you talked a lot about what the states are doing in working with the MCOs -- Monica, I really appreciate your sustainability thought process. How do you align with what the state expects, what you want the MCOs to do, and then the providers? Because what I often see is the state -- excuse me. The MCOs have one direction, and then the providers are looking -- when I say providers, hospital, physician groups -- looking at their data, and they're chasing another area of social determinants, and the two don't mix. So it creates some confusion and heartache. So is anybody working where you're trying to align all of those pieces together from an expectation standpoint?

MR. PIGGOTT: So I think in North Carolina, we're trying to align those expectations. That's why we've started down the line of doing the health equity payments, to advance health equity in the primary care space, and to align that with what's going on in the managed care space

as well as the managed care entities also aligning the priorities that the state has with what they are also doing with the providers, so that we are all aligned and on one accord.

That is a huge undertaking that we are moving down that path right now, and we are hoping that we will come out closer to where all entities are addressing the priorities for the state.

MS. TREVINO: I mean, I'll just echo Patrick's sentiments as well. I think there will inherently be some mismatch, even within MCOs. So that the Michigan -- and I'm sure many other states as well -- published the criteria on which plans will be gauged, which subset of measures are in the bonus, things like that, or will be a particular focus area. They publish those in advance. All the plans have the same requirements to look at the same measures, and the plans push that out to their providers to the extent that they need improvement in those spaces.

If you have ten plans, as Michigan does, and three of them are doing fantastically well in childhood immunizations, the state says childhood immunizations are a priority, those three plans are already doing the thing.

So they may not continue to focus on childhood immunizations. So what you'll hear from that plan, from the provider perspective is "We're not going to include childhood immunizations in the plan-specific bonus space, but we are going to include other measures like women's health measures". So there's always going to be that sort of mismatch. Are you going to have a pediatrician's office that can or does prioritize diabetes measures like you would for a PCP office or a family doc who sees more adults with diabetes? You're going to have some inherent mismatch.

I do think when the state agency, when the state Medicaid agency says these things are a priority for the entire population, I think that's where the plans can say, "Hey, look, hospitals and provider systems" or " hospital systems and provider networks, the state is pushing us in these spaces." So there is a certain amount of finger pointing where the plans can turn around and say, "Look, this isn't us. This is coming from the state" and the state has to be willing to own that and should.

But I think there will be some disconnect, I think, just on the basis of who serves which populations.

The hospital space, I think, is particularly disconnected from the provider organizations, and some of that may change with sort of big systems getting bigger. But there will always be some mismatch. I think if equity is the goal, then it doesn't matter what your priority populations are necessarily or your priority measures. If equity is the goal, then you're looking for a measurement methodology to be inserted into that performance framework. So whether this provider organization is working on immunizations and child measures and this provider organization is working at adult care measures, if the goal is equity, then as long as you have a framework that you've established and agreed upon, at least there can be consistency in that space.

MR. PIGGOTT: And this is Patrick.

I think the state really would need to engage at multiple levels. If there is a priority of the state, then the state really would need to engage with the beneficiaries on a level, the providers and the plans in a way that it's going to be consistent and align. And I think when we do engagement, before we even decide what the priorities are, that helps pretty much everybody to be engaged and really to help the state identify some of those

priorities.

DR. JAMES: In the last 10 seconds, I would just add also there is an opportunity to think really hard and strategically about multisector collaborations because we are seeing at this point, the social determinants that we're trying to address are not things that the health sector can solve alone, so working with education, working with business, working with others.

We were sort of excited to see in some of what we've been looking at is a roadmap of how do we build that equitable recovery with those multisector collaborations being part of that. The New York Fed as well as the St. Louis Fed have lifted up health as one of their priorities. So there is opportunity to pull those sectors in and think about what is everyone's role in addressing income inequality or education disparities and becoming a little bit more, as I say, bilingual and multilingual so that we in health can talk to education about these issues in a way that they understand in saying the finance, because what they're looking at is different from the outcomes of what we're sort of looking at, but we can all work to improve outcomes for everyone.

COMMISSIONER DUNCAN: Thank you.

MR. PIGGOTT: And just to give one last little bit of information, North Carolina from our department standpoint has NC CARES 360, which is a program to address social determinants of health, non-drivers of health beyond the Healthy Opportunities initiative that's going on, and that is statewide. And it's a platform also to be able to receive referrals, immediate referrals once individuals are assessed, and be able to really get them the services and supports that they need. And that is happening in North Carolina right now. I think we went live with that maybe a little bit over a year ago, but that is happening, and we do have a platform. Technology is the key. We do need technology to align with social determinants of health so that we could get the services and supports to beneficiaries all across the state.

CHAIR BELLA: Thank you all.

I saw Darin and then Heidi and then Stacey and then Kisha, and just to remind us, we have about nine minutes left with the panelists. I want to be respectful of their time. So, Darin, go to you next.

COMMISSIONER GORDON: Sure. Audrey and panel,

thank you. This has been great, great perspectives and great thoughts shared.

First of all, Cara, I appreciate you don't wait for perfect. I think that is good. That's helpful, and I actually heard someone speaking on this topic not too long ago. You don't have to have 100 percent of the data to identify if there's some equity issues in a particular locale. If you have 70 percent of it, it's very evident at that point. So I think that's very instructive, and I think we need to remember that.

I do want to follow up specifically with Patrick, something you had said, that it's the first time I had heard anyone speak to it, and I think it's very interesting, and this whole concept of alignment between the different players, the states, plans, and providers and the members.

You had talked briefly about how you all were incorporating a bit about health equity factor into the actuarial rate-setting process. Did I hear that correctly?

MR. PIGGOTT: We are looking at that now to figure out how we can impact the actuarial way we adjust things regarding per member per month, what are some of the

factors that we could impact. So we're looking at that piece right now, but we're not actually doing that at this present time, just assessing it.

COMMISSIONER GORDON: Well, the fact that you're looking at it, I think, is very, very important. As I think about where we had seen this in our state and the historic underutilization, largely driven by health inequities, when rates were being set, it's based off that history. Well, you're in essence, perpetuating underfunding in that situation. So I applaud you all for looking at that, and I think that's something that more states should incorporate. I know it's new in thinking about how to incorporate it, but that's something I haven't heard anyone addressing. I'm glad you all are moving in that direction. Appreciate it.

CHAIR BELLA: Thank you, Darin.

Heidi, then Stacey.

COMMISSIONER ALLEN: Thank you so much to the panel. Actually, my comment kind of follows up on Darin's comment.

It's been so refreshing to hear all of the ways that states can put incentives and guardrails around health

equity and align their vision with the way that they do every step of the process. I think that seems so important.

My question is related to these kinds of targets that are set, whether it's immunization rates or diabetes management. How is the denominator established? I'm thinking, is this coming from claims data where people are actually using care, and so you look among the people who used car, this is the rate that we're giving? Diabetics who were given an eye exam, for example. Or are you able to look at the population metrics to kind of get at that issue related to not everybody is getting care? And if you're not getting care, and if you're not getting care, you can't get high-quality care. The disparities may be worse than what you're able to observe because of the missing population.

So it may be that this is the approach everybody is taking, which is the denominator approach, but I was just curious because I'm not actually sure.

MS. TREVINO: I really love that comment, frankly, and I think it's important to be clear about what exactly you're talking about when you put some sort of

metric out there in the world.

What Michigan Medicaid historically used was a HEDIS specification disaggregated by race and ethnicity, simply because we needed to socialize the idea with health plans, and that is the framework that they were most familiar with, that Michigan Medicaid requires all of its health plans, whether they're accredited -- they have to be accredited. They don't have to be NCQA accredited. But regardless of who accredits the plan, all Medicaid health plans in Michigan have to submit HEDIS data through the audited HEDIS process.

So the process in Michigan was to use the HEDIS specification and denominator, and apologies to any of my NCQA friends out there, but we have talked to them about it as well. It was to use that HEDIS specification to define the population generally, sort of the universe with continuous enrollment and what is considered a person with diabetes, and then the subsection of those folks who qualify for the denominator and then, of course, the numerator is who got the thing, the eye exam, the foot exam, the guidance on nephropathy.

But I think to your point, Commissioner Allen,

who is it, of all the people who should have been in the denominator, who was in the denominator? So I think that's a really important point to be made, and at this point, there really aren't -- I've seen a couple of maybe dental measures who look at how many people had the annual dental visit and, conversely, how many people didn't show up at all for any, like no claim pinged in the system at all in what those populations look like. I would love to see more work in that space. Frankly, other than dental, I really haven't seen a measure where who didn't show up for care and what does that population look like. But it's definitely something worth exploring.

CHAIR BELLA: Thank you.

Stacey.

COMMISSIONER LAMPKIN: Thank you. So, first, I want to say, Audrey, wow. Your first public meeting session, and what a session. What a great panel. Thank you for bringing us this panel and your leadership and walking them through the discussion this morning. It's great.

And, panelists, thank you so much. It's been amazing to hear about what North Carolina is doing, what

Michigan has done. It's very exciting.

Patrick, I think what you described, that list that you ran through is the very definition of how to look at your program through with a health equity lens where you're infusing it through everything. So it's very exciting.

My question for all three of you is related to another topic that we have in front of us that we're spending time on this cycle and this public meeting, which is improving access measures and monitoring generally.

So, definitely, we've heard things from you today about the importance of data, high-quality data collected systematically with good definitions and the disaggregation of measures using that data. Do you have any other tips or call-outs you would have for us related to a health equity lens as we think about a framework for improved access and monitoring?

MR. PIGGOTT: In all of our plans, we have access standards, and we also have reporting related to access and whether individuals are getting access within a timely manner. All those things are embedded in the managed care contracts, and we expect to see data out of all of those

areas of access and timeliness and whether they're meeting the standards, and then if they gain access, are they actually getting into the appointments? Are they actually showing up, kind of like what you guys were just describing? Are they actually showing up for the appointment once they have gained access?

Then we have quite a few rural areas in North Carolina. Those are some of the hot areas that we are considering too. We have programs that are monitoring. Of course, the rural health centers are out there that we are also trying to monitor, where the individuals are gaining access in a timely manner.

Then one of the bigger things that we're looking at is are the providers able to advance telehealth services to get access to care and to get it more timely so individuals are getting the care that they need.

CHAIR BELLA: Cara or Monica, did you want to comment on that? I do want to note that we are at time. I don't know if you have any ability to stay a little bit longer. If so, we have a couple more questions. If not, we know where to find you, and we probably won't be shy about doing that.

Let me first ask, do you have a couple more minutes, probably five, knowing that we have questions, or no?

DR. JAMES: I have a hard stop because I have another meeting that is starting right now.

CHAIR BELLA: Okay.

DR. JAMES: But I'm happy to follow up with other questions if there's things that you want me to look at later.

I think on the access measures, I think there's also still more work, obviously, that we need to be doing, thinking about patient and family-centered measures and thinking about access for what we're looking at for, again, understand there's some. There was a CAHPS module that opens on cultural competency, things about that, that hasn't necessarily taken off, but thinking about that again as well as how we're developing those measures of not just could you get the appointment but also those challenges that people may have barriers in order to be able to attend and sustain that appointment.

Thank you. I apologize. I do have to go.

CHAIR BELLA: Thank you so much.

DR. JAMES: I'm happy to follow up.

CHAIR BELLA: Monica, you nodded; you can stay a few more minutes, I think? Patrick, are you able to?

MR. PIGGOTT: Yes.

CHAIR BELLA: Okay, Patrick. Did either of you want to say anything then, any additional comments on Stacey's question? And then we'll take two more, Toby and Dennis. And I'll ask you guys to be succinct in your questions.

MR. PIGGOTT: Right. I think just going along the line of access to care, one of the things, too, that, you know, sometimes individuals, especially from historically marginalized populations, if they don't see people that are working in those specific environments that look like them to address their needs, a lot of times they won't go. Sometimes it's that whole issue of sometimes there's fear; sometimes there are past thoughts about historical issues, and so they choose not to go. But we in North Carolina right now are looking at our historically underutilized providers and seeing if there's something that we can do in that space to advance health equity and to advance access to care for individuals that would

ordinarily not go to an appointment because they are leery of the health care that they might receive.

So we know that providers that look like the people that are served, they tend to have good health outcomes for those individuals that they are serving.

CHAIR BELLA: Thank you.

MS. TREVINO: And I'll just say in terms of access, again, to build on sort of the previous conversation about denominators and who is eligible versus gets care, I think there is something to be said for implementing some sort of methodology where you look at essentially level of acuity. If you have a population that accesses behavioral health services or SUD services, you know, one time, then they go to the -- then sort of the subset of those who go to the ED, and then the subset of those that go to an inpatient facility of some kind. So looking at the population across different points in the system and looking at where there are differences in quality of care or in disparities across those different segments of the population, right? Not so much that it's bumping two measures up against each other, but bumping a -- measuring the system and how it treats people at

different points versus an individual measure applied to a different universe of people every time, I think that's something we're just starting to toss around in Michigan in the behavioral health space, looking at sort of who is mild to moderate and then who is ED and then who is inpatient, and are there differences in the populations generally who get those services, but then, you know, as a follow-up after an ED visit, there are significant disparities, follow-up after an inpatient visit there are significant disparities, and are those disparities bigger after those more acute events than they are with that mild to moderate population. We're just on the front end of looking at that, but that sort of concept of looking at different levels of the system in terms of access I think is important and should be explored.

CHAIR BELLA: Thank you. Toby.

COMMISSIONER DOUGLAS: Thank you. First, what a great panel, and thank you all, including Audrey, for the wonderful discussion.

I just want to follow up on Heidi's and Monica's point on the denominator and concerns we're excluding a marginalized population from data analysis. It really

brings up this issue around beneficiary engagement of individuals of color who are less trusting of the system, and I wondered -- Patrick, you kind of touched on it, and, Monica, what are some of the best practices on how we engage those underserved populations and build trust, especially through the lens of like an MCO, Medicaid, what we can do in those areas?

MS. TREVINO: I think to Cara's previous point about using trusted mechanisms in the community, trusted resources in the community, you know, in Michigan there has been a requirement in the contracts since 2015 that health plans provide community health worker services to beneficiaries. Health plans can hire their own CHWs. There is a definition of CHW, and there are some core competencies in the contract. Health plans can either hire their own, or they can subcontract out with community-based organizations. You know, the state wants to encourage those contracts with community-based organizations for exactly that reason, because if you have those trusted sources in the community, again, to Cara's point, you're not going to knock on someone's door as the Feds and say, "I really want to help you."

But if you can meaningfully engage with an organization who can meaningfully engage with the population, I think that's a really great start, and I think encouraging or requiring or incentivizing community health workers by a state agency is a really great step in the right direction, I think mostly because it's -- you know, you build on those. As long as the CHWs are operating in the typical way that they do, it is a great way to get beneficiary perspective, not so much that you would only talk to the CHWs, but I think that the CHWs can help bring that perspective -- bring those beneficiaries to the table just as their own self-advocates. I think that's an important point.

CHAIR BELLA: Patrick, anything to add there? Otherwise, we'll go to our last question.

MR. PIGGOTT: Yes, just a little bit. We have human service organizations (HSOs) in our state who are right there. They're the community-based organizations, and through our new Healthy Opportunities Program, they are in those communities, so they will be engaging members and beneficiaries from, you know, different standpoints. Also, we have community health workers that work with our NC

CARES 360 as well as even from the public health side of the house.

So there are more community-based organizations that are working to engage the members and get the members exactly what they need, and I think that's what we need to be focused on as we move forward to address health equity and advanced health equity in the Medicaid and CHIP space.

CHAIR BELLA: Thank you.

Dennis, last question, and we are seriously over time.

COMMISSIONER HEAPHY: Okay. I guess my question is about advancing health equity for folks with disabilities and specifically within racial and ethnic minority populations. How do we ensure that folks with disabilities in these populations are not just treated as a poor health outcome but there's real efforts to advance equity for folks with disabilities broadly, but more specifically within racial and ethnic minority populations? Because, historically, there has been this siloing of the populations, and how do we bring that together? Because in COVID we saw that intersection and how it played out with a disproportionate impact on folks with disabilities for

racial and ethnic minority populations, African-Americans in particular. And so how do we make sure that we're able to prevent those disparities from happening in the future?

MS. TREVINO: Well, I'll just start and say that I think the easiest -- one of the easiest things to do is to disaggregate data and to look at specific populations to disaggregate those data. I'm going to start in the next couple of weeks looking at in Michigan the Children's Special Health Care Services Program (CSHCS) and looking at their standard quality and performance measures and breaking those down by race/ethnicity, not only just to get a program-specific look at how equity operates in that program, but, frankly, to then look at those differences in CSHCS versus differences in Medicaid and CHIP overall, because I am guessing there will be some -- there will be a difference in those differences.

So that's sort of, you know, one of the first and, frankly, I think easiest things you can do, but it has to be someone's job to do it, to sustainability as well, build this work, equity in all of the spaces into someone's job. You know, as part of your two- or three-year grant or whatever it is, rewrite position descriptions, redo your

organizational infrastructure to include this work very clearly in actual job descriptions. If it's no one's job to do it, it will not get done. Yeah, and I think that disaggregating those data by all of the things, but especially disability, race/ethnicity, and how those intersections work I think is key. And I don't see people doing that, and I think you're absolutely right, Commissioner.

CHAIR BELLA: Thank you. Patrick.

COMMISSIONER HEAPHY: Exciting.

MR. PIGGOTT: Commissioner Heaphy, I think it goes back to beneficiary engagement, engaging individuals with disabilities, hearing their experience, hearing their stories as well as those trusted sources that they are connected with to bring about change within the Medicaid program and CHIP program as it relates to advancing health equity.

Also, you know, the data is important, very important. I think we can't really move without having the data. But there are gaps in data that does not speak to sometimes what the beneficiary's experience is, and we need that to really hone in and focus on those specific areas

that are true, equity issues and disparate issues related to individuals with disabilities.

Recently, we just had a series where the department has talked about advancing health equity within individuals with disabilities, and those series have been really beneficial to the Medicaid program here.

COMMISSIONER HEAPHY: Thank you.

CHAIR BELLA: Thank you both. We really could keep talking to you forever. We won't. But, again, I wasn't kidding when I said we won't be shy. We know where you are. And you know where we are, and this is -- you know, we're going to struggle for a while figuring out how do we apply this lens, and we're going to need to hear from real people who are doing the work -- not that other of my fellow Commissioners aren't doing the work, but you know what I mean. And so our door is always open for you to say, like "if I'm sitting in your seat, this is what you should be doing, and, you know, you need to be doing more and you need to be giving states cover and you need to be" -- whatever it is, don't hesitate to reach out. And I just can't thank you enough for spending this time with us today. Thank you both.

MS. TREVINO: It was a pleasure to be here.

CHAIR BELLA: Thank you so much

MR. PIGGOTT: Thank you. Thank you for inviting us.

CHAIR BELLA: Thank you for the work you're doing.

Okay, Commissioners, we have a little bit of time left. This is a really important subject. If we need to run a little over, we will run a little over. Kisha is going to kick us off, and I just have a question, though, Audrey. I'd love to know, as we continue this work, how many states are creating chief equity officer type positions within their agencies. I think that would be really interesting to understand if we're seeing some of that. I know we are seeing that at CMMI and at the federal level, but it would be interesting to keep an eye on that kind of thing.

So, Kisha, I'm going to turn to you to kick us off.

FURTHER DISCUSSION BY COMMISSION

* VICE CHAIR DAVIS: Sure. Thank you again, Audrey, for putting together just a wonderful panel. You

know, one of the things that struck me as we were listening, as we were -- you know, we're hearing from the folks who are doing a great job. You look at the examples of North Carolina and Michigan and what they are doing in their state. And, you know, I think this being a platform to just share those best cases of examples of states who are earlier in the process.

I'll just say generally, you know, in our materials, Audrey, you gave us this list of potential policy levers, and it's a long list, and there's a lot we can do. And I think in a lot of ways, health equity can feel overwhelming. We don't have great data. There are so many places to impact. There's -- and it in many ways feels hard to start and hard to make an impact, and if you can't impact all of it, then are you really making a difference at all?

You know, I would just encourage us as a Commission to think about where do we start and where real opportunities are for impact. I think one of the things as a Commission, we have the opportunity to really shine a bright light both on what's going well, like North Carolina and Michigan, but also where there are troubles. And so

using our platform to highlight the disparity where we see it, and I think really going beyond just here's this barrier, but really tracking and monitoring over time so that we're starting to see impact and improvement.

I think, you know, the work that we have done in the maternal space is a good example of that. Here's an issue that everybody is talking about, but how are we really going to get crisp on not just there's a problem, but get really working towards a recommendation that's going to improve equity in that area. And I think if we as a Commission think about what are the -- you know, rather than boiling the ocean, what are the two or three topics that we really think that we can have an impact on?

You know, a suggestion I have in that area is really around access. How are we making sure that access to Medicaid, to health insurance, to health care is equitable and looking at that, I think as Cara mentioned earlier, as a population of the United States and as a population within states and how state differences in application of Medicaid eligibility result in inequitable access across the country.

And then the last thing that I'll just say --

and, you know, Patrick brought this up at the end around community health workers and the workforce that we have. And I think community health workers are such a great program for that last -- I call it the last mile of the way health care, you know, helping to translate whatever's happening in that medical space to the patient.

But I also think it's a poor commentary that we haven't done a great job with our medical workforce in them being able to communicate with the patients that they have, that we need that intermediary. So as we think about continuing to encourage that cultural competency in our medical workforce, but also diversity in that workforce and those programs and incentives that, one, help folks get to the table, to be a provider of care, but also that help them stay in the game and continue to provide services for Medicaid patients. There's lots of reasons providers drop out and don't want to continue to see Medicaid patients, and so as we're continuing to look at access on the patient side but access in terms of network specificity, network availability.

CHAIR BELLA: Thank you, Kisha.

Other Commissioners? Laura, then Martha.

COMMISSIONER HERRERA SCOTT: So, Audrey, great job. It was just a really great panel, great facilitation of the panel, and, you know, Kisha, I agree with the comments you said.

A few things that I heard and talking about, like you said, Kisha, those concrete next steps, Cara described the data and health equity starts with the data, but we have almost half the states that don't have good data. I think she said 22 states' data was either concerning or unusable. So if we're going to start looking at this across all our markets, what is it -- what do those states need to shore up their data so that once we start moving in this direction, everyone has what they need in their data systems to pull it out.

And, two, thinking about the opportunities or some of the low-hanging fruit, you know, almost all the states are using HEDIS as a quality, and I know, Kisha, you just mentioned access. But could we start disaggregating that data and see what it looks like.

And then, Heidi, to your point, if it's not representative of the population, who's rolling out of the denominator and why? And is that the proxy for access? So

just thinking about what we have today and how do we start assessing that.

And then, last, I know it's not necessarily a purview of this Commission, but thinking about how do we start ticking and tying some of the opportunities across our federal partners, so thinking about food insecurity as a driver for health inequities as an example, and whether or not there could be some data sharing and opportunities to facilitate enrollment in programs like WIC or SNAP that can help address food insecurity that's driving a health problem that's disparate because of access to food.

I could go on and on, but lots of opportunities, and great presentation.

CHAIR BELLA: Thank you, Laura. Martha?

COMMISSIONER CARTER: I think there's so much to think about here. I'm having a little hard time sort of pinpointing. But a couple things really struck me. One was Monica's talk about how it's important to give plans time to change and, you know, how they've got to build that into their contracts -- both speakers talked about that -- work with the plans, build measures into their contracts, give the plans time to then arrange their contracts with

providers. And so I think that was just really important. And the expectation that the plans and the providers build in beneficiary engagement to develop their plans.

I also, again, from Monica, heard that she wants the Feds to be stronger in requirements to the states and to provide technical assistance. I think that's an area that we could comment on. I'm not entirely sure what all CMS is already doing. I think you all mentioned some things. But like you said, Melanie, maybe providing the states some cover and saying this is a requirement that you build health equity into your contracting, into maybe your value-based payments, and here's some best practices to accomplish that. Then there's more, but -- like Laura said, there's a lot more.

I had also just a question. This is really a basic question. I apologize. How is the CAHPS survey administered? Really, that's kind of a leading question, because if it's just administered electronically, then who are we missing? So can somebody help me understand how CAHPS is administered?

COMMISSIONER ALLEN: I don't use CAHPS because I study Medicaid. There's only been one CAHPS. But most

federal surveys are multimodal where they have mail surveys and then telephone surveys, and some of them are moving into electronic surveys. So I can't speak specifically to CAHPS, and if anybody else has any idea, that would be great. But I do think that most of the time they don't just rely on one approach.

COMMISSIONER CARTER: That's good to hear. I know from experience that people that we were reaching in our community health centers and our SUD program didn't respond to electronic surveys. So I think that's just a point to put out there. That's all I've got for now.

CHAIR BELLA: Thank you, Martha. Tricia and then Kathy and Verlon, and then I'm going to go to public comment, and then we'll come back.

COMMISSIONER BROOKS: I just wanted to lift up something I think that Monica said. I don't know if people know Monica's background or read the bios, but she really launched a lot of the data collection that was started in Michigan and is a real model many, many years ago, but that is, someone has to own this. And I think that's true of other aspects of Medicaid and CHIP, for example, outreach. One of the things that happened when CHIP came along is

that you had Child Health Insurance Program officials who were charged with outreach, and that really drove enrollment in both Medicaid and CHIP.

So I think lifting up this idea that somebody has to own it is important, and I just want to comment again, I was really blown away by Audrey's facilitation. She did a fabulous job.

CHAIR BELLA: Thank you, Tricia. Kathy?

COMMISSIONER WENO: I'll just second that. I mean, I was kind of blown away by this whole panel. There's just so much that we discussed that I don't really know what to hook on right now. But in oral health, we've been tussling with this for a long time. There's a lot of disparities in oral health, and I was really happy that we really touched on the social determinants of health here because in my time at CDC we were always trying to engage community-based resources and community-based interventions in order to impact large populations, things like school-based services and getting to the beneficiaries we wanted to get to in the places where they were. And I think that's something that we really need to stress in any intervention.

So I want to also talk about, you know, providers and the way that we were looking for providers that look like the beneficiaries that we're trying to help, and that's something that needs to be in every discussion that we talk about with health equity, because that's a huge issue, and making sure that the beneficiaries really understand the benefits that they have. Heidi had a great comment yesterday when she talked about people that were calling dentists to get a dental appointment, and then they assumed that their entire Medicaid benefit was just emergency when, in fact, it was only their dental, because as we know, dental doesn't -- there isn't a broad-based dental benefit for everybody that's on Medicaid.

So, anyway, those are topics that really engage me that I wanted to comment on. Thank you so much for this panel. It was great.

CHAIR BELLA: Thank you, Kathy. Verlon?

COMMISSIONER JOHNSON: So I will just echo the comments to Audrey. Fabulous panel, very helpful, and all the great things everyone else said.

I think one of the remarks that stood out for me the most, especially as we consider Cara's guidance around

not waiting for the perfect, was this idea behind finding the easiest pathways forward. And, you know, I've been in Medicaid for a long time, so I'm really trying to think of what are those pathways, right? So I'm not sure that obviously we all know that. I know that Monica had mentioned the APD funding process in her remarks a little bit, but I'm hoping that we can maybe get to a little bit more of that kind of thought as we talk to states and best practices, but also, you know, if there's additional intel that we can gather that may help us with those different pathways, especially as we look at the policy levers that are kind of identified, I think that would be helpful.

CHAIR BELLA: Thanks, Verlon.

Dennis, I have you in the queue, and I'm going to go to see if we have public comment on this session and on our panel. If so, please use your hand icon. A reminder to introduce yourself and your organization and to please limit your comment to three minutes or less. It looks like we have one.

PUBLIC COMMENT

* MS. HUGHES: Yes, Ellen, you've been unmuted. Now if you could unmute yourself and make your comment.

Ellen Breslin, we have a microphone icon at the top of your control panel if you'd like to unmute yourself.

MS. BRESLIN: Sorry about that. I think I did that by accident, but I would be happy to comment and share with you some work that Minnesota also did a few years ago. I was working on this project in 2016 which came out of the legislative mandate requirement to look at health disparities. And so Minnesota took the bull by the horns and really re-created a population health framework, and we leveraged the claims data. So to the many comments focused on the denominator today and how problematic that is, but it doesn't capture, you know, complete access and coverage, those are really, really legitimate concerns about using claims data.

But I think there is a way to do this work now and now wait for a perfect data set, and so that we can really focus on the disability populations and we can focus on disaggregating the data using the claims to create algorithms to sort, and I'd be happy to share that report with the Commission.

Thank you.

CHAIR BELLA: Thank you, Ellen.

Do we have anyone else who would like to speak?

[No response.]

CHAIR BELLA: It does not look like it. Okay, Dennis, back to you.

COMMISSIONER HEAPHY: I'm thinking about -- this is a little bit of what Ellen was saying -- how do we work with the data we have and not wait for the perfect data to be there. I think that's something I'd love to see the professional folks at MACPAC work on. What are the best practices going on in states in data collection or utilization of data that exists? Because a lot of it is garbage, and is there anything we can do in this phase to collect Medicaid data on health disparities impacting racial and ethnic minority populations? I say that because we're struggling with it in Massachusetts, and I sit on several committees, and there are all these conversations about culturally competent and humble collection of data and different understandings of what the data is going to be used for. So do we jump that step and then just go to the data that exists?

I'm asking folks, where do we even begin with this process of looking at the data and the data

collection? And if there is data out there that is good, even if it's claims data, can that be used? What do we use? What's available to us now? And not just do it in one state, but do it nationally and maybe even understand the capacity of states to collect data and see what needs to be done to increase their capacity to collect data on race/ethnicity and other disparity groups.

CHAIR BELLA: Yeah, I'm going to suggest -- Dennis, that's a really good point, and I will throw a suggestion out there, and, Audrey and Anne, you can decide if you think that makes sense. It feels to me like -- I mean, there obviously is great Commissioner interest here. There is a question on the table about do we want a chapter in June. I think the answer is yes, we want a chapter in June this year, and March and June next year, and March and June the following year. We have done work, Dennis, on the data piece, and we didn't get time to go through all of the specific policy levers that were in the write-up. I'd like to see this come back where we are getting to talk more specifically about those pieces. We could also have a refresher, I think, on what we found in the data and what's there and what's not there and what we could make of what

we have and what's disaggregated and what's not. So that to me feels like a pretty -- like a whole discussion that we probably wouldn't do full service to today if we tried to squeeze it in right now.

Anne?

EXECUTIVE DIRECTOR SCHWARTZ: I'm just going to say we have a brief on data that will be coming out in January. There are also some other resources that others have done, particularly around how states are trying to improve collection of race and ethnicity data at application and some techniques they're using. So there's a lot that we can share with you all in advance of a next Commission discussion around specific levers.

CHAIR BELLA: Does that work, Dennis? So high on the list, and we'll bring it back and have a more detailed focused conversation on data, and then also, Anne and Audrey, the policy levers, digging into those a little more, maybe how you might want to bring them back to us, having heard what we heard from the panel and the discussion today.

COMMISSIONER HEAPHY: That's good. I wasn't looking for it today.

CHAIR BELLA: The good news is there is some work already out there today, but it sounds like we're continuing to build on it. Okay. Does that sound like a plan, Anne? And you can tell us if January makes sense or we need to wait, but obviously we'll bring this back in one of the next couple of meetings. Then we'll work toward a June chapter.

Any further comments from Commissioners?

[No response.]

CHAIR BELLA: Very strange. It's time to take our lunch break, Toby's breakfast break.

All right. We've had public comment. We're done with this session. Audrey, let me just say again thank you so much. You obviously hit the mark here, so we look forward to having you bring this back to us.

Thank you, Commissioners, thank you, Anne, thanks, Jim.

We will see everyone back here at 1:00 p.m. Eastern time, and we will start back with a panel on policy levers to look at and nursing facility staffing issues. So we'll see you all back here shortly. Thank you.

* [Whereupon, at 12:03 p.m., the meeting was

recessed for lunch, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

CHAIR BELLA: We are ready to get started. Welcome back, everybody. Rob is going to take us into a session on policy levers to address nursing facility staffing issues, a very timely topic.

Rob, take it away. Welcome.

STATE POLICY LEVERS TO ADDRESS NURSING FACILITY STAFFING ISSUES

* MR. NELB: Great. Thanks very much, Melanie.

I'll be talking today about state policy levers to address nursing facility staffing issues. This work comes out of our prior work around nursing facility payment and is also related to our ongoing work around issues related to the long-term-care workforce.

So I'll begin today's presentation with some background about current nursing facility staffing requirements, and then I'll share some of our findings about the current variation in staffing rates and payer mix

and discuss some of the implications of these findings for quality care and health equity.

Then I'll discuss some of the findings of our review of state policies related to nursing facility staffing listed here and the association between these policies and the staffing rate.

Finally, I'll conclude by highlighting several policy questions and potential next steps for the Commission's work in this area. There are a lot of specific questions we can examine, but one overarching question to keep in mind as I go through the presentation today is listed here on this slide: What is the role of Medicaid payment policy in helping to ensure access to high-quality nursing facility care, especially for racial and ethnic minorities, who have historically received substandard care?

I know many Commissioners are interested in efforts to rebalance long-term care and promote greater use of home and community-based services rather than nursing home care, but for today's presentation, we're going to focus on ways to improve the care for those beneficiaries who remain in nursing facilities for whatever reason,

perhaps because of unstable housing or complex care needs that may be difficult to get in other settings.

First, some background. As you likely know, Medicaid is the primary payer for most nursing facility residents in the country, and the vast majority of Medicaid-covered nursing facility residents are dually eligible for both Medicare and Medicaid. What this means is that Medicare covers skilled nursing care for up to 100 days following a hospitalization, and then Medicaid covers subsequent days of long-term care. For these dual-eligible patients, the payment incentives are further complicated by the fact that Medicare is the primary payer for hospital care for these patients, and so any savings from reduced hospitalizations as a result of better nursing facility care tend to accrue to Medicare rather than the Medicaid.

One last note is that the analyses in this presentation focus on freestanding nursing facilities, those that are not part of a hospital, as well as focusing on those dually certified by Medicare and Medicaid. This accounts for 91 percent of the approximately 15,000 nursing homes in the country.

So in this presentation, we're also going to

focus on direct care staff in nursing facilities. These are the primary providers of care for patients and account for more than half of nursing facility costs.

By direct care staff, there are three primary types that we examined. First, registered nurses, or RNs, have at least a two-year degree and are responsible for overseeing a resident's care. Second, licensed practical nurses, or LPNs, typically have a one-year degree and help provide routine bedside care. And, finally, certified nurse aides, or CNAs, have at least 75 hours of training and generally assist residents with activities of daily living.

It's important to note that CNAs account for about two-thirds of direct care staff in nursing facilities, and most CNAs are paid close to the minimum wage, and more than half are people of color.

Staffing rates are often measured in hours per resident day, and there's a large body of research going back several years showing an association between higher hours per resident day and better health outcomes for patients, including reduced infections, fewer hospitalizations, and decreased mortality.

So most of the current nursing facility staffing requirement go back to 1987 and the Federal Nursing Home Reform Act. Since then, nursing facilities have been required to have a licensed nurse 24 hours a day and a director of nursing eight hours a day. For a typical 100-bed facility, this translates into 0.3 hours per resident day.

Over the years, there have been various efforts to push for higher minimum staffing standards. Most notably, in 2001, CMS convened an expert panel that recommended that facilities provide 4.1 hours per resident day in order to reduce the risk of harm for long-stay nursing facility residents. However, most nursing facilities currently staff below this level.

In this presentation, I'm going to focus on the number of facilities with a one- or two-star staffing rating on CMS' Nursing Home Compare website, which is part of a five-star rating system that measures how staffing rates compare to other facilities.

In the 2019 data that we used a two-star staffing rating was equivalent to less than half an hour of RN care and 3.6 hours of total direct care staffing per resident

day. These are levels that have been described by researchers as "dangerously low."

One other note is that I know there's been a lot of discussion about the quality of the data in Nursing Home Compare, especially some of the data related to surveys and inspection results. But I want to note that the staffing data that we're using in this study is different from that and, in fact, there have actually been a lot of efforts in recent years to improve the quality of the staffing data. As a result of the Affordable Care Act, nursing homes now submit auditable payroll data to describe the staff that they provide, which is more accurate than previous measures, and that's the data that we're using in this analysis.

So moving on to some of our results, this figure shows the share of nursing facilities with a one- or two-star staffing rating by payer mix of facility in 2019. You can see that the facilities that serve the highest share of Medicaid patients, on the right of this graph, are more than twice as likely to have a one- or two-star staffing rating compared to the facilities that serve the lowest share of Medicaid patients, shown on the left of this

graph.

In addition, it's important to note that the facilities that serve the highest share of Medicaid patients also serve a much higher share of Black and Hispanic beneficiaries, and so this variation by payer mix also contributes to health disparities.

Looking behind these numbers, we also see considerable variation in the share of nursing facilities with a one- or two-star staffing rating by state. For example, in 2019, 13 states had less than 10 percent of facilities with a one- or two-star staffing rating while three states had more than 70 percent of facilities with these low ratings.

Overall, the disparities that we see by payer mix and the variation in staffing rates by state suggest that state policies, especially Medicaid payment policies, could have an important role to play in addressing staffing challenges. In this presentation, we looked at three broad categories of policies. First, states could increase their Medicaid payment rates, which theoretically could help facilities hire more direct care staff and pay them higher wages. Second, states could change their Medicaid payment

methods in order to incentivize facilities to spend more of their payments that they do receive on staff rather than retaining those payments as profit. These incentives are likely big motivators since many nursing facilities are for-profit.

We looked at three different types of payment methods in our analysis: first, cost-based payment methods, which base a portion of Medicaid payment rates on direct care costs; second, we looked at wage pass-through policies, which require facilities to spend a specific portion of the Medicaid rate on staff wages; and, finally, we looked at value-based payment incentives that are tied to staffing metrics.

Last, but not least, states can simply require minimum staffing standards that exceed the federal requirements. This isn't a Medicaid payment policy per se, but we included it in our review since it's one of the other policy levers that states have to affect staffing rates.

So to better understand the use of these various policies, we contract with RTI to develop a compendium of current state policies related to staffing, and we

validated this information with the relevant state officials. More information about each of these policies is in your materials, but in general, we found that state adoption of these policies was mixed.

Many states do have some minimum staffing standard that exceeds the federal requirement of 0.3 hours per resident day, but only 11 states and D.C. had standards above three hours per resident day, which is currently the cut-off for a one-staff staffing rating.

We did find that most states used cost-based payment methods for nursing facilities, but as we reported last year in our payment compendium, the use of cost-based payment seems to be declining. More states are adopting price-based methods.

Finally, we find ten states with wage pass-through policies and 14 states with pay-for-performance incentives related to staffing.

For each policy we then examined the extent to which the state policies helped explain some of the variation in staffing rates that we saw in 2019, and, in general, we found positive associations between state adoption of these policies and better staffing rates.

These findings are generally consistent with prior research in this area, and just one note that there is quite a bit of research on this topic. We contracted with About Associates to do a more formal lit. review of prior research, and more information about that is in your materials. But, anyway, there's a lot of research sort of supporting what we found in our study.

We don't yet have complete data on Medicaid payment rates by state, but prior research does suggest that higher Medicaid payment rates are associated with higher staffing rates. As a proxy for Medicaid payment rates, we examined facilities' non-Medicare margins in 2019 using data from MedPAC that ultimately came from Medicare cost reports.

Non-Medicare margins include both Medicaid and private-pay patients, but because Medicaid is such a large payer for nursing facility care, the non-Medicare margins are primarily driven by Medicaid.

In the aggregate, non-Medicare margins were negative 2 percent in 2019, lower than Medicare margins, which were positive 20 percent in 2019. However, we found considerable variation by state. In 21 states there were

positive non-Medicare margins in the aggregate, and in 15 states the non-Medicare margin was 3 percent or greater, suggesting that Medicaid is not always paying less than costs.

In our analyses of the 2019 staffing data, we found positive associations between non-Medicare margins and the share of facilities with a one- or two-star staffing rating, which is consistent with prior research.

So the data I've presented so far highlight the many staffing challenges that existed in 2019, before the COVID pandemic. Since then COVID has obviously exposed many long-term-care staffing challenges and in some cases has made them worse.

In nursing facilities, the total number of staff has declined during the pandemic, but so has the average nursing facility census. As a result, total hours per resident day is more or less the same as before the pandemic, and in some cases has improved slightly.

The pandemic has also prompted some states to take action to improve their staffing policies. In our review, we identified ten states that increased minimum staffing standards, one state that added a new wage pass-

through policy, and two states that added new minimum wage requirements -- sorry, four states that implemented new payment incentives related to staffing. In our review, we also identified two states that added new minimum wage requirements for direct care staff and one state that added a new direct care loss ratio requirement that caps nursing facility profits and requires them to spend a portion of their revenue on staff. These last two policies are relatively new, and we haven't seen them implemented in other states, and so it will be interesting to see how they work out.

In our review, we also identified 12 states that added hazard pay for nursing facility direct care workers, which is a temporary increase in payment rates during the pandemic, but it's important to note that it's not clear whether these increased payment rates will continue after the pandemic.

Now that I've reviewed the results, I just want to spend a little bit of time talking about potential next steps for the Commission. So we do plan to publish our state policy compendium on our website, which helps describe some of the various policies by state, and

hopefully it will be a useful resource for states and other stakeholders interested in this issue.

However, if there is Commission interest in making some policy statements in this area, we could also draft a chapter that comments more specifically on Medicaid's role in addressing staffing issues.

From the work we've done so far, the Commission may be able to draw some conclusions or make comments in some of these following areas listed. For example, we could comment on the effects of low staffing on access and quality of care, and comment more specifically about Medicaid's role in addressing some of the health disparities that we see.

Next, from our review of the payment methods, we could talk more about which payment methods are better than others and create appropriate incentives for staffing.

We could also comment about the relationship between state policy and federal staffing requirements, given increased discussion at the federal level about potentially increasing minimum staffing standards.

And, finally, we could talk about opportunities to align efforts to improve nursing facility staffing with

efforts underway to improve the home and community-based services workforce.

In the next report cycle, we're hoping to compile more detailed information about how Medicaid payment rates compare to nursing facility costs using data from T-MSIS and other sources. This task is technically challenging, and we're not actually sure yet whether we can do it, but we're going to convene a technical panel earlier in the year to review our methods, and hopefully we'll be able to present some findings in the next report cycle.

If we are able to come up with more data on payment rates, we can also work -- it will hopefully help inform Commission discussion about potential policy options to improve nursing facility payments in the future.

I welcome Commission feedback about whether there's particular policies you'd like to examine further. For example, CMS is currently required to ensure that Medicaid payment rates are sufficient to ensure access, but it's not always clear how this is enforced, and so there may be some opportunities for improvement in this area.

Finally, to help guide your conversation today, here's a list of policy questions you might want to

consider, those questions that we may be able to comment on in this cycle in a potential report chapter as well as some questions we might want to consider as we develop future work in this area.

I'm happy to answer any questions you have, but mostly I'll be listening for your feedback on where you'd like to take this work. Thanks.

CHAIR BELLA: Thank you, Rob. Appreciate you laying it out so clearly. It feels like we should be absolutely going forward in this area, and so I'd love for the Commissioners, as you comment, to affirm whether you're feeling that too and then be very specific about the areas of interest.

Heidi, I'm going to turn to you and see if you want to kick us off, and then I see Martha, Bill, Brian -- Rob, I may have seen you, but maybe not, but we'll come back and we'll get everybody. Thank you, Rob.

COMMISSIONER ALLEN: Thank you, Melanie, for letting me kick us off, and thank you, Rob, for this presentation and for the memo, which was really, really helpful. I am interested in the Commission looking at this further. I'm interested in us exploring the way that the

Medicaid program can support states in implementing approaches that would address staffing issues.

I think that the things that came to me that I've heard both today in the speaking and when I read the report or when, you know, earlier this morning, when we talked about health equity and how do we get to health equity in the Medicaid program, and all I could think about is that every conversation, every one of these policy conversations that we have really are like an opportunity for us to engage in health equity. And in this case, the report calls out very quickly that it's not just that Medicaid is disproportionately people of color, but that facilities who serve Medicaid patients disproportionately serve more racial and ethnic minorities.

From the report, you could see that serving primarily Medicaid beneficiaries -- so, again, which is another way of saying serving primarily racial and ethnic minorities -- is clearly related to quality and that staffing seems to be one of those mechanisms or levers that we could look at that could improve quality.

Of the three policy options, I felt like the ones that from the table seemed to be associated with movement

out of the one- to two-star category into a higher star category were the state minimums and staffing that exceed the federal requirements and align with the research that we -- I mean, it's just great that there's a deep research evidence in this that we can rely on, but the states that have aligned their requirements, what the research suggests is associated with higher quality or getting better outcomes; and that the wage pass-through plus cost-based payment approach seems to be a winning combination for the states that have it.

In terms of information that could help me think more deeply about this issue, I'm interested in the relationship between wages and staffing. I know it might be hard to kind of get a sense of what the wage -- the average wage per hour per resident day is, you know, to try to get a sense of like how that's distributed. But I'm wondering if we can use any of the data that we have about wages to inform our analysis of payment methods and payment adequacy. Specifically, what kind of wages do they need to have in order to ensure access? And at what point do low wages get associated with poorer staffing and access? And what should we benchmark against locally?

So those are the questions that come to mind, and I look forward to the discussion.

CHAIR BELLA: Thank you, Heidi. Bill, then Martha.

COMMISSIONER SCANLON: Yes, thank you, Rob. This was an incredible amount of very helpful and useful information, and I'm going to agree with both Heidi and Melanie that this is a timely topic. It's an incredibly timely topic. Medicaid nursing home payment has been a perennial issue for the program. The Congress first intervened on this in 1972, so it's been like 40 years that we've been thinking about this. And the pandemic just brought home even more strongly sort of how important it is and how we really need to pay sort of more attention to it.

You've outlined sort of options for us with additional work, and there certainly is an incredible amount of additional work that needs to be done. But let me be so bold as to way I think we're ready to make some recommendations immediately. And the first one relates to a world we used yesterday with respect to directed payments. We need total transparency about Medicaid nursing home payments and how those dollars are being used.

The idea of more states adopting wage pass-throughs is positive, but the details matter in terms of the policies with respect to a wage pass-through, and then sort of what happens exactly to the money matters. So we're talking about transparency that goes beyond the usual cost report that you get from an individual facility to knowing about the kinds of payments that may be flowing between related party companies that are owned by a single entity, because we do not want sort of additional money being devoted to -- that we think is being devoted to improving staffing resources to be spent -- given to a related party and becomes -- part of that becomes that related party's administrative costs and profits. So we really need 100 percent transparency.

It also, though, extends sort of to other areas in terms of what nursing homes spend their money on. I think it's very important for Medicaid programs not to set a single daily rate that is for an undefined sort of set of services, because other things besides staffing matter in terms of a resident's sort of quality of experience. It can include dietary, it can include activities, it can include maintenance of the facility. And it used to be the

norm almost that states would take all of those things into account and set targets for each of those things. And when states were updating their rates on an annual basis, facilities were strongly encouraged to continue to spend their money in the way the states were directing that money because otherwise they were going to have lower rates sort of in the future.

So I think thinking about sort of returning somewhat to the past, so to speak, in terms of how states were paying and move away from the trend which I find relatively unfortunate that you've identified that we have more than ten states that are paying price, which in some respects to me is naive, because you do not know sort of what's happening to your money. It's naive in part because I think it's based upon a false assumption. I've heard sort of in policy discussions that we really need to maximize the incentives for efficiency and that something like a price rate or a single rate is going to maximize that incentive.

The reality is what it does is it maximizes the incentive to reduce your costs, and there are two ways to reduce your costs if you're an operator. One is to improve

your efficiency; the other one is to reduce the quality of your product. And we don't know how much of either of those is happening, so to me we'd be much better off if we knew where the money was going, and then we could assess sort of how different allocations of resources affect the quality and the services that we care about.

In terms of our future work, I think that we definitely need to see how far we can get in terms of looking at sort of data and comparing sort of experience between sort of the rates that are being paid and costs. But at the same time, I would be cautious, recognizing that I had spent a lot of time, again, 30 years ago almost, working in individual states, and it was a complicated task one state at a time. To try and do it on any broad scale basis will be very, very challenging. I think, though, what we can do is we can be very thoughtful about setting forth a conceptual framework for how one should consider setting nursing home payment rates with sort of a very strong rationale for why these types of principles, the types of principles that we identify, would make sense.

I'll look forward to our future work here because I think it's absolutely critical to the well-being of the

over 1 million Medicaid beneficiaries that are in nursing facilities today.

Thank you, Rob.

CHAIR BELLA: Thank you, Bill. Martha, then Brian.

COMMISSIONER CARTER: Thanks. Again, a wonderful presentation and a lot to think about. I agree with Heidi especially about linking -- understanding the link between payments and quality, and with Bill in terms of the need for transparency in payments.

I also want to take a step back and look at how payments, staffing in particular, because that's often the biggest expense, but how payments in general affect whether a nursing home exists at all. And I wondered if we have looked at nursing home per whatever the metric is, 100,000 people or 10,000 people over age 65. You know, where are there access gaps that could be serving Medicaid beneficiaries, but the facilities just aren't there at all? And why aren't they there? Because I think that's -- you know, we can focus just on the facility, but I think we also need to maybe take a broader look.

CHAIR BELLA: Rob, do you want to say anything to

that or just note it as you take everything back?

MR. NELB: Yeah, noted, and we have started work around issues on nursing facility closure, especially in rural areas, and we can think about that as part of this work as well.

CHAIR BELLA: Okay. Brian, you're up.

COMMISSIONER BURWELL: Thank you, Melanie. Rob, again, this is really excellent, and I agree with what everybody has said about they're definitely interested in pursuing this as a policy issue, and I look forward to your future work, which is always of very high quality.

I have three questions. One, did you look at the data by ownership status, for-profit versus not-for-profit, in terms of staffing ratios and quality ratings?

Two, I always get nervous when I heard the word "costs," because I wonder to what degree costs are a manipulable number, and how similar that metric is across Medicaid cost reports or whatever source of data we have, and since it relates to margins. It seems like nursing homes, like other health providers, are always trying to demonstrate low margins by somehow raising costs, at least on paper.

The third is more of a comment. Since I've been reviewing state ARPA HCBS spending plans quite a bit in recent weeks and months, you know, almost half -- a very large percentage of that money is going to increasing wages for direct care workers in HCBS. And many -- several states are doing it as a broader initiative to raise wages for both direct care workers in community-based services and in nursing homes. I think it would be worthwhile just to keep track of that as we do this work, and maybe do some analytical work after that, because wages for persons in the community are definitely going up, sometimes by significant amounts, and I don't know if that's having any impact on the nursing home labor market.

MR. NELB: All great points. I can comment on your first two questions. In terms of ownership, we did look at that, and for-profit facilities generally have lower staffing rates than other types of facilities. It's also true that high Medicaid facilities are also more likely to be for-profit, and so that's probably part of what's going on there.

And then, second, on your point about, you know, really understanding what's in the cost reports, that's a

really good point, and as we convene our technical panel, that will be one of the things we discuss. But the point that Bill raised about sometimes when a facility has -- maybe pays -- rather than paying staff directly but hires through an agency that is then associated with the nursing home chain, there may be some things that are sort of related party transaction, I think is one of those topics that gets at the concern you raised, where something that looks on a cost report like a staffing cost may not actually be going to the direct care workers themselves. And so we want to keep an eye on that.

CHAIR BELLA: Thank you, Rob. Thank you, Brian. Bob, did I see your hand, or Verlon? I missed somebody. I'm trying to play a game with myself. Bob, yes?

COMMISSIONER DUNCAN: Yeah, you did, but, one, I too am in support of moving forward with addressing this. And between Heidi and Brian, my questions or statements were handled. Some were on the payment, and the other was the question around the for-profit versus not-for-profit, so those questions have been answered.

CHAIR BELLA: Wonderful. Other Commissioners?

[No response.]

CHAIR BELLA: Well, Rob, I'll just reiterate where we started, which is there is a lot of interest here. It's incredibly important. The timing is important. I particularly would love to go in the weeds on some of the payment incentives and thinking about that and what we can learn. You know, I'm thinking about what Bill said, though, about having the conceptual framework. So, you know, we'll leave it in your capable hands to figure out the best way to bring it back, but do you have what you need in terms of interest, areas of interest? Are there any other sub-topics on here that you didn't get feedback on that you want to just make sure that we opine on?

MR. NELB: No, I think this has been really good and gives us a lot of areas to think about. I guess one question we'll think about as we take this back is sort of whether we think we're -- it makes sense to try to pull something together for a chapter in this cycle or maybe wait until we have some more of the payment info, like Bill's point about if we want to think about some larger payment framework or conceptual thing, you know, maybe it would help to have some of that payment information. But we'll think about what you all said and sort of what we can

bring back when, but definitely keep up our work in this area.

COMMISSIONER HEAPHY: This is Dennis. I -- I'm sorry.

CHAIR BELLA: No, go ahead, Dennis, and then I'm going to take public comment, Rob, before we let you escape. And it looks like Brian may have had a hand up again, too. Go ahead, Dennis.

COMMISSIONER HEAPHY: I'd like to find out if you have any information on the quality of the workforce, quality of life of the workforce, quality of the working environment, and how that might be connected to what's paid to the folks. I appreciate everything Brian and Bill and everyone said -- and Heidi, but I wonder about the quality of the work environment for folks, because I know people who are in skilled nursing facilities and right now they're really struggling. There's one in particular that is a really good facility, and the working conditions are really tough because of high staff turnover, not enough staff. One friend of mine is actually in -- doesn't get out of bed much anymore because there's just not enough staff to get her out of bed. So these are the types of issues that the

facilities are -- that good facilities are facing and the impact on folks that are living in the facilities. Like, for me, the quality of life is also important in terms of the quality of -- like retaining the workforce.

MR. NELB: Good point, and yeah, we do have some new data on staff turnover, and we can think about how to incorporate that in our future work.

CHAIR BELLA: And I would just say I know we review policies, which is super important, but at some point making sure we're actually talking to some states and some CMS folks to make sure we're understanding those policies. Maybe they did and I just missed that, but we have plenty of time. Plenty of work to do in front of us.

Brian, did you have a hand? And then I'm going to go to public comment.

COMMISSIONER BURWELL: Yes, so there is one more policy lever that I've always found very interesting in that the state of Minnesota has a state law that nursing homes cannot charge more on private-pay patients than they get from Medicaid. So there's price equivalency both across private-pay patients and Medicaid patients, and that creates some interesting dynamics around incentives, and it

also creates more political pressure from the nursing home, and, you know, you have Medicaid rates that are viable to keep the facilities open. And I just find it a very interesting policy. I don't know if we can do anything, and that's one state. I don't know if -- to what extent we could extrapolate from what's going on in Minnesota, but I would just find the findings in Minnesota to be of particular interest to me.

COMMISSIONER SCANLON: If I could just note that North Dakota is another state that does it. You might expect it next from Minnesota, and actually, North Dakota in Rob's work was one of the outliers on one of the dimensions. I can't remember which one. And I thought it might be associated with that equalization law.

COMMISSIONER BURWELL: It was high-quality percentage with high-quality nursing homes.

CHAIR BELLA: Okay. Thank you both.

I'm going to open it up for public comment now. Many of you know this drill, but if you'd like to make a comment, please indicate with your hand icon, and we will recognize you.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: I can always tell when it's a Friday afternoon because our numbers start dropping off a little bit. Nothing personal, Rob.

All right. It does not appear that we have any comments.

COMMISSIONER DOUGLAS: I was going to say one other thing, just to Rob, around when it kind of goes back to our directed payments discussion, and it really hits. You know, nursing facilities have some of the highest, as we look at fees and quality payments, as you examine just looking at how that plays out and those implications that are paid by the nursing facilities and kind of how that drives the ability to truly drive what we're talking about around staffing and quality, so it's just an area to look at.

CHAIR BELLA: Thank you, Toby.

Any last comments from Commissioners?

[No response.]

CHAIR BELLA: All right. Rob, thank you. We'll look forward to having you come back.

Okay. We are heading into our final session.

We're going to round out today with access monitoring and next steps and be sure we're really clear with all that we've heard, both yesterday and then prior meetings.

Ashley, welcome. Martha and Linn must be somewhere. I can't see.

Kisha is going to moderate this. So, Kisha, I'll turn it to you.

VICE CHAIR DAVIS: All right. Thanks. Welcome back, everybody. This is our final session of the afternoon. So we are saving the best for last here.

I want to turn it over to Ashley, Martha, and Linn to step us through.

NEXT STEPS ON ACCESS MONITORING

* MS. SEMANSKEE: Thank you so much, Kisha. Thank you, Commissioners, and good afternoon.

As you know, this cycle we've been discussing, how to design a system to monitor access for Medicaid beneficiaries. In October, we had a panel on data availability for monitoring access, and yesterday we heard from a panel of stakeholders on design and implementation considerations for a monitoring system.

Today we are focusing on tying these threads

together, and the Commission will have a chance to weigh in on the goals and key elements of an access monitoring system. We thought it would be good to start the discussion at this meeting to inform staff members as we come back at later meetings with a sketch of a more robust monitoring system as well as potential policy options.

So we'll start today, as I mentioned, by discussing the goals of an effective access monitoring system -- let me just go back one slide; there we go -- based on Commission discussion to date as well as findings from a literature review and stakeholder interviews with states, CMS, beneficiary advocates, plans, and providers.

Then we'll discuss the key elements of an access monitoring system. Feedback on whether these are the correct elements and how to think about certain design and implementation considerations will help focus staff efforts going forward.

In terms of the goals for an effective access monitoring system, we heard that access measures should be meaningful for beneficiaries and also actionable for states and plans so as to identify problems and make meaningful changes to improve access. We also heard that monitoring

should use a common set of measures that are comparable across states and delivery systems and encompass both acute care and long-term care, particularly home- and community-based services.

The Commission has also said that effective monitoring should be timely, although we also heard that a state system will be more likely to capture data in real time compared to a federal system. Even so, monitoring should prioritize simple measures that could be collected in a timely manner to detect problems and intervene appropriately.

Commissioners have also emphasized that an effective monitoring system should be efficient and minimize administrative burden, whether through the use of federal data sources or by building off existing systems and data, wherever possible.

We also discussed how effective monitoring should be adaptable and allow for updating over time, including dropping measures that are no longer useful and adding new elements as they become available.

Now we'll discuss some of the key elements of an access monitoring system, starting with the access measures

themselves.

In October, we discussed how a comprehensive system should measure access across three domains to get a complete picture of access, and Karen LLanos also mentioned these yesterday in her remarks. These domains include provider availability and accessibility, which measures potential access, including provider supply, provider participation in Medicaid, and accessibility, which may include language access, physical accessibility for those with disabilities, and wait times for care.

The second domain is beneficiary utilization or realized access. It would include service use, the appropriateness of these services, and health outcomes. As we have heard, it's important to stratify this data by race and ethnicity in order to monitor access for groups that have been historically marginalized in order to reduce disparities and improve health equity.

The last domain is beneficiary perceptions and experiences, which includes patient experience, barriers to care and unmet need, culturally competent care, and perceived quality of care.

In October, we discussed the data available

across each of these domains, gaps and limitations as well as potential solutions to fill the gaps. As a refresher from that discussion, we heard that T-MSIS is the main source of service use data but has some limitations in terms of reliability, missing race and ethnicity data, as well as consistent definitions of services and providers that limits comparability across states and populations.

We also discussed the need for better data systems to monitor beneficiary experience, as existing administrative data does not capture unmet need, barriers to care, or beneficiaries' perceived access to care, and grievances and appeals information may not be aggregated and transparent or representative of general experiences.

Yesterday we also heard from panelists about the roles of different stakeholders and the design and implementation of an access monitoring system. Decisions will have to be made about the federal, state, and plan roles and responsibilities in such a system, including who should lead the design of a system and who should take on different roles in the implementation process. These roles may include the selection of access measures, benchmarks for adequate access, data collection, and a calculation and

analysis of access measures.

We also heard that stakeholder engagement is very important in the design of a monitoring system, particularly engagement with states, beneficiaries, plans, and providers. Engaging stakeholders can help ensure that access measures are meaningful for beneficiaries and also feasible for states and plans to collect.

Stakeholders also noted the importance of transparency throughout the implementation process, including making results of monitoring available to the public in a consumer-friendly format.

There are several design considerations for access monitoring that the Commission may wish to weigh in on, including considerations around implementation process and timeline, including how to phase in a more robust monitoring system over time, how to select access measures and set benchmarks for adequate access, and how often access measures should be reported.

Given limited state and federal capacity, a monitoring system will also need to prioritize populations and services to monitor, and the Commission may wish to weigh in on these priorities.

We heard yesterday that one way to prioritize may be to focus on areas with known access issues or where existing data is already available. Stakeholders have suggested prioritizing services for which Medicaid already plays an important role, including pediatrics, behavioral health, maternal health, and long-term services and supports.

Finally, implementing additional data collection for monitoring may be costly, and decisions will need to be made about whether the federal government or states should bear the additional cost of resources needed.

In terms of next steps, in January, staff plans to present a sketch of what a more robust access monitoring system would look like based on the goals outlined today and the Commission discussion, and we may also introduce potential options for such a system, including a core set of access measures across acute care and long-term care, a focus on further standardizing T-MSIS data for comparison across states, or a survey to capture beneficiary experience with care.

Commissioner feedback on the goals and key elements of an access monitoring system that we discussed

today, including which features are most important and how to weigh those different design and implementation decisions as well as priorities for access monitoring would help focus staff efforts.

With that, I'll turn it back over to the Commission.

VICE CHAIR DAVIS: Thank you, Ashley, and thanks to the staff for this right now, this session, and really over the course of this year. We've been spending a lot of time on access monitoring in the panels and conversations that we've been having, both in September and October, and have really helped to kind of lead us to where we are now.

I think the way we'll approach this is around the overall goals, and then looking at some of those design elements, there are some key decisions for us to make that will help guide as we craft that ideal model for them to help us build in January.

One thing that I did just want to say when we were talking about the goals -- and maybe we can go back to that slide. The one thing that I didn't see there is equitable and how the goals of an access monitoring program -- and we mention it when we talk about beneficiary

utilization but really across the board is that making sure that the access monitoring is getting us to a more equitable place, and so how that thread runs through all of the monitoring that we're doing. So I just wanted to bring that in for consideration.

Then we'll open it up to other folks, either specifically on some of the goals that they have listed on access monitoring or the other key design elements.

Yeah, Brian, and then Heidi.

COMMISSIONER BURWELL: I had to miss part of the session yesterday, so I don't know if this came up, but I think we need to be very aware in measuring access to HCBS services, about the impact of the pandemic on HCBS populations.

During the pandemic, many direct care workers left the workforce, did not want to go into people's homes, et cetera, and for IDD populations in which often people live at home but then go to day programs during the day, those day programs stopped operating, and people stayed at home all day long.

States were able to apply under Appendix K for retaining payments. So a lot of providers were being paid

for services that they actually did not provide but as a way to keep them whole during the pandemic. So both direct care, personal care attendants, and persons in a lot of day programs for IDD populations were just paid lump sums based on their historical utilization.

So any, I think, analysis of T-MSIS data during the public health emergency, we have to be acutely aware of that in regard to whether people were actually accessing and utilizing services. As we come off the public health emergency, I think we really need to track when those retainer payments stop and when actual utilization is getting measured.

VICE CHAIR DAVIS: Thank you, Brian.

COMMISSIONER BURWELL: Make sense?

CHAIR BELLA: Heidi.

COMMISSIONER ALLEN: Yes. Thank you.

So my thoughts over the last couple months have really coalesced around a couple of things: one, the need to have a CAHPS, a regularly administered CAHPS survey to get at beneficiary experience, and I would add experiences of discrimination in health care in that as we're trying to assess equity; second, to improve race ethnicity in T-MSIS

and the cost of T-MSIS so that researchers can actually use it to really build an evidence base; a denominator for access. So that wouldn't be captured by T-MSIS or by a CAHPS, but out of your patient population, what is the standards of care that we all agree on should happen every year, and who is not getting that? If you have populations like people with mental health disorders or substance use disorders, are they having any treatment? I think just some of those very, very basic questions would be very helpful.

Then this is a little random, but I've been thinking about this a lot, which is if Build Back Better does expand Medicaid, expand Medicaid through marketplace, who owns that population? Who will be looking at their access to care? It's a very interesting counterfactual to Medicaid, because my understanding is that the cost sharing will resemble Medicaid and that there won't be deductibles or copayments or coinsurance, but that the provider payments will resemble marketplace.

I know from my own research, it's considerably higher, and so it's a counterfactual for the way that we pay people and the way that other providers pay for them in

terms of access. But I have no idea who and what data is going to be used to assess the care that they're receiving and whose domain. If it's not MACPAC, it's not MedPAC, whose domain is it to make sure that this population that looks exactly like our Medicaid population is getting the care that they need and what the quality of that care is? So I just wanted to throw that out too.

Thanks.

VICE CHAIR DAVIS: Thank you, Heidi. That's a great point for us to kind of keep our eyes on.

Maybe we can march forward a couple slides -- oh. Yeah, go ahead, Stacey.

She's going to march through a couple slides to the design elements.

COMMISSIONER LAMPKIN: I'm sorry, Kisha. Did you call on me?

VICE CHAIR DAVIS: Yeah, go ahead.

COMMISSIONER LAMPKIN: Okay, thanks.

I'm not exactly sure this fits, but I think it fits in the context of comparable and how we think about the structure. I mean, it stems from some conversations I've been having with people, based on the work that

they're doing or expressing a lot of concerns about the medical provider workforce too and the stress that that workforce has been under and the number of retirements and practice closures that are happening and just general capacity stresses there and asking them to do more at the same time around social determinants development and some of the other initiatives that are going on.

So, thinking about that and the variability from state to state with provider scarcity or workforce stress, is it important for this framework to think about relating access statistics, not just comparing states with other states, but across payers and relating the access measures to overall workforce scarcity in the geographic area or the regional area? I don't know exactly that it's this, but it seems like there's some kind of underlying baseline there that needs to be brought into the conversation in some way.

VICE CHAIR DAVIS: Thanks, Stacey.

Other comments as we think about the different key elements around access measures? Actually, if we can go back to that one.

Yeah, Laura.

COMMISSIONER HERRERA SCOTT: Well, besides what

everyone said around access but thinking about telehealth and how will we count that for access, if it's not given locally but still provided as a service; for example, that's one. Then access thinking about -- and I know the taxonomy will have to be decided, but how are we going to do that -- urban, suburban, rural -- because the criteria that we're measuring access, unless we're doing it at the population level, 10,000 per 100,000, will the measures look different, depending on the taxonomy we use to define access geographically?

VICE CHAIR DAVIS: Thanks, Laura. That's a great point as we're thinking about access and where telehealth fits into the bigger picture.

Other comments around access? If not, we'll move on to responsibilities.

Darin and then Tricia.

COMMISSIONER GORDON: Thanks.

I'm just thinking about the long-term care aspect of it, and the area that I continue to struggle with is home-based care and how to measure that effectively. At times, I think about electronic visit verification, but then that won't capture the folks where the individual

didn't go to the home at all. I feel that's the one I struggle with the most, one, because Medicaid is the principal payer for those types of services, so there's not a proxy for which we can leverage, but I do think that's an aspect of all of this that is probably, from my perspective, one of the harder ones to wrap our heads around, and it's obviously one that's growing precipitously and is only going to continue to grow with the direction where everything is headed, whether it's Build Back Better or just consumer choice.

So I do think that's an area, that as I look at these three areas, I think the only thing that really truly captures it is the beneficiary perception and experience.

I'm sure, Ashley, you all have given it some thought, but that's one that I have yet to figure out what is a good accurate measure in that particular delivery model.

VICE CHAIR DAVIS: Thanks, Darin.

Ashley, I don't know if you had any response to that on what you guys might have looked at already.

MS. SEMANSKEE: I would just agree that I think we also heard from Dr. Caldwell in October that the only

way to really get at access for HCBS is to ask beneficiaries directly. So either using beneficiary surveys or other ways to engage with beneficiaries is probably the best way to measure access.

COMMISSIONER GORDON: Yeah.

I would add just one other that I'll just throw out there, although I just don't know how you get a geographic perspective, but it is authorized hours versus served hours. I just don't know how you -- I don't know if the data sources are really conducive at this point. So I don't know if the state has that ready visual map that we share. I just throw that out.

VICE CHAIR DAVIS: Tricia, I saw you. But, Heidi, were you jumping into this point?

COMMISSIONER ALLEN: Well, I'm jumping in the point about beneficiary experience, which is I just wanted to emphasize something that we heard earlier today that totally matches my experience as a researcher, and that is that this misconception that beneficiaries don't want to talk to us, that they don't want to engage, it really is a misconception.

There is a fact that people bring up that

response rates are low in Medicaid surveys, and that is true. But that's generally because people move around, and it's really hard to find people. Once you find them, people want to talk. They want to tell you their experience. They want to say what's working. They want to say what's not working.

I know this from personally leading studies where we've interviewed thousands of people, and I think it's just this huge untapped resource that we have not figure out how to do. And I think that that myth that, like, "Oh, well, they don't really want to" just gets in the way all the time, when really it just takes a little extra effort to find people. But once you find them and once you tell them what you're there for, I found that they're very, very eager to tell you what's going on.

COMMISSIONER GORDON: I'd just say on that point -- Kisha, I just want to follow up on Heidi's point -- is that we've been doing beneficiary surveys since the beginning of the TennCare program, so I agree with your point.

I think the challenge is what I don't think most of those things have not really looked down to more

discrete geographic areas. They're more broad-based when they're doing their sampling across the entire state.

When I think about administering a program and understanding where my gaps are, I need -- for like this purpose, I need more discrete surveys to get into the smaller communities so I know where the true gap is, and I think that would take -- even though we've been doing beneficiary surveys for decades, it would have to amp up in order to get a sufficient, I think, number of folks so that we could actually look in and say, "Okay. Here's a gap in this particular community for these types of services," and that's something I think I haven't seen a lot of folks do up to this point.

COMMISSIONER ALLEN: Just to respond to that, for the Oregon Health Insurance Experiment, we had names of people. So we had to find very specific people, which is very different than the sampling strategy where you just pull names out of a hat. Really, the biggest challenge was just finding out where they are.

It seems so silly, but people move. They move a lot, and then mail delays and return addresses and numbers that are wrong, they change phone numbers. Those are the

kind of things that I think make it really hard when you're trying to say, "Okay. I need to talk to a diabetic who's used the emergency department in the last six months," which is at some point how we did our qualitative sampling is we looked very specifically for people who had had very specific experiences, and it's having a very sophisticated tracking program, which I actually think would benefit Medicaid beyond beneficiary experience.

It would benefit so much on churn if we could figure out how to stay in touch with people in a way that they knew how to contact us, and we knew how to contact them. I think that that would do a ton for relationships and the program at large, and to your point, to be able to find specific people to ask them specific questions like, "Why did you go to the emergency department? Were you able to get in touch with your provider?" Those kind of questions really matter when you're trying to design specific programs, but you need to be able to find people.

VICE CHAIR DAVIS: That's a great point in terms of beneficiary experience, getting really down to the nitty-gritty and not just taking that kind of surface level, easy to find folks if you're really going to be

measuring that disparity.

Tricia and then Dennis.

COMMISSIONER BROOKS: Yeah. I know we've talked a lot about the beneficiary experience, but I just want to echo Heidi's comments. She's mentioned a couple of times deploying a federal CAHPS.

When I was CHIP director in New Hampshire, we did, every other year, studies of recent enrollees, established enrollees, disenrollees. That was our best sources of information about ways we could improve the program.

We're currently involved in a project that is gathering lived experiences of Medicaid beneficiaries, and they are willing to talk, particularly if they know that what they're going to share with you is something that is going to be used to try to improve the programs for their benefit. So I just want to echo all of that. I think that has to be at the top of the list. Having effective access measures in terms of the beneficiary perceptions is really key.

VICE CHAIR DAVIS: Thanks, Tricia.

Dennis?

COMMISSIONER HEAPHY: Yeah. Something we haven't discussed today is linguistic access, measuring access by languages, and I'm wondering, Ashley, if you have thoughts on that.

MS. SEMANSKEE: I think we heard in a lot of our interviews that that is something that's really hard to measure for states and plans. Some plans track access to interpreters, but that is one of the gaps in this provider availability and accessibility domain.

COMMISSIONER HEAPHY: So I'm wondering if that might be something that we note and address. It's a major issue that we grapple with and all states grapple with, which language to make accessible or available to folks. Is there any way to use as proxy data with hospitals that provide linguistically to see about at least hospital access?

MS. SEMANSKEE: I think that's something we can look into and bring back in future meetings.

COMMISSIONER HEAPHY: Thanks.

VICE CHAIR DAVIS: Thanks, Dennis.

Let's move here to the next one and talk a little bit about roles and responsibilities and where the

responsibility lies. Does anybody have any thoughts or comments here as we think about those, the differentiation between federal and state roles?

Yeah, Heidi.

COMMISSIONER ALLEN: I mean, I really feel like there is a federal role in this, and I think that that's probably where the CAHPS is. I think that when it's state-administered, from a research perspective, it's just super hard to get a multi-state agreement in place. It's hard enough to build relationships with one state, but to build relationships with multiple states, it's just incredibly different, and yet that really is -- you have kind of two ways of comparison. You have within state and you have across state, and both of those are just so important to give some sense of benchmark of what you should expect to see.

So I just want to say that even though I know in a lot of surveys states -- I think that we should definitely consider how to let states create questions that they would want to add to a federal survey. They do that for PRAMS. They do that for BRFSS. There's so many examples of states coming up with their own priorities and

adding a module related to what they want to know, but having a core set of indicators that every state uses, I think, is just so important.

COMMISSIONER HEAPHY: I just have a clarifying questions for Heidi. Heidi, when you say CAHPS, are you also thinking HCBS CAHPS?

COMMISSIONER ALLEN: Yeah, but what it's specific to. I mean, so there is HCBS CAHPS, but there was one adult Medicaid beneficiary survey that was conducted in 2016. It hasn't been done since then, and that's more what I was thinking.

VICE CHAIR DAVIS: Yeah. Go ahead, Anne.

EXECUTIVE DIRECTOR SCHWARTZ: I think we're going to need to change our nomenclature because the federal survey was called "CAHPS," but it's not the CAHPS that plans administer routinely. So we can think about anothername fora Medicaid beneficiary survey, which captures the beneficiary experience for both acute care and long-term services and supports, and then we can get rid of this confusion around using the word "CAHPS."

VICE CHAIR DAVIS: Thanks, Anne, for helping us clarify.

Tricia.

COMMISSIONER BROOKS: Yeah. So there is a huge federal role, I think, from two perspectives. One is that more of the Medicaid dollar comes from federal taxpayer dollar, and so we have to be good stewards of making sure the program is effective and is meeting its goals.

Secondly, just for consistency across the board and comparability, you know, there's hope that at some point, T-MSIS would be a good source for compiling or calculating the core set measures so that they're all done consistently, and we know that we're comparing apples to apples. I think that's another prevailing reason to make sure that the federal government has a role in this.

VICE CHAIR DAVIS: Go ahead, Darin.

COMMISSIONER GORDON: Yeah. I do think the federal government has a role, but I want to just add a voice that the states are the administering entities. That's the design of the program, and they need this information in a way, that to fill some of the voids and the gaps that they feel they need to adequately administer the program.

I totally agree the federal role has always been

there or should always be there, I should say, but I don't think it should be in lieu of states. Hopefully, if the feds took a certain approach that it isn't getting in a situation where states then stop doing some of the things that they were going to do and just be deferential, I don't think that's particularly helpful in doing this.

But I just want to emphasize I do think that if there are issues that certain states are doing, not doing certain things that are considered best practices, I think setting those standards of expectations are necessary. Unless we're going to fundamentally redesign the program, states do administer this, and so they should have a role as well.

VICE CHAIR DAVIS: Yeah, a great point. Thank you, Darin. Thank you, Tricia.

Anybody else on this kind of roles and responsibilities?

COMMISSIONER JOHNSON: I'll just go ahead and say I'll echo what I think everyone else said about the feds having a role here.

Then to Darin's point, what I got from a sense of Karen LLanos' remarks yesterday is the role that they're

playing to get that feedback and those ideas from states but also through the RFI, the larger community. So I feel like that's in place, but I definitely think -- as I think about what Monica said earlier today, with the feds really starting out with the language and being able to trickle that down with insights, I think that's really more helpful than them not really having a large role to begin with. So I would say that they need to have that role.

VICE CHAIR DAVIS: Thanks, Verlon.

I think that what I would add here is just alignment as we start to kind of do more measurement and reaching out to beneficiaries more directly and making sure that those surveys are aligned and folks aren't getting hit with the state survey and the MCO survey and the federal survey and really just being intentional on who needs what data and what can be shared and not feeling like the beneficiaries are continuing and willing to be surveyed, surveyed, surveyed.

Well, let's transition here to talk a little bit, if anybody has comments, on the key design elements, which was more of our focus of the conversation from yesterday.

[No response.]

VICE CHAIR DAVIS: I'm not seeing many hands. We had quite a bit of time to talk about this yesterday, so there may not be anything additional to add.

Any other comments overall before we start to wrap this session as we're thinking ahead to January?

[No response.]

VICE CHAIR DAVIS: All right. Ashley, Martha, Linn, any other questions from the Commissioners? Do you feel like you have good direction going into kind of shaping out a strawman for us?

MS. SEMANSKEE: Yes. I think we have what we need. Thank you so much.

VICE CHAIR DAVIS: All right. Thanks, everybody.

I will turn it back to you, Melanie, to close us out.

CHAIR BELLA: Thank you, Kisha.

We'll give it one more shot to see if anybody would like to make public comment on the access monitoring discussion. We'll pause just a second to see if anybody raises their hand.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: I do not see anyone.

All right. Any last comments, questions about anything we've discussed over the last couple of days from Commissioners?

[No response.]

CHAIR BELLA: No. Everybody is busy and tired in the month of December.

Well, thank you, everybody, for being so engaged, as always. Thank you to the staff and to Jim behind the scenes and to Anne.

And for those of you in the public who did not hear our announcement at the outset, we are happy for Anne but sad to be saying we'll be recruiting a new Executive Director, that the press announcement went out on that effect. The job is posted on the MACPAC website. We will be engaging a formal search firm, but people that are interested should not hesitate to go ahead and submit a resume through the website or to reach out to one of us.

With that, I think we are a wrap for our December session.

Anne, anything you want to say?

EXECUTIVE DIRECTOR SCHWARTZ: No, thanks. I hope

everyone gets some time off, and we'll see you in the new year.

CHAIR BELLA: Yeah. On that note, our January meeting is January 20th and 21st. We will continue to be virtual for January, still working on return to in person, hopefully, in '22, but for January, we'll keep it virtual.

Thank you, all. Enjoy your weekend. Enjoy your holidays, and we will see you back in January. Bye-bye.

* [Whereupon, at 2:14 p.m., the meeting was adjourned.]